

**EVALUATING EFFECTS OF LOCAL-LEVEL OUTSIDE GOVERNMENT  
GENDER BUDGET INITIATIVES IN MATERNAL HEALTH  
AN APPLICATION OF THEORY-BASED EVALUATION, PROCESS TRACING AND A  
QUASI EXPERIMENT IN KABALE, UGANDA**

PROEFSCHRIFT VOORGELEGD TOT HET BEHALEN VAN DE GRAAD VAN  
DOCTOR IN ONTWIKKELINGSSTUDIES AAN DE UNIVERSITEIT ANTWERPEN

SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF  
DOCTOR IN DEVELOPMENT STUDIES AT THE UNIVERSITY OF ANTWERP

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Doctoral dissertation

ISBN: [arranged by Katleen van Pellicom]

Depot number: [arranged by Katleen van Pellicom]

This research was funded by a Ph.D. grant of the Flemish Interuniversity Council (VLIR-UOS) – ICP Ph.D. 2012 -010 and VLIR-UOS via the HEFS Platform Harvest Call (ZIUS2016VOA0902).



Dedicated to my late parents, Ruth and Yosiya Bamanyaki and Rev. Canons Mabel and Ernest Katahweire. Am sure you would have been proud.



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## LIST OF ABBREVIATIONS

AMREF	African Medical and Research Foundation
ANC	Antenatal Care
BFP	Budget Framework Paper
CBGA	Centre for Budget Governance and Accountability
CEDAW	Convention of the Elimination of all Forms of Discrimination Against Women
CEHURD	Centre for Health Human Rights and Development
CSBGAG	Civil Society Budget Advocacy Group
CSDH	Commission for Social Determinants of Health
EmOC	Emergency Obstetric Care
FOWODE	Forum for Women in Democracy
GAD	Gender and Development
GRB	Gender Responsive Budgeting
GSDRC	Governance and Social Development Resource Centre
HIPC	Heavily Indebted Poor Countries
HLG	Higher Local Government
HSDP	Health Sector Development Plan
ICPD	International Conference on Population and Development
IDS	Institute of Development Studies
LGDP	Local Government Development Plan
LLG	Lower Local Government
MDG	Millennium Development Goal
MKSS	Mazdoor Kisan Shakti Sangathan
MMR	Maternal Mortality Rate
MoFPED	Ministry of Finance Planning and Economic Development
MoGLSD	Ministry of Gender Labour and Social Development
MoLG	Ministry of Local Government
NDP	National Development Plan
NGO	Non-governmental Organisation
NPA	National Planning Authority
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PWDs	People with Disabilities
TAIs	Transparency and Accountability Initiatives
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UDN	Uganda Debt Network
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM/UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UN-JPGE	United Nations Joint Programme on Gender Equality
UNMHCP	Uganda National Minimum Health Care Package

UNRISD	United Nations Research Institute for Social Development
USAID	United States Agency for International Development
VHT	Village Health Team
WHO	World Health Organisation
WID	Women in Development
WRA	White Ribbon Alliance





## ACKNOWLEDGEMENTS

The past four years have been the most challenging, as well as rewarding years of my life. I embarked on the PhD journey with the intention of making it an experience where I would learn new things. With my economics and finance background, I decided to focus on gender and maternal health and apply uncharted evaluation methodologies – process tracing, which I combined with quantitative methods. All of this required extensive reading of new concepts, which at times caused me to question the torture I had brought upon myself. It gives me pleasure to reach the end of this journey in shortly over four years. All this has been possible because of the support and encouragement of the people who surround me.

I am truly indebted to VLIR-UOS for the funding I received, first as a student of the Master in Development Evaluation and Management course, followed by this PhD under VLIR-ICP project (ICP Ph.D. 2012-10). I am also grateful for the additional funding I received from VLIR-UOS via the HEFS Platform Harvest Call (ZIUS2016VOA0902), which is managed by the Epidemiology for Global Health Institute of the University of Antwerp.

I am very grateful to my supervisors Prof. Dr. Nathalie Holvoet and Dr. Henry Manyire for your unreserved supervision throughout the four years. I am especially thankful for the confidence you placed in me, by allowing me to explore new methodologies and decide on the direction of the thesis. I also thank you for being patient with me when I failed to meet some deadlines. I must say it was an honour to work with both of you and would appreciate the opportunity to work with you again.

I thank the members of my jury, Professor Maria Bustelo, Professor Babara Befani, Professor Kristien Michielsen, Professor Nadia Molenaers and Professor Danny Cassimon for taking the time to read my very long first draft of the thesis. I am thankful for the constructive criticism I received, which I believe has improved the thesis. I take full responsibility for any errors that remain and hope to improve on them in future studies.

I am also very grateful to the management and staff of FOWODE National office and Kabale Programme Office. Special appreciation goes to Mrs. Patricia Babiiha and Mr. Julius Mukunda for accepting me as an intern at FOWODE for three months, which helped me learn a lot about gender budgeting and civil society work in the Uganda context. I also thank Florence at the FOWODE Kabale office, for working tirelessly to provide me with all the documents I needed. Thanks go to the district officials and district councillors of Kabale District Local Government, district officials of Kanungu District Local Government, health in-charges and staff, local leaders and community members in Kabale and Kanungu, for providing me with information used in this study. In a special way, I would like to recognise the 500 mothers we interviewed, each of who sacrificed a day off from their work routine to wait for my enumerators at home.

I thank my team of enumerators, Doreen, Pross, Leo and Emmanuel. It was pleasurable working with you. You pushed yourselves to complete the data collection in the scheduled period, despite the rough terrain and unfavourable weather. I was humbled when we got stuck in the field in Kanungu and had to spend the night in the car. You offered to carry on with data collection the following day ensuring that our schedule was not affected. I thank the Village Health Team members for compiling the village population lists and guiding my enumerators to all the selected households.

I thank the professors at IOB who have guided me while here. I regret that I did not participate much in social events while at IOB; not because I did not want to, but I felt pressured to maximise my time here and take advantage of less distraction to complete the Ph.D. I also thank friends who have been there for me in different ways. In a special way, I thank Katrien and Robin for making my stay in Antwerp smooth. Each time I came, you always provided me with the household items I needed and also occasionally prepared meals for me, which I enjoyed. I also thank Katrien, Allelie, Loresel, Janvier, Kelbesa, Francis, Tri, Miet and Christian for the guidance you gave me during my moments of confusion. You always accommodated me even when you were very busy and your encouraging words gave me resolve I needed to carry on. I also thank Christina, Jolino, Patterne, Janus, Dimitri, Frank, Klara, Lisa, Sara D., Sara G., Mollie, Dennis, Els, Liesbeth, Frédéric, Greet Hans, Katleen, An, Jöelle, Nicole and all other staff at IOB, who I may have omitted. I appreciate you all.

To My friends from ACF, who I consider to be my second family in Antwerp, thank you. Your prayers and support encouraged me. I also enjoyed the lunches, picnics and other fun outings we shared. Special thanks go to Lolita, Titabel, Jannic, Ana, Nadine, Edward, Fiona, Sassie, Landa, Yessika, Lheonie, Abraham, Kelly, Rhani, Nicole, Coleen, Khan, Melvin, Hide, Rie, Wim, Evi, Joseph, Dinah, Cynthia and Ben. I also thank Nahom for making sure I took breaks off work to relax. I look forward to hosting you all in Uganda someday.

I would also like to recognise some people I consider to be my mentors, professionally as well as in other aspects of life. Special thanks go to Prof. Muhindo for the advice I received while writing the proposal for this PhD, Eng. Dr. Seith Mugume, Mr. Andrew Obara and my dear friend Aisha Samula. You all challenged me to be critical and analytic in thinking.

Lastly, but by no means the least, I thank my family members who have cheered me on for many years. I am deeply grateful to Mr. and Mrs. Bamwesigye (mum and dad) for seeing me through school and for shaping me into the person I am now. I thank Uncle Yusuf and Aunt Idah, Uncle Arthur and Aunt Lillian and other aunts and uncles who took up the role of my parents. You have been very instrumental in my life. I thank my sisters and brothers, Doreen, Stella, Florence, Ben, Bruce, Byron, Benon, Brian, Barnabas and all my in-laws, nieces and nephews. Stella, I am especially grateful to you for managing my affairs whenever I was away from home. May God bless and reward you all. In him I trust.

## ABSTRACT

Although decades have witnessed the implementation of numerous interventions to improve maternal health outcomes, maternal mortality remains a pronounced problem, particularly in Sub-Saharan Africa and South East Asia. Growing literature acknowledges that maternal morbidity and deaths are not just a consequence of biological factors, but also structural, socioeconomic and cultural factors. Inequalities within societies, communities and households affect the access and use of maternal health care among women, leading to undesirable maternal health outcomes. Various studies also link undesirable maternal health outcomes to poverty and gender inequality.

Since the 1990s, gender responsive budgeting has emerged as a popular tool for governments to meet their commitments towards gender equality, women's empowerment and the realisation of women's rights. Proponents advance that gender responsive budgeting enhances state responsiveness through the careful consideration of the impacts and implications of policies, programmes and budgets on women, men, boys and girls belonging to different social groups, when taking decisions about public expenditure and revenue generation. Gender responsive budgeting ensures that the available resources are allocated in a way that prioritises social groups with the most need. Despite two decades of implementation, limited empirical evidence exists of the efficacy of gender budget initiatives. Widely accessed literature is mostly policy- or practitioner oriented and reports results at national level. Intrigued by the high maternal mortality rates in Uganda and the potential posed by gender responsive budgeting, this research focuses on an outside government gender budget initiative at local government level and investigates the broad question "how and to what extent do local-level outside government gender budget initiatives in health influence gender-responsive service delivery and the use of maternal health care services by rural women of reproductive age?" The research utilises the case of the Forum for Women in Democracy (FOWODE) gender budget initiative in Kabale, rural Uganda.

A sequential exploratory mixed methods approach is adopted to answer three central questions which draw from the broad research question. In light of the limited empirical evidence, the research starts with a qualitative phase, which integrates theory-based evaluation principles with theory-testing process tracing to develop a programme theory and causal mechanism of how local-level outside government gender budget initiatives may influence gender responsive maternal health service delivery and the use of maternal health care among rural women. The case-specific theorised causal mechanism is then tested using formal Bayesian logic to update our confidence in the claim that the FOWODE gender budget initiative contributed to the observed changes in gender responsive maternal health service delivery and use of maternal health care among rural women of Kabale District. The findings from the qualitative phase are also used to inform specific research questions for the second quantitative phase of the study,

which investigates the effects of outside government gender budget initiatives at household level. A quasi-experiment was conducted in three research sites: a treatment sub county with direct exposure to the outside government gender budget initiative at grassroots level; a control sub county in the same district as the first, but without the outside government gender budget initiative (indirect exposure) and a second control sub county with no outside government initiative at all (no exposure). A total of 500 recent mothers of children aged three years and below were interviewed.

The empirical evidence evaluated using Bayesian logic made us more confident than not in the claim that the outside government gender budget initiative contributed to gender responsive maternal health service delivery in Kabale. Relating to the demand side, the effects of the outside government gender budget initiative at grassroots level were restricted to sensitisation of communities (mostly women) on maternal health services, rights and entitlements. Women with direct exposure to the grassroots level outside government gender budget initiative were significantly more knowledgeable than those with indirect exposure and no exposure at all. Knowledge of maternal health services, rights and entitlements was found to be significantly associated with the utilisation of four or more prenatal care visits, but not delivery at a health facility, delivery assisted by a skilled birth attendant, nor postnatal care attendance. Our findings suggest that gender responsive budgeting should be combined with other maternal health interventions for enhanced results.

## **CHAPTER 1:**

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### **POSITIONING THE STUDY**



## INTRODUCTION

This mixed methods impact evaluation research explored the contribution of outside government gender budget initiatives towards gender-responsive maternal health service delivery and the use of skilled maternal health care by rural women at local government level. Examining a case of Kabale District, south-west Uganda, the study sought to understand the objectives, activities, processes, mechanisms and outputs of local-level civil society-led gender budget initiatives in the health sector, followed by an assessment of the impact of such initiatives on the supply of and demand for gender-responsive maternal health care by rural women. I underscore that civil society gender budget work does not, by itself, cause gender-responsive maternal health service provision and the utilisation of skilled maternal health services, but is an important catalyst to stimulate responsive action from duty bearers in government as well as citizens so as to yield the anticipated effects. On the basis of this, I position the study to evaluate the contributory effects of local-level civil society gender budget initiatives on maternal health service delivery and use, while noting the efforts and achievements of other players in the health sector.

I begin this chapter by discussing the central issue inspiring the study – gender responsive budgeting as a necessary intermediate solution to addressing maternal health challenges – followed by a contextualisation of the central issue broadly and specific to the Ugandan case. Next, I discuss the research objectives and questions, followed by the rationale, significance and limitations of the study. I conclude this chapter with a description of the layout of subsequent chapters of the thesis.

### 1. THE CENTRAL ISSUE

“If maternal mortality is to be reduced, and women’s rights to the highest attainable standard of health protected, governments must allocate and effectively spend increasing and sustained resources to strengthen the health systems to make them available, accessible and affordable” (Hofbauer and Garza, 2009:5).

The preceding quote alludes to a belief held by many international donor organisations, governments, civil society organisations and academics alike that the solution to addressing maternal mortality lies in adequate investment to strengthen public health systems. The quote signals three issues that are central to this research. Foremost, that maternal mortality is a pronounced global problem that requires redress by individual governments; second, that high maternal mortality has strong linkages to gender inequality and poverty within countries; and third, that adequate and effective (gender-responsive) spending in public health systems has the potential to significantly reduce maternal mortality.

According to statistics reported by the World Health Organisation (WHO) in 2015, the global target for MDG 5a – to reduce the maternal mortality ratio (MMR) by 75 per cent between 1990 and 2015 – was not met and only a 45 per cent reduction of the MMR was achieved by 2013 (WHO, 2015). Although the Africa region recorded substantial progress, marked by a 49 per cent reduction in the MMR between 1990 and 2013, the MMR still stands at 500 deaths per 100,000 live births and is particularly high in low income countries (WHO, 2015). Over the decades, especially following the launch of the Safe Motherhood Initiative at the United Nations International Conference on Population and Development (ICPD) in 1987 and the subsequent incorporation of MDG 5 at the United Nations (UN) Summit in 2000, governments and independent organisations worldwide have implemented numerous interventions aimed at reducing maternal mortality and achieving universal access to reproductive health (WHO, 2014a).

Global interventions to address maternal mortality have largely concentrated on health system-related factors, notably strengthening the delivery of family planning, antenatal care, delivery care and postpartum care at community as well as referral levels (Mbivzo and Say, 2012; Starrs, 2006). The demand-side of maternal health care has also been targeted, although to a lesser magnitude. The spotlight on the need to address demand-side related factors of maternal health care dates back to the international recognition of women's health as a fundamental human right at the ICPD in 1994 and the Fourth World Conference for Women in Beijing in 1995.

Increasingly, advocates for women's rights, scholars and medical professionals have drawn attention to a host of interrelated problems that affect maternal health at household and community levels. The Commission for Social Determinants of Health (CSDH), launched in 2005 by the WHO, gathered global evidence of social determinants of health and their impact on health inequity (WHO, 2008). The CSDH made recommendations of actions to be adopted by governments to promote equity in the health sector, among which included that "governments create and enforce legislation that promotes gender equity and makes discrimination on the basis of sex illegal" (WHO, 2008: 147). As a prerequisite for the effective enforcement and implementation of laws that support gender equity in health, the CSDH emphasised that governments must allocate appropriate budgets that are "sufficient to reach the entire population and address the magnitude of the problem" (WHO, 2008: 147).

Gender responsive budgeting (GRB) has emerged as a popular tool for governments to meet their commitments towards gender equality and the fulfilment of women's rights. GRB involves a systematic assessment of public policies and budgets for their impacts and implications on women, men, boys and girls, followed by informed actions to change policies and budgets so as to promote gender equality (Sharp, 2007). Proponents argue that GRB ensures that the specific needs and interests of females and males belonging to different social groups are adequately considered in decision-making regarding public expenditure and



revenue generation (Sodani and Sharma, 2008; Budlender and Hewitt, 2006); and that public expenditure “benefits those who need it most” (Budlender and Hewitt, 2006:12).

The euphoria with which GRB is touted as an effective solution to address gender inequity in social and economic sectors is widely assumed and seldom questioned on how it works to produce the anticipated outcomes and the resulting effects. This is confirmed by the scant availability of literature on the effectiveness and impact of GRB initiatives despite more than two decades of implementation across countries worldwide (Carlitz, 2013). A synthesis review conducted by McGee and Gaventa (2010) highlights that most of the existing literature is policy- or practitioner-oriented and largely descriptive. Combaz (2013: 2-3) adds that a large part of recent GRB literature focuses on “policy recommendations and tools for analysis, implementation and assessment”, or “processes of demanding, shaping and achieving gender-responsive budgeting”, with few studies “document[ing] evidence about actual outcomes and impact.” Furthermore, accessible literature is mostly reported at national level, leaving us in the dark about real GRB impacts at lower levels of government within countries (Budlender, 2008; UN Women, 2010).

With the ultimate objective of outside government GRB initiatives being to ensure that government policies and budgets specially meet the priority needs of the poor and vulnerable segments of society, it becomes pertinent to understand how GRB works and evaluate, not only sector-specific effects of GRB on policies and budgets, but also the impact of GRB implementation on public service delivery and the utilisation of public services by the citizens at local government level.

The present study uses a case of the Forum for Women in Democracy (FOWODE) GRB initiative in the health sector of Kabale district, rural Uganda to investigate the broad question, “*how and to what extent do local-level outside government GRB initiatives in health influence gender-responsive maternal health service delivery and the use of maternal health care services by rural women of reproductive age?*” It is anticipated that the findings and recommendations of this research will provide an insight into the operations and effectiveness of local-level GRB initiatives in the health sector and the evaluation of gender mainstreaming interventions in general.

## **2. CONTEXTUALISING THE ISSUE**

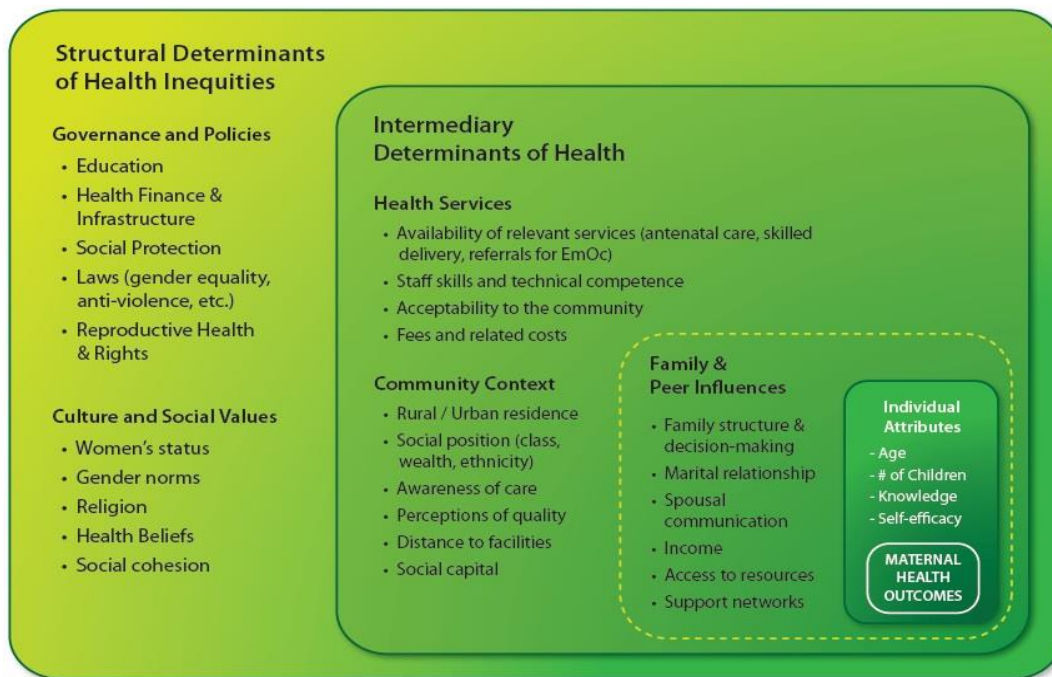
In this section, I contextualise the central issue of the research to the ongoing debate on maternal health and gender responsive policy and make use of the Social Determinants Approach to Maternal Health to describe the specific case of Uganda. Next, I trace the origin, evolution and key players of GRB in Uganda, followed by a description of the local government context and the spaces and opportunities for GRB initiatives at local government level. I

conclude the section with a discussion of the successes and flaws in the uptake of gender concerns and GRB in Uganda's health sector.

## **2.1. Revisiting the debate: maternal health and gender responsive policy**

Gender inequality in health manifests as “excess mortality of female children and differences in life expectancy [between females and males] that do not accord to biological norms” (Stotsky, 2006:4). Owing to inherent biological differences between females and males (such as maternity) equal health outcomes for females and males are not often achievable. Gender equity in health replaces gender equality as a goal, with the aim of eliminating “avoidable differences between women and men, ensuring equal access to health resources for equal need and enhancing resources for unequal need” (Diaz-Granados et al., 2011: 154). The focus on gender equity broadens the perspective that health outcomes are not just a function of biological factors, but also social, economic and cultural influences on individual health behaviour.

Building on the works of researchers such as Bronfrenbrenner (1979) and McLeroy (1988), social ecological models of health behaviour have evolved and are progressively being used to analyse the influences of interactions between individuals and their multiple environments on health outcomes (Nkechi, 2015). Specific to maternal health, the CSDH of the World Health Organisation developed the Social Determinants Approach to Maternal Health framework in 2008 to guide actions aimed at improving health outcomes and reducing health inequities (United Nations Development Programme, 2011). The Approach distinguishes two categories of determinants of maternal health outcomes, namely structural determinants of health inequities and intermediary determinants of health as depicted in Figure 1.

**Figure 1: A Social Determinants Approach to Maternal Health**

Source: United Nations Development Programme (2011: 8)

Structural determinants include governance systems and policies (education, health finance and infrastructure, laws, social protection, reproductive health rights), as well as culture and social values (women's status, gender norms, religion, health beliefs, social cohesion) that "determine distribution of wealth, power and prestige across social groups" (United Nations Development Programme, 2011: 7). The structural determinants of health inequities at national and/or regional level shape the intermediary determinants of health, which "establish the extent to which those [social] groups are able to access health and social services for prevention and treatment and to adopt healthy lifestyles " (United Nations Development Programme, 2011: 7). The intermediary determinants of health include the status and organisation of health services (availability, quality, acceptability, affordability) and the community context (location, social position, perceptions of health service quality, awareness of care, social capital). Nested in the intermediary determinants of health are family and peer influences, as well as individual attributes, which directly affect maternal health outcomes (utilisation of skilled maternal health care and/or maternal deaths). Individual attributes include the mother's age, number of births, education/knowledge level and self-esteem; while family and peer influences include attributes such as marital status, household income status, family structure and household gender relations. The Social Determinants Approach to Maternal Health illuminates the hierarchical ecological levels of influence on maternal health outcomes and how changes in one of the ecological levels can have multiple effects on other levels (Nkechi, 2015).

As will be discussed in more detail in the second and third chapters of this thesis; GRB interventions in maternal health target to influence gender-responsive governance, policies and health services delivery at both structural and intermediary levels. At societal and community levels, GRB interventions also target to empower women and transform perverse cultures, norms and social values that perpetuate gender and social inequities, with adverse effects on women's health seeking behaviour.

Keith-Brown (2004) suggests that initiatives such as GRB can influence the provision of maternal health services by: (1) ensuring that good comprehensive policies, with all the essential elements (such as skilled care and emergency obstetric care) are in place and verifying that these policies are translated into specific budget commitments; (2) scrutinising the allocation of funds across departments, levels of government, regions and programmes for adequacy, appropriateness and suitability of purpose and ensuring that funds are allocated to regions and populations in most need; and (3) following the funds to ensure that the right budget allocations were implemented on the intended outcomes and that the services reached the people that were targeted to make the difference. On the demand-side of maternal health care, GRB initiatives can expand opportunities for citizen participation (especially women) in priority-setting, budgetary processes, services design, delivery and evaluation, with the potential of increasing awareness and demand for health services and making the health system more responsive and accountable to client needs (Langer et al., 2000; Malena et al., 2004). Sharp and Elson (n.d.) additionally point out that GRB initiatives may undertake time use studies that bring to light the problems and effects of unpaid care work on maternal health care utilisation among women of different social groups, thereby informing responsive government policy, programming and budgeting.

## **2.2. Redefining gender responsive maternal health services**

Maternal health services comprise pre-conception and family planning, routine care (antenatal, delivery, postnatal) and emergency care (ante-partum, intra-partum, post-partum and abortion services) (Government of Uganda, 2009). Safe motherhood literature defines three core components of maternal health service delivery as skilled birth attendants, an enabling environment and a functioning referral system (Graham and Graham, 2006; Thorsen et al., 2014). Skilled birth attendants refer to health workers who are qualified and technically competent to provide care to mothers during pregnancy, childbirth and immediately after birth (Thorsen et al., 2014). An enabling environment represents the "context that provides [skilled birth attendants] with the necessary backup support to perform routine [examinations and] deliveries to ensure women with complications receive prompt emergency obstetric care" (Thorsen et al., 2014: 17). The elements of an enabling environment include, among others, health infrastructure, supplies, equipment, organisation of services, guidelines, supervision and accountability (Thorsen et al., 2014; WHO, 2001). Lastly, a referral system relates to the handling of clinical conditions within different levels of a health system in a way

that ensures that clients “receive the best possible care closest to home” (WHO, 2016: 1). In a well-functioning maternal health care referral system, mandated lower level health facilities are ably equipped to handle normal deliveries and basic emergency obstetric care and can readily move obstetric complications to higher level facilities to receive comprehensive obstetric care (Thorsen et al., 2014).

The distinction between generic maternal health services and gender-responsive maternal health services is that the latter “recognise[s] and respond[s] to a broader range of factors that impact on women’s health” besides biological factors (Women’s Centre for Health Matters, 2009: 5). Gender-responsive maternal health service delivery takes into account the social determinants of maternal health and attunes service delivery to address the unique challenges that affect health care utilisation by women, such as fewer resources in terms of time, money and limited knowledge. The Women’s Centre for Health Matters (2009) summarises four qualities of gender-responsive maternal health service delivery as being services that are available, accessible, affordable and appropriate (culturally acceptable) for women. These four qualities will be discussed in more detail in Chapter 3.

In the context of the present study, gender-responsive maternal health care relating to the dimension of availability includes the presence of a skilled health provider capable of providing maternal health services round-the-clock at the health facility; regular operating hours that expectant women can trust; adequate supplies (ergometrine, gloves, delivery kits, blood) and maternal health equipment that concurs with the respective level of health facility. Relating to the dimension of accessibility, gender-responsive maternal health service provision would ensure that: maternal health services are within at most five kilometre distance from mothers, maternal health facilities are located close to access roads and can be reached easily using public means of transport; and roads to the health facilities are passable all-year round. Regarding affordability, gender-responsive maternal health service delivery would take into account the constraints on women’s access to resources and ensure that all mothers belonging to different social classes are able to obtain the minimum required obstetric care at no cost. This may entail the provision of free maternal health care and delivery kits to mothers. The provision of an integrated package of maternal health care (family planning, antenatal care, prevention of mother-to-child transmission of HIV services, delivery care) in the same facility would also save costs in terms of time and transport. Lastly, gender-responsive maternal health care relating to acceptability would entail provision of services that are sensitive to the culture and values of women in the community, presence of female health providers to provide women with the option of choice of carers, respectful relations between health providers and patients (communication and care that takes into account the difference in literacy levels of the women) and facilities that allow privacy during consultation, examination and delivery.

### **2.3. Maternal health in Uganda through a social determinants lens**

According to the WHO (2015), the MMR of Uganda stands at 360 deaths per 100,000 live births. Although Uganda registered a 54 per cent reduction in the MMR (from 780 to 360 deaths per 100,000 live births as at 1990 and 2013 respectively), the progress was not sufficient to meet the MDG target of 131 deaths per 100,000 live births by 2015 (WHO, 2014 b). The three leading causes of maternal deaths are listed as obstetric haemorrhage (42 per cent), pre-eclampsia and eclampsia (12 per cent) and post-partum sepsis (11 per cent) (Republic of Uganda, 2015). The Uganda Demographic Health Survey (2011) reports that while 95 per cent of the expectant mothers attend at least one prenatal care visit, only 48 percent (57 percent in urban areas and 46 percent in rural areas) attend four or more prenatal care visits during the entire pregnancy. Furthermore, 57 per cent of the deliveries in Uganda occur in health facilities, of which 44 per cent take place in public health facilities and 13 per cent take place in private health facilities (Uganda Bureau of Statistics and ICF International Inc, 2012). Among the deliveries taking place at health facilities, 58 per cent are attended to by skilled health workers while 42 per cent are not (Uganda Bureau of Statistics and ICF International Inc, 2012). This suggests that an estimated 67 per cent deliveries (24 per cent at health facilities and 43 per cent taking place at home) are unattended by skilled health workers. Relating to postnatal care attendance, the statistics reveal that only 33 per cent of new mothers receive an examination by skilled health workers within two days after birth (Uganda Demographic Health Survey, 2011).

At national level, Uganda's health sector is currently guided by the National Health Policy 2011-2020 and the Health Sector Development Plan (HSDP) 2015/16 – 2019/20. The HSDP is aligned to international human rights agreements, which take into consideration gender concerns, notably the International Covenant on Economic, Social and Cultural Rights; Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol); Convention of the Elimination of all Forms of Discrimination against Women (CEDAW); ICPD Programme of Action; the Beijing Declaration and Platform for Action; as well as the Constitution of Uganda and National Gender Policy. The Constitution of Uganda 1995 provides for gender balance and fair representation of disadvantaged groups, as well as affirmative action in favour of women (Tanzarn, no date). The Uganda Vision 2040, a thirty-year vision that guides the development of five-year National Development Plans (NDPs), emphasises the promotion of gender and human rights as a core component of the planning process and prioritises the integration of "gender issues into development plans and programmes" (Government of Uganda, 2010b: 96).

The Ministry of Health provides overall leadership for the sector, including: policy formulation, strategic planning, resource mobilisation, budgeting, capacity development, regulation and setting of standards for quality assurance, among others (Republic of Uganda, 2010c). Health services in Uganda are delivered through a decentralised system comprising of districts and

health sub districts (Government of Uganda, 2010a). Public health facilities are structured into national referral hospitals, regional referral hospitals and general hospitals at district level; and health centres I, II, III and IV at health sub-district level (Government of Uganda, 2010a). District local governments are authorised to manage public general hospitals and health centres, as well as supervise and monitor all health activities – including those of the private sector – within their area of jurisdiction (Government of Uganda, 2010a). The responsibility to recruit, deploy, promote and manage human resources for public health lies with the district service commissions; while health sub-districts are responsible for planning, organising, budgeting and managing public health centres. The health system structure and respective services provided at each level are summarised in Table 1 in Annex I.

Uganda's health sector is largely constrained by inadequate funding, which is compounded by a fast growing population<sup>1</sup>. Between the period 2010/11 to 2014/15, the average allocation of government expenditure to the health sector was 8.4 per cent which is below the national Health Sector Strategic Investment Plan target of 10 per cent and the Abuja Declaration target of at least 15 per cent (Republic of Uganda, 2015: 17). In a bid to ensure cost-effectiveness of health service delivery, the National Health Policy defines the Uganda National Minimum Health Care Package (UNMHCP), which prioritises maternal and child health as one of the four clusters of health interventions and services (Government of Uganda, 2009). Over the years, the Government of Uganda – with assistance from development partners – has undertaken strategic interventions to improve maternal health outcomes, among which include: the abolition of user fees for maternal health care at public health facilities in 2001 (Xu et al., 2005); hiring and training health workers in the provision of sexual reproductive services, including management of obstetric care; engagement of men in family planning and use; institutionalising deliveries at lower level health facilities in hard-to-reach areas (Government of Uganda, 2010a); as well as the adoption of universal primary education in 1996 and universal secondary education in 2007, which were envisaged to increase enrolment rates for girls and boys and have long term benefits in terms of better reproductive health indicators (Ssengooba et al., 2003).

Civil society organisations have also played a role in improving the maternal health situation in Uganda through advocacy interventions targeting government and service providers, on the supply side of maternal health care, and communities on the demand side. Renowned civil society organisations that have been active in advocating for improved maternal health care at national and district level include White Ribbon Alliance (WRA), World Vision Uganda, Centre for Health, Human Rights and Development (CEHURD), Action Group for Health, Human Rights and HIV/AIDS and Save the Children – Uganda, among others. Such organisations have mainly concentrated on sensitising communities about their health rights and empowering them to demand for quality and responsive services from government. On

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<sup>1</sup> Uganda's population growth rate, according to the national population and housing census 2014, is 3.03 per cent with a total fertility rate of 6.2 children per woman.

the basis of facts and opinions generated from communities, civil society organisations have petitioned<sup>2</sup> or litigated<sup>3</sup> government to address the deficiencies in maternal health service delivery. Other NGOs such as AMREF Health Africa and World Vision Uganda have provided direct support to the health sector in form of construction or renovation of maternity wards at health centres, provision of solar lighting in maternity wards to facilitate night deliveries and provision of other maternal health equipment, among others. In a bid to enhance their influence on government health policies, budgets, and service delivery, civil society organisations have formed coalitions at national level such as the Coalition for Maternal and New born Child Health, Voices for Health Rights and the Uganda National Health Consumers Organisation. Other NGOs such as FOWODE and Civil Society Budget Advocacy Group (CSBAG) similarly target to influence gender-responsive maternal health service delivery indirectly through advocacy and capacity building in GRB.

Inequities in maternal health care provision, and consequently maternal health outcomes, are evident across regions in Uganda. The regions of Northern Uganda and Eastern Uganda, which happen to be the poorest in the country “tend to have very limited availability of infrastructure and equipment in their health facilities” (World Bank, 2016: 115). High patient caseloads, overcrowding and long queues also characterise service delivery in public health facilities, especially in the poorer regions of Northern and Eastern Uganda, as compared to Central and Western Uganda (World Bank, 2016). The incidence of health worker absenteeism at public health facilities in Uganda is high at 42 per cent (irrespective of the wealth quintile) (World Bank, 2016). The health system delivery of maternal health care is also characterised by a weak emergency referral system, frequent stock outs of life-saving commodities at health facilities and inequalities in access to services to the disadvantage of the rural population (Government of Uganda, 2015b: 33).

At society and community levels, women are generally regarded as having a low status compared to men. One study in Uganda notes that women in some communities are regarded as having the purpose of child bearing, with limited decision-making or negotiation in issues regarding the number of children to have and the use of contraception (Nalwadda et al., 2010). Men are also the main decision-makers in the use of maternal health care and provide the permission, money required; and may escort their wives to the health facilities (Amooti-Kaguna and Nuwaha, 2000). Studies highlight that in polygamous settings, such as in Muslim families, men desire to have many children from different wives (Nalwadda et al., 2010), and poverty, particularly in rural households, drives the desire to have many children to provide labour (Ssengooba et al., 2003). In many cultures, pregnancy and child birth is also viewed as

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<sup>2</sup> In October 2013, White Ribbon Alliance Uganda petitioned the Minister of Health over the increasing deaths of women and children during pregnancy and child birth since 2006 (WRA, 2013).

<sup>3</sup> CEHURD petitioned the Constitutional Court in 2011 (Constitutional petition No. 16) and the Supreme Court against the Attorney General, alleging that the non-provision of maternal health services in Uganda was a violation of health rights and the rights of women. The Supreme Court ruled in November 2015 that the Constitutional Court should hear maternal health cases (CEHURD, 2015).



an inevitable burden for the continuation of lineage and a major area “where women still command power and status” (Kyomuhendo, 2003: 18). Women who deliver by themselves are highly respected, while women who seek professional care or die during childbirth are considered to display weakness (Kyomuhendo, 2003). As a result, utilisation of skilled maternal care in many rural communities is considered as a last resort (Kyomuhendo, 2003). Community perceptions of maternal health care in rural public health facilities are also largely negative, especially with regard to delivery care being “culturally inappropriate and interpersonal relations between women and health workers [being] far from ideal (Kyomuhendo, 2003: 22).

At the individual level, studies (Amooti-Kaguna and Nuwaha, 2000; Kakaire et al., 2011; Uganda Bureau of Statistics and ICF International Inc, 2012) reveal that factors including the woman’s age, level of education, birth order, economic status, as well as the presence of complications during pregnancy influence the utilisation of maternal health care services among women in Uganda. Very young mothers and older women with multiple births are less likely to utilise skilled maternal health care out of fear of being ridiculed by health workers (Amooti-Kaguna and Nuwaha, 2000). Highly educated women (above secondary level) and women having the first child are also more likely to utilise maternal health than their counterparts with no education and/or with previous births.

## **2.4. Tracing gender responsive budgeting in Uganda**

GRB initiatives in Uganda are predominantly located outside government and are led by civil society organisations working in collaboration with researchers, legislatures and government departments. Other collaborative partners include the media, donor agencies and – in some cases – ordinary citizens at the grassroots. The growing participation of outside government actors in public policy and decision-making processes is closely associated with the national policy on decentralisation which was adopted in 1992 (Kakumba, 2010). The argument for decentralisation was that it would enhance local democracy, improve service provision and reduce poverty by empowering citizens to participate in decisions that affect their localities (Kiyaga-Nsubuga and Olum, 2009).

Budlender and Hewitt (2006) suggest that GRB initiatives in Uganda emerged from advocacy initiatives by non-governmental organisations (NGOs) in response to the negative effects of structural adjustment programmes on education and health in the 1990s. deRenzio et al. (2008) similarly trace the origin of GRB initiatives in Uganda to campaigns by a coalition of NGOs and individuals for debt relief for Uganda under the Heavily Indebted Poor Countries Initiative (HIPC). They assert that the successful debt relief campaign in 1998 subsequently led to activities aimed at ensuring that the increases in public spending – resulting from debt cancellation as well as increasing aid flows – were channelled to priority sectors and effectively utilised through improved service delivery (deRenzio et al., 2008).

To date, while more than four hundred NGOs are registered and operating in Uganda, the number of NGOs working on policy advocacy, and more specifically on budget issues, remains limited. The initiator and lead player of GRB in Uganda is FOWODE, which emerged out of a caucus of Uganda women parliamentarians in 1999 (Kusambiza, 2013). FOWODE was created with the objective of building the capacity of women parliamentarians in gender mainstreaming and GRB to enable them to “participate more effectively in parliamentary debates” (Kusambiza, 2013: 6). Other civil society organisations engaged in gender budget advocacy mainly operate under an umbrella organisation, CSBAG. CSBAG was formed in 2004 by Uganda Debt Network (UDN), FOWODE and Oxfam GB to bring together civil society organisations at district and national levels to collectively “influence government decisions on resource mobilisation and utilisation for equitable and sustainable development” (CSBAG Website, 2016). CSBAG has a membership of over 70 organisations, including NGOs, community based organisations and NGO umbrella associations engaged in the sectors of health, women advocacy, environment, agriculture and water, among others. Since 2004, CSBAG has actively engaged in the budget process at national and district level to ensure that “budgets incorporate the views of the poor and that they are gender sensitive” (CSBAG Website, 2016).

Inside-government GRB initiatives started in 2003 and were spearheaded by the Ministry of Finance, Planning and Economic Development (MoFPED) (Tanzarn, no date). Tanzarn documents the first government-led GRB initiative to have been the inclusion of gender and equity budgeting in the Budget Call Circular of 2003/04 financial year. This was followed by the preparation of a User’s Manual and Implementation Strategy Guidelines by MoFPED in collaboration with the Ministry of Gender, Labour and Social Development (MoGLSD) in 2004 (Tanzarn, no date). In 2005, MoFPED further undertook capacity building of selected gender focal persons, planners and budget officers of priority sectors on GRB (Tanzarn, no date). To date, not all local governments have benefited from capacity building in gender mainstreaming and GRB owing to limited funding of the national machinery - MoGLSD.

Various authors, however, affirm that inside- and outside-government GRB initiatives are being undertaken on a limited scale in Uganda, largely due to financial and human resource constraints faced by the national machinery (MoGLSD) and related civil society organisations (deRenzio et al., 2008; Okille, 2008; Tanzarn, no date). FOWODE operates in 17 out of the 111 districts in Uganda. GRB initiatives in Uganda have predominantly focused on ensuring that government policy, budgets and public service delivery address women’s needs (Kusambiza, 2013). The future outlook of GRB in Uganda seems promising, following the enactment of laws that promote gender equality. Section 9(6) of the recently passed Public Finance Management Act 2015 specifically requires that for every Budget Framework Paper (BFP) prepared, a certificate should be issued by the Minister of Finance, in consultation with the Equal Opportunities Commission, certifying that the BFP is gender- and equity-responsive and

specifies “measures taken to equalise opportunities for women, men, persons with disabilities and other marginalised groups” (Government of Uganda, 2015a: 16).

## **2.5. The local government structure, planning and budget processes**

Administratively, Uganda is divided into 111 district local governments and one capital city – Kampala – covering an area of 241,039 square kilometres (Uganda Bureau of Statistics and ICF International Inc, 2012). The Constitution of the Republic of Uganda, 1995 establishes the district as the highest level of local government. Below the district, are lower local governments comprising of municipalities, city divisions and town councils in urban areas; and sub-counties and parishes in rural areas (Kakumba, 2010). The local government council is the highest political authority within its area of jurisdiction and operates through executive committees and statutory organs, namely district service commissions, district contracts committees and local government public accounts committees (Kiyaga-Nsubuga and Olum, 2009). Under the decentralisation system, the local government council has planning, administrative, financial management, budgeting, legislative and judicial powers, which it exercises in accordance with the Local Governments Act 1997 (Kiyaga-Nsubuga and Olum, 2009).

The districts have wide-ranging responsibilities to deliver basic services in health, education, agriculture and infrastructure (deRenzo et al., 2008). Institutionally, the local government system provides for effective involvement of communities in the articulation of needs and participation in programmes that foster local development (Kakumba, 2010). The interests of gender and minority groups are also protected through reserved seats for women, youth and persons with disabilities at all levels of local government (Devas and Grant, 2003). Although fiscal powers were devolved to local governments, districts are mostly able to generate up to 10 per cent of revenue from local sources – fees and taxes – and rely on the central government for the remaining 90 per cent (Kiyaga-Nsubuga and Olum, 2009). Fiscal transfers from the central government are in the form of conditional grants, unconditional grants and equalisation grants (Kiyaga-Nsubuga and Olum, 2009). Conditional grants are intended to be disbursed on pre-determined programmes in line with the priority areas of central government, while unconditional grants permit some discretion to local governments to allocate resources to specific local development objectives (Kiyaga-Nsubuga and Olum, 2009). Equalisation grants are given to the least developed local governments as a subsidy to enable them to meet minimum standards of social service delivery (Kiyaga-Nsubuga and Olum, 2009).

In principle, lower local government plans and budgets are prepared using a bottom-up approach, with each village preparing community action plans based on local needs and priorities. The community plans are then integrated into parish/ward plans, followed by sub county/division plans and lastly an integrated district development plan (Kakumba, 2010). The integrated district plan is discussed by different stakeholders at district level before it is

approved by the district council (Kakumba, 2010). Feedback is then provided to the sub counties and parishes on the final plan and budget for implementation.

Regarding budgeting, Uganda's budget system is clearly defined in legislation and is supported by the 1995 Constitution of Uganda; the 2001 Budget Act; the 2003 Public Finance and Accountability Act (deRenzio et al., 2008); and the 2015 Public Finance Management Act. Annually, government budgets are prepared in consultation with different stakeholders and are aligned to be consistent with the NDP for the period, the Charter of Fiscal Responsibility, and the corresponding Budget Framework Paper (Government of Uganda, 2015a). Sector and district spending ceilings are set in light of the prevailing macroeconomic environment and prospects for revenue mobilisation (Kuteesa et al., 2006). The key actors in the nation's budget process include MoFPED, which drafts the annual budget; the Cabinet, which reviews and endorses budget proposals; sector ministries and local governments, which execute the budget; aid donors, who support the government in efforts to strengthen public expenditure management; and the Office of the Auditor General, which audits expenditures made under the annual budget (Kuteesa et al., 2006).

Institutional spaces are provided for civil society and the public to engage throughout the budget process, including sector working group conventions, local government budget workshops held at regional level, public expenditure reviews and consultative meetings (now held once every five years), and during the preparation and distribution of budget framework papers (deRenzio et al., 2008). At district and lower local government levels, spaces for engagement of civil society organisations and the public also exist at district budget conferences and sub county budget conferences.

Throughout the planning and budgeting process, districts and lower local governments are mandated to implement gender budgeting in accordance with the Gender Budgeting Guidelines and Analytical Tools provided by the Ministry of Local Government (MoLG) and MoGLSD in 2005. District local governments are also annually assessed on their performance on gender mainstreaming<sup>4</sup> and are awarded a 20 per cent increment in the total budget for an overall score of above 7 out of 10 points; penalised a 20 per cent reduction in the total budget for a score below 5 out of 10 points; and neither rewarded nor penalised for a performance score of at least 5 out of 10 points (Tibamweda and Kabuchu, 2008).

## **2.6. Uptake of gender concerns in Uganda's health sector: successes and flaws**

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<sup>4</sup> The gender mainstreaming performance indicators for local governments are: proportion of local government staff knowledgeable about sector-specific gender issues; percentage of staff trained in gender mainstreaming; presence of a gender focal points person; and evidence that the LGDP contains: sound gender analysis; specific strategies to address gender issues; annual budget allocations for gender-responsive activities; gender impact analysis and gender-disaggregated data for each sector (Tibamweda and Kabuchu, 2008; NPA/UN-JPGE, n.d.). While a district may have a score ranging from 0 to 10, the basis upon which scores are awarded is not made explicit in performance reports.

The health sector in Uganda is credited for integrating a gender perspective into its policies, plans and budgets. The health sector implements a human rights based approach to health service delivery (Government of Uganda, 2015b). One of the social values of the health sector, that is explicitly stated in the Health Sector Strategic and Investment Plan 2010/11 – 2014/15, is that “a human rights and gender-sensitive and responsive national health delivery system shall be achieved and strengthened through maintaining human rights and gender analysis in planning and implementation of all health programs” (Government of Uganda, 2010a: 50). The Plan further underlines the disaggregation of health data by age and sex and the conducting of gender analysis on the results “in order to enhance the effectiveness and efficiency of interventions and programmes” (Government of Uganda, 2010a: 50).

Whereas the health sector policy documents characterise an integration of a gender perspective in public health service delivery, the National Planning Authority (NPA) in collaboration with the UN Joint Programme on Gender Equality and Women’s Empowerment (UN-JPGE) already detect flaws in gender mainstreaming in the health sector (NPA/UN-JPGE, 2012). Among the flaws detected were that gender mainstreaming is limited to gender disaggregation of health data and that performance monitoring in the health sector is “largely based on ill-health indicators and the quantitative aspects of service delivery” (NPA/UN-JPGE, 2012: 10). The NPA and UN-JPGE noted that the health sector is also silent on monitoring “socio-economic conditions that pose burdens on women’s and men’s health and hindrances in access to quality health care” (NPA/UN-JPGE, 2012: 10). The flaws detected can be partly explained by the lack of capacity in gender mainstreaming among health sector executives, which can be rectified if addressed.

### 3. RESEARCH OBJECTIVES AND QUESTIONS

The **core objective** of this study is to explore the effects of outside government gender budget initiatives at local government level, with a special focus on maternal health. The study seeks to understand the attributes, objectives and activities of local-level outside government gender budget initiatives in the health sector and the causal processes and mechanisms through which such initiatives may influence gender responsive maternal health service delivery and the use of maternal health care services by rural women. The study will also establish the effects of outside government gender budget initiatives in the health sector at local government and grassroots levels, taking Kabale District in rural Uganda as the case study. In order to meet this objective, three **central questions** are posed:

- 1) How may outside government GRB initiatives influence gender-responsive maternal health service delivery and the use of maternal health care services by rural women at local government level?
- 2) How have outside government GRB initiatives contributed to gender-responsive maternal health service delivery and the use of maternal health care services among rural women in Kabale District?
- 3) To what extent have outside government GRB initiatives influenced the demand for skilled maternal health care services among rural women of Kabale District?

The above three questions highlight three fundamental elements of the study. First, the need to understand *how* and *why* local-level outside government GRB initiatives *may influence* gender-responsive maternal health service delivery and the use of maternal health care among rural women; second, to *determine* the contribution of outside government gender budget initiatives towards gender-responsive maternal health service delivery and the use of maternal health services by rural women in Kabale District; and third, to *estimate* the effects of the outside government (FOWODE) GRB initiative on the knowledge and utilisation of maternal health care services among rural women of Kabale District.

The three central questions are further broken down into specific objectives and sub-questions accordingly.

On the grounds that there is no established guiding theory of how to evaluate the impact of outside government GRB initiatives in health at local government level, **Central question 1** has the specific objectives of: developing a theory of change; theorising a causal mechanism through which outside government GRB initiatives may influence gender equity in the health sector leading to gender-responsive maternal health service delivery and use of maternal health care services; and operationalising the theorised mechanism by predicting its case-specific observable implications in Kabale District, along with the probabilities of observing the evidence . Specific **sub-questions** to help answer central question 1 are:

- 1a) What is the cause-effect sequence through which outside government GRB initiatives are expected to influence gender-responsive maternal health service delivery and the use of maternal health care services by rural women at local government level?
- 1b) How do the actions and activities of entities (parts of the mechanism) transmit causal forces from the interventions of the outside government GRB initiative in health to the outcomes of gender-responsive maternal health service delivery and the use of maternal health care services among rural women of reproductive age in Kabale District?
- 1c) What types of evidence should be found if each part of the mechanism linking the outside government GRB initiative in health to gender-responsive maternal health service delivery and the use of maternal health care services is present in Kabale District? What is the probability of finding this evidence?

**Central question 2** has two specific objectives, namely testing the theorised mechanism – using formal Bayesian updating – to make inferences about its presence and functioning in Kabale District to contribute towards producing the observed outcomes; and identifying relevant factors for use in the evaluation of outside government GRB effects at household level. Specific **sub-questions** to help answer central question 2 are:

- 2a) What types of evidence relating to the parts of the theorised causal mechanism are present in Kabale District?
- 2b) What inferences can be made about updating our confidence in the presence and functioning of the theorised mechanism in Kabale District to produce gender responsive maternal health service delivery and use of maternal health services among rural women?
- 2c) What specific attributes of outside government GRB initiatives play a role in influencing the use of maternal health care services among rural women in Kabale District?

**Central question 3** has the objective of estimating the extent to which outside government GRB initiatives have influenced the demand for and/or use of maternal health care services among rural women of Kabale District. The specific **sub-questions** to answer central question 3 are:

- 3a) What is the effect of exposure to outside government GRB initiatives on the knowledge of maternal health services, rights and entitlements among rural women?

- 3b) How does the knowledge of maternal health services, rights and entitlements associate with the utilisation of skilled maternal health care among rural women of reproductive age?
- 3c) What is the relationship between exposure to the outside government GRB initiative and perceptions about the responsiveness of maternal health service delivery among rural women of reproductive age?

In answering the above questions, the study employs a sequential exploratory mixed methods design (Creswell & Clark, 2011) starting with an exploratory qualitative phase and concluding with a quantitative phase to further examine the qualitative findings.



#### 4. STUDY RATIONALE, SIGNIFICANCE AND LIMITATIONS

This study focuses on evaluating the contributory effects of local-level outside government GRB initiatives in maternal health. The study critically examines a case of a civil society-led GRB initiative with advocacy and capacity building interventions that target executives and female councillors at district level and women-dominated community groups at grassroots level. The study provides a detailed account of how such initiatives work to influence change and the resulting effects on maternal health service delivery and utilisation of services.

The choice of an outside government GRB initiative (FOWODE) as the case study was influenced by the fact that preliminary research revealed that GRB in Uganda was spearheaded by and is predominantly being implemented outside government by FOWODE. Attempts to study and contrast the effects of outside government with inside government GRB initiatives were not feasible. The decision to situate the study at local government level was personally arrived at with the view of making a unique contribution towards the limited existing literature on GRB, which is mostly reported at national level. Conducting the research at local government level also permitted the evaluation of GRB effects on the demand side of public maternal health care. Noting that outside government GRB initiatives have mainly targeted the sectors of health and education, the choice of the health sector, and particularly maternal health, was influenced by personal intrigue with the persistently high MMR in Uganda and the desire to establish the contribution of GRB interventions towards reducing maternal mortality in Uganda.

The study appeals to architects and practitioners of GRB initiatives, particularly at lower levels of government, as it offers fact-based empirical evidence to inform programming. The study also attempts to demystify the myths about the failure of gender mainstreaming interventions by systematically tracing the steps through which interventions such as GRB bring about gender transformation (Bamanyaki & Holvoet, 2016). Lastly, it is hoped that the methodological approach and findings of this study will stimulate future academic research in GRB and other gender-focused interventions.

Some limitations of the study ought to be noted beforehand. As will be explained in Chapter Two, outside government GRB initiatives are quite diverse in terms of origin, goals/objectives, actors involved, focus, coverage, processes and outputs, among others. While the study findings may be applicable to outside government GRB initiatives operating in different contexts, it should be noted that the study was largely tailored to the context of the FOWODE GRB initiative in Kabale District.

Secondly, confidence intervals, rather than statistical powers, (presented in Chapter Four) were used to determine the sample size for the quasi-experiment, whose population was known. The study partly intended to estimate the prevalence of knowledge of maternal health

services, rights and entitlements among rural women. One treatment sub county (Kamwezi, N= 165) was contrasted with two control sub counties; one located within the same district as the treatment sub county (Nyamweru N=161) and the other located in a separate district (Mpungu, N=167). A post hoc power analysis calculated in Stata 14 revealed that, on the basis of the mean scores, between groups comparison effect size observed for Kamwezi and Nyamweru was  $d = 0.20$ . In order to obtain a sample with the minimum recommended power of 0.80 (Cohen, 1988), a sample size of N= 1021 per group was required, which was both infeasible and exceeded the respective population sizes. The between groups comparison power for Kamwezi and Mpungu was  $d = 0.97$ , while the between groups comparison for Nyamweru and Mpungu was  $d = 0.94$  respectively.

Thirdly, the study also defines exposure to the outside government GRB initiative at grassroots level as first-hand interaction with village budget club groups formed by the initiative at parish level, or listening to radio talk show programmes hosted by the FOWODE GRB initiative personally. This definition excludes rural women who may have learnt about the FOWODE GRB initiative through a friend or relative, because it was not easy to verify the amount and validity of information that was passed on. The result of this exclusion may, therefore, reduce the magnitude of effects reported of the outside government GRB initiative at grassroots level.

Lastly, the study sample used in this investigation mostly comprised rural women with an education level of up to three classes of primary school. The education level of a mother is widely considered as an important determinant for the utilisation of skilled maternal health care. As such, the findings of this study relating to utilisation of maternal health care services among rural women may, therefore, be different for populations with dominance of women with higher levels of education. The study limitations notwithstanding, this research provides an insight of the operations and effectiveness of outside government GRB initiatives.

## 5. THESIS LAYOUT

This thesis is composed of seven chapters. It began with this chapter (**Chapter 1**) which has introduced the study, including the central issue of the research and a contextualisation of the central issue broadly (using the social determinants approach to maternal health) and specific to Uganda at national and local government level. The chapter has also provided a background of GRB in Uganda and discussed the study objectives, research questions, study rationale, significance and limitations respectively.

**Chapter 2** expounds on the concept of gender responsive budgeting, discussing it as a gender mainstreaming strategy and as a transparency and accountability initiative. The chapter also explores the supportive conditions for GRB initiatives by examining GRB implementation across countries worldwide.

**Chapter 3** justifies maternal health as a concern for GRB intervention by discussing it from a gender and poverty perspective respectively. The chapter also discusses supply- and demand-side factors that influence maternal health access and use, ending with a review of existing theories that link maternal health to initiatives such as GRB and a discussion of experiences of GRB interventions in maternal health.

**Chapter Four** presents the research design and methods. The chapter explains the exploratory sequential mixed methods research design and elaborates the procedures that were undertaken for data collection analysis and interpretation during the qualitative and quantitative phases of the research.

**Chapter 5** presents and discusses the qualitative findings of the study. It starts with a description of theory-based evaluation and process tracing methodology principles, followed by an application of theory based evaluation and process tracing (using formal Bayesian updating) to evaluate the presence and functioning of the FOWODE GRB initiative in Kabale District to contribute to gender responsive maternal health service delivery and the utilisation of maternal health care among rural women.

**Chapter 6** presents and discusses the quantitative findings of the study. In this chapter, the effects of the FOWODE GRB initiative on knowledge of maternal health services, rights and entitlements among rural women are investigated, followed by an assessment of the influence of knowledge of maternal health services rights and entitlements on the utilisation of maternal health services among rural women. The chapter also utilises the perceptions of recent mothers to assess the gender-responsiveness of maternal health service delivery at public health facilities.

**Chapter 7** concludes the thesis by reviewing the study processes, findings and conclusions drawn from the study, which are linked to the study objectives. It also suggests implications for policy, evaluation and future research.

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## ANNEX I.

**Table 1: Public health facility levels and related services**

Infrastructure level	Administrative level	Target population	Services provided
HC I	Village	1 000	Community-based preventive and promotive health services. Village Health Committee or similar status.
HC II	Parish	5 000	Preventive, promotive and outpatient curative health services, outreach care.
HC III	Subcounty	20 000	Preventive, promotive, outpatient, curative, maternity, inpatient services and laboratory services.
HC IV	County	100 000	Preventive, promotive, outpatient, curative, maternity, inpatient services emergency surgery and blood transfusion and laboratory services
District	General hospital	500 000	In addition to the services offered at HC IV other general services are provided. It also provides in-service training, consultation and research to community based health care programmes.
Regional	Regional referral hospital	2 000 000	In addition to services offered at the general hospital, specialist services are offered at this level. Such services include; psychiatry, ear, nose and throat (ENT), ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical and medical services.
National	National referral hospital	24 000 000	These provide comprehensive specialist services. In addition, they are involved in teaching and research.

Source: Africa Health Workforce Observatory (2009: 21)

## **CHAPTER 2**

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### **THE GENDER RESPONSIVE BUDGETING DEBATE**



## **INTRODUCTION**

This chapter focuses on the current GRB debate. It starts with a brief description of the origin, evolution and typologies of GRB and, in so doing, elaborates the distinction between different types of GRB initiatives. Next, the chapter delves into a discussion of GRB as a gender mainstreaming strategy and GRB as a transparency and accountability initiative. It explores the two standpoints and reviews available literature on the implementation and effects of different kinds of GRB initiatives worldwide. The chapter concludes with an examination of the contexts in which GRB initiatives have been successfully implemented and identifies the necessary supportive conditions that yield enhanced results.

### **1. A SYNOPSIS OF GENDER RESPONSIVE BUDGETING**

GRB is concerned with ‘mainstreaming’ gender into government budgets (Elson, 2003). As an integral part of gender mainstreaming, GRB contributes towards promoting gender equality by ensuring that the different needs and priorities of men and women are given equal consideration during budgetary processes (Elson, 2003). GRB involves two distinct stages: namely, analysing the implications and effects of budgets (and underlying policies and programmes) for women and girls compared to men and boys – referred to as gender analysis; and systematically integrating a gender perspective into policies and budgets (Budlender, 2005; Elson, 2003; Holvoet, 2006). As such, GRB does not only focus on the content of budgets, but “aims to include a gender perspective in all phases of the budget cycle”, notably diagnosis and appraisal, budgeting, implementation, monitoring and evaluation (Holvoet, 2006: 7).

#### **1.1. The origin and evolution of gender responsive budgeting**

GRB, also known as ‘women’s budgets’, ‘gender-sensitive budgets’ or ‘applied gender budget analysis’ dates back to the mid-1980s (Budlender and Hewitt, 2006). The first GRB initiative was by the Australian Government at federal level in 1984, and focused on assessing the impact of government budgets on women and girls in order to address perverse gender inequalities and advance their economic role and contribution (Rubin and Bartle, 2005; Sharp, 2003). The next renowned initiative was a one-off effort by the Canadian Women’s International League for Peace and Freedom in 1993. It involved the publishing of an alternative ‘women’s budget’ which proposed cuts in military spending and the redistribution of funds to social programs that benefit women and their families (Hewitt, 2002). The South African GRB initiative started in 1995, and was a collaborative effort of the civil society (NGOs and researchers) and parliamentarians to analyse public expenditure and revenue-raising measures in the context of benefits that accrue to women and girls relative to men and boys (World Bank, n.d.).

Whereas earlier initiatives occurred somewhat in isolation, GRB initiatives became prominent after the Fourth World Conference on Women in Beijing in 1995, where a call was made for governments to integrate a gender perspective in budgetary decisions on policies and programmes, as well as adequately finance specific programmes for securing equality between women and men (United Nations, 1995). By 2007, more than ninety countries had implemented GRB initiatives (UN Women, 2008).

Various authors (McGee and Gaventa, 2010; Robinson, 2004; Krafchik, 2002) attribute the emergence and recent growth of GRB initiatives – particularly in transitional and developing countries – to international developments, notably democratisation, decentralisation, reforms in public expenditure management systems, and an emerging international consensus of the complementary role of the state and non-state actors in development. Robinson (2004) alludes to the political imperative to increase citizen engagement in public deliberation in several countries, during the 1980s, as having been a motivating factor behind many civil society and legislative GRB initiatives, especially at provincial and municipal levels. He further asserts that the focus of the good governance agenda on “accountability, transparency and participation as desirable attributes of effective states” led to greater openness of budget processes to legislative and citizen oversight which, in turn, fostered the development of budget initiatives (Robinson, 2008: 3).

The decentralisation of powers from central to local governments in several states also created opportunities for citizen participation in the processes of priority-setting and decision-making. In a preliminary appraisal of gender responsive budgeting and fiscal decentralisation in India, Chakraborty (2007: 4) notes that the combination of “greater fiscal autonomy” with “effective participation of women in governance at lower levels” advances variations in public expenditure decisions which correspond better to the revealed preferences of women. Furthermore, the close proximity of local governments to the people accords better information on gender differentials regarding needs and preferences and, thus, allows for spatial gender needs to be identified ex-ante to budgeting (Chakraborty, 2007).

Reforms in public expenditure management systems, such as the adoption of medium-term expenditure frameworks and public expenditure reviews, have also influenced greater participation and independent oversight by the civil society and legislatures (International Labour Organisation, 2006; Krafchik, 2002). McGee and Gaventa (2010) suggest that the increasing demand for budget transparency and accountability among aid donors (who provide budget support) also contributed to a wide array of civil society- and state-led initiatives at various stages of the budget process to ensure that donor funds are appropriately spent for intended purposes. Additionally, global efforts to implement and monitor the progress of poverty reduction strategies in relation to the MDGs, SDGs and other international commitments have fostered the development of several state-led and civil society-led GRB initiatives (International Labour Organisation, 2006).



The above developments in the international arena also explain the progression of GRB initiatives since the 1990s. Whereas early GRB initiatives predominantly focused on making changes to policies and budgets at national level, several initiatives are currently being undertaken at lower levels of government, with some involving the participation of citizens at grassroots level. Budlender (2005) recounts that most GRB initiatives in Africa started by focusing on the largest of expenditures in sectors at national level – notably education, health and agriculture – owing to the adverse effects that structural adjustment programmes in these sectors had on poorer women. She notes that some GRB initiatives, such as FOWODE in Uganda, subsequently broadened their focus to the local level following concerns about the implications of decentralisation of government for gender equality and the participation of women in general (Budlender, 2005). GRB initiatives worldwide have generally focused on addressing women-specific issues, as women are considered more vulnerable and marginalised compared to men.

## **1.2. Typology of GRB initiatives**

Notwithstanding the common agenda to make policies, budgets and budgetary processes more responsive to gender inequalities, GRB initiatives are quite diverse. Various authors, such as Budlender (2005), Çağatay et al. (2000), Elson (2002) and Holvoet (2007) have attempted to differentiate GRB initiatives into separate categories.

Çağatay et al. (2000) distinguish “people-centred” budget initiatives according to four broad aspects, notably (i) social and economic vision; (ii) actors, institutions and processes; (iii) methods and tools used; and (iv) impacts and accomplishments. With regard to social and economic vision, they highlight that while some initiatives may primarily focus on one theme such as gender or poverty, many others extend beyond a singular theme to include other social inequalities as well as environmental concerns (Çağatay et al., 2000). The outputs of GRB initiatives also differ, with some initiatives producing no more than social impact analyses and audits of existing budgets, while others additionally formulate alternative “people-centred” budgets by reprioritising expenditures and/or revenue-raising policies (Çağatay et al., 2000).

Çağatay et al. (2000) also note differences in initiatives relating to actors, institutions and processes involved. They state that initiatives may be undertaken inside government, outside government, or involve the cooperation of governments with civil society organisations, international actors or citizens respectively (Çağatay et al., 2000). Relating to methods and tools used, they highlight that whereas some initiatives adopt participatory approaches and tools, other initiatives are more technical and utilise tools such as public revenue incidence and benefit incidence analyses to analyse budgets (Çağatay et al., 2000). Linked to the approaches adopted is the distinction that some budget initiatives – especially the ones that

adopt participatory approaches – operate as tools for political and economic empowerment of poor people and women, while initiatives with more technical approaches tend to be less focused on empowerment and more concerned with equity of budget policies and allocations (Çağatay et al., 2000).

Budlender et al. (2005) and Budlender (2005) broadly categorise GRB initiatives in terms of actors and the focus of the initiatives. With regard to actors, Budlender et al. (2005) distinguish between government-led and civil society-led GRB initiatives, noting further differences within each respective category. Within the category of government-led GRB initiatives, they differentiate initiatives that are led by the bureaucracy or executive arm of government from those that are led by the elected or legislative arm (Budlender et al., 2005). With regard to civil society-led initiatives, they highlight differences among GRB initiatives led by NGOs that are women organisations, research organisations, sector-specific organisations and academic institutions (Budlender et al., 2005). Budlender (2005: 14) further notes, that many civil society budget initiatives are dominated by technical “experts” and think-tanks rather than more activist-type or grassroots organisations; and by economists rather than social scientists, lawyers or people with less formal education.

Relating to the focus of the initiatives, Budlender et al. (2005) affirm that while some initiatives focus on the budget as a whole, many initiatives focus on selected sectors, with the most common ones being health and education, as well as agriculture and other economic sectors. Budlender (2005) adds that different GRB initiatives may focus on the interests of particular groups, particular issues or on particular agencies.

Another distinction is made by Elson (2002), who categorises GRB initiatives in terms of political location, the extent of coverage, and the stage of the budget cycle at which the initiative is undertaken. With regard to political location, Elson states that GRB initiatives may be inside government departments, organised by officials and ministers; in elected assemblies, organised by elected representatives; or outside government, organised by researchers and civil society organisations (Elson, 2002). In terms of coverage, Elson asserts that some initiatives may cover the whole budget, while others focus on expenditure of selected departments or programmes, new projects, selected forms of revenue, changes in the tax system, or implementation of a new legislation (Elson, 2002). Elson also identifies four phases of the budget cycle, namely planning, appraisal, audit and evaluation, noting that different GRB initiatives target particular phases of the budget cycle (Elson, 2002).

Holvoet (2007) similarly classifies GRB initiatives according to political location (inside government, outside government or a combination of inside- and outside government); coverage, with some initiatives focusing on the content of budgets and others on budgetary processes; phases of the budget cycle targeted (budgeting, accounting or audit) and the specific instruments used in GRB implementation. With regard to the methodology employed,

<sup>59</sup>Holvoet (2007: 281) additionally classifies GRB initiatives according to three types of functional approaches, namely the three-way categorisation or “Sharp framework” (Budlender et al., 1998); the five step approach or “Budlender framework” (Budlender, 2000); and the budget cycle framework or “Elson framework” (Elson, 2002). The Sharp framework involves categorising three types of expenditures, namely expenditures that specifically target women, men, boys and girls; expenditures aimed at creating equal opportunity in public sector employment; and general or mainstream budget expenditures (Sharp, 2003). Gender disaggregated analysis tools are then used to assess the impacts of the different categories of expenditures, followed by the preparation of a budget statement that highlights gender issues, gender impacts and planned changes to address gender inequalities (Sharp, 2003). The Budlender framework involves five steps, namely (i) analysing the situation of men, women, boys and girls; (ii) assessing the gender-responsiveness of policies; (iii) assessing budget allocations; (iv) monitoring spending and service delivery; and (v) assessing the outcomes of budget implementation (Budlender and Hewitt, 2006). The Elson framework, on the other hand, involves undertaking a gender analysis of the four dimensions of Ministry or programme budgets, notably “financial inputs, activities financed, outputs delivered and impacts on people’s well-being” and identifying gender gaps and the necessary budgetary and policies changes required to address them (Sharp, 2003: 55).

Consolidating the foregoing classifications of GRB initiatives, a unifying typology, which this thesis adopts, is by political location – notably inside government, outside government and combined (inside- with outside-government) initiatives. Within each broad type of initiative, analogous differentiations are made relating to actors, goals, focus and coverage, phase of the budget cycle, approaches, processes and tools, and outputs. Table 2 below summarises the criteria used to differentiate GRB initiatives accordingly.

**Table 2: Typology of GRB initiatives by key criteria**

Criteria	Distinguishable features of GRB initiatives
1. Political location and actors	<ul style="list-style-type: none"> <li>– Inside government               <ul style="list-style-type: none"> <li>· Executive arm of government (Ministries of Equal Opportunities, Finance, Women Affairs and designated departments at lower levels of government)</li> <li>· Legislative arm of government (within parliaments, elected assemblies at local government level)</li> </ul> </li> <li>– Outside government               <ul style="list-style-type: none"> <li>· Civil society NGOs (Women’s organisations, research organisations, sector-specific organisations, professional institutions)</li> <li>· Academic institutions</li> <li>· International agencies and networks ( such as International Budget Partnership, UN-Women)</li> </ul> </li> </ul>

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Criteria	Distinguishable features of GRB initiatives
	<ul style="list-style-type: none"> <li>– Combined (inside and outside government) <ul style="list-style-type: none"> <li>· Government with international development agencies (Commonwealth Secretariat, multilateral and bi-lateral development aid partners)</li> <li>· Government with civil society organisations</li> <li>· Government with citizens (participatory budgeting initiatives)</li> </ul> </li> </ul>
2. Goals	<ul style="list-style-type: none"> <li>– Fulfilment of international commitments regarding gender equality</li> <li>– Distributive justice and equity <ul style="list-style-type: none"> <li>· Challenging economic policies, social policies and macroeconomic policy frameworks</li> <li>· Challenging and correcting for gender biases of macroeconomic policies, programmes and budgets</li> </ul> </li> <li>– Efficiency and effectiveness of government policy and implementation</li> <li>– Transparency and accountability</li> <li>– Enhanced citizen participation and advocacy</li> <li>– Empowerment of poor people, women and other marginalised groups</li> <li>– Improved democracy and good governance</li> </ul>
3. Focus/ coverage	<ul style="list-style-type: none"> <li>– Themes <ul style="list-style-type: none"> <li>· Single theme (gender or poverty)</li> <li>· Multiple themes (gender, poverty, social inequalities and environmental concerns)</li> </ul> </li> <li>– Coverage <ul style="list-style-type: none"> <li>· Entire budget (overall expenditures and revenues across all sectors)</li> <li>· Specific items (sectors, programmes, categories of expenditure, forms of revenue)</li> <li>· Budgetary processes</li> </ul> </li> </ul>
4. Phase of budget cycle	<ul style="list-style-type: none"> <li>– Planning and appraisal phase (priority-setting, formulation and enactment of the budget)</li> <li>– Implementation and monitoring phase</li> <li>– Audit and evaluation phase</li> </ul>
5. Approaches, processes and tools	<ul style="list-style-type: none"> <li>– Approaches <ul style="list-style-type: none"> <li>· Three-way categorisation framework</li> <li>· Five step approach</li> <li>· Budget cycle framework</li> </ul> </li> <li>– Processes <ul style="list-style-type: none"> <li>· Participatory approaches (involving citizen groups at the grassroots)</li> </ul> </li> </ul>

Criteria	Distinguishable features of GRB initiatives
	<ul style="list-style-type: none"> <li>· Technical (mainly analysis conducted by “experts” without citizen participation)</li> <li>– GRB tools               <ul style="list-style-type: none"> <li>· Gender-aware policy appraisal</li> <li>· Gender-disaggregated beneficiary assessments</li> <li>· Gender-disaggregated public expenditure incidence analysis</li> <li>· Gender-disaggregated revenue incidence analysis</li> <li>· Gender-disaggregated time use studies</li> <li>· Gender-aware medium-term expenditure framework</li> </ul> </li> </ul>
6. Outputs	<ul style="list-style-type: none"> <li>– Social impact analyses</li> <li>– Gender aware budget statement</li> <li>– Gender responsive budget guidelines or call circular</li> <li>– Public sector performance audit reports</li> <li>– Alternative (gender-sensitive) budgets</li> </ul>

Sources based on Çağatay et al. (2000); Elson (2002); Budlender et al. (2005); and Holvoet (2007).

Existing literature widely affirms that GRB initiatives are predominantly located outside government and are led by civil society non-government organisations – mainly policy research organisations, women’s or gender organisations – with funding and/or capacity building support from international organisations such as UN Women, International Budget Partnership, as well as bi-lateral agencies (Budlender, 2000; Krafchik, 2002). Many civil society GRB initiatives “see themselves as supporting the government’s agenda” by pushing for the implementation of national policies on gender equality (Budlender, 2000: 7). Krafchik (2002) notes that a number of civil society GRB initiatives have built the capacities of government executives and legislatures, collaborated with governments in forums and undertaken research of special interest to governments.

Many GRB initiatives (inside and outside government) are implemented at national and federal/local government levels, with a few initiatives (such as Tanzania, Uganda) also targeting actors at the grassroots level (Budlender, 2000; Krafchik, 2002). Although GRB involves “gender-sensitive budget analysis and the formulation of gender-sensitive budgets”, many GRB initiatives worldwide have mostly restricted to gender budget analysis (Holvoet, 2006: 6). Relating to the budget cycle process, Krafchik (2002) distinguishes four stages, namely drafting, legislative, implementation, and auditing; highlighting that many GRB initiatives have concentrated efforts on the legislative, followed by implementation stages. The closed nature of the drafting and auditing stages of the budget process to executives in

government in many countries has excluded the effective participation of civil society NGOs, except in countries with participatory budgeting such as Brazil.

At the legislative stage, civil society interventions have mainly included budget training, “preparation of accessible summaries and guides to the budget”, provision of technical support, and the preparation and coordination of independent budget analysis (Krafchik, 2002: 79). At the implementation stage, a number of civil society budget initiatives have engaged in tracking the flow of public funds from central to lower levels of government (Uganda, Tanzania, Zambia), while other initiatives have also evaluated the impact of public expenditure on citizens (South Africa, Ghana, India) (Krafchik, 2002).

The Ugandan GRB initiative (FOWODE), which is the focus of this study, represents a case of a civil society women’s organisation that evolved from an inside-government legislative initiative (started by the women’s caucus of the Constitutional Assembly 1994-1995). FOWODE partners with diverse actors, including international and national civil society organisations, government, the media, elected representatives, researchers, research institutions and individuals, to advance its aim of influencing government gender and economic policy to enable women and men to benefit equally from economic policy and programmes (FOWODE, n.d.). FOWODE operates at national and local government levels, where it targets legislators (women parliamentarians and women councillors), selected technocrats, as well as citizens at the grassroots level, organised in groups referred to as village budget clubs.

The FOWODE initiative focuses on key sectors that directly affect the livelihoods of the rural poor, notably health, education, agriculture, infrastructure (roads and bridges) and water and sanitation. Whereas FOWODE targets the entire budget cycle phases and processes, more efforts are concentrated on the planning, monitoring, audit and evaluation phases of the budget cycle. FOWODE emphasises the use of participatory approaches to enhance ownership of government programmes among the citizens, as well as transparency and accountability of the legislatures and executives (duty-bearers) towards the citizens they serve. FOWODE also conducts independent researches, which are technical in nature, to gather evidence that is used to inform and back its advocacy activities. Over the years, FOWODE has conducted studies involving gender-disaggregated public expenditure incidence analyses, gender-aware policy appraisal and gender-disaggregated beneficiary assessments of various sectors and the NDP. Detailed activities undertaken by the FOWODE initiative at local government level are explained further in Chapter 5 of this thesis.

## <sup>63</sup>2. GENDER RESPONSIVE BUDGETING AS A GENDER MAINSTREAMING STRATEGY

[The agreed conclusions of the United Nations Economic and Social Council (ECOSOC) 1997/2 define gender mainstreaming as:

“[...] the process of assessing the implications for women and men of any planned action, including legislation, policies and programmes in all areas and at all levels. It is a strategy for making women’s as well as men’s concerns and experiences an integral part of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men can benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality” (United Nations, 2002: v).

Concerns about the visibility of women and the importance of integrating a gender perspective in policies and programmes started at the 1985 Third World Conference on Women in Nairobi, which culminated into the adoption of forward-looking strategies for the advancement of women (Hafner-Burton and Pollack, 2002). The preoccupation of women activists and entrepreneurs during the 1970s and 1980s – the Women in Development (WID) era – was to increase the visibility of women in economic development through implementation of specific programmes and projects that target women. The exclusion of women (half of the productive resources) from the development process was seen as the central problem affecting economic development at the time, justifying the need for specific strategies that focused on integrating women into the development process (Hafner-Burton and Pollack, 2002).

The decade that followed 1985 saw a shift in paradigm from focusing on ‘women’ as the disadvantaged or oppressed group to ‘gender’ and the unequal relations between women and men. According to Razavi and Miller (1995), the aim was to empower disadvantaged groups by addressing the problems of gender subordination as constructed by rules and practices of different institutions notably the household, market, state and the community. With its roots in the equity approach of the WID era, the Gender and Development (GAD) era of the 1980s and 1990s focused on “gender relations (rather than women) as the primary analytical tenet, and the integration of a gender perspective in all development activities and at all levels of the development planning process” (Chant and Gutmann, 2007: 9). The actual adoption of gender mainstreaming as a UN strategy, however, took place at the Fourth World Conference on Women in Beijing in 1995, where the UN and its signatory states were called upon to mainstream gender issues across the policy process to ensure that the effects of policies on men and women are analysed prior to decisions being taken (Chant and Gutmann, 2007).

GRB gained prominence in the aftermath of the Fourth World Conference on Women. Paragraph 346 of the 1995 Beijing Platform for Action particularly recommended that:

“Governments should make efforts to systematically review how women benefit from public expenditures; adjust budgets to ensure equality of access to public sector expenditures” (United Nations, 1995: 128).

UNIFEM (now UN Women) (2000) asserts that gender budget analysis permits the scrutiny of government budgets for adequacy of resources to implement the government’s plan of action for gender equality, as well as the effects of fiscal policies on women, as compared to men. To this end, GRB is seen as instrumental in bridging the gap between development of government policy and appropriation of budgetary resources (UNIFEM, 2000). Gender budget analysis also facilitates accountability for gender equality by tracking government spending on implementation of international commitments, national policy statements and obligations (UNIFEM, 2000).

Sharp (2003) suggests that gender mainstreaming objectives are promoted through the assessment of budgets for gender impact. She articulates three interrelated hierarchical goals of gender budget assessments, namely (i) raising awareness and understanding of gender issues in budgets and policies; (ii) fostering accountability of governments for their gender equality commitments; and (iii) actuating necessary changes to budgets and policies in light of the gender assessments. By placing emphasis on participatory principles – such as the inclusion of women, poor people and other marginalised groups in priority setting and decision-making processes – Sharp argues that GRB initiatives ably promote the goal of gender equality (Sharp, 2003). Çağatay et al. (2000: 19) echo this view, asserting that “the act of participation in itself is an aspect of empowerment, which is a key element of effective strategies against poverty and social inequalities.” Jahan (1996), an earlier proponent, also proposed an ‘agenda-setting’ approach to addressing gender inequality and women’s empowerment issues, stressing the need for more inclusiveness of existing decision-making structures and processes to allow women to have a proactive role in shaping objectives, priorities and strategies of development. Seen in this way, GRB initiatives are thus helpful in the empowerment of women, which is also a goal of gender mainstreaming.

The perceived ‘gender-neutrality’ of government budgets has been criticised by several authors for its failure to address existing gender inequalities. Holvoet (2007) notes that the differences in needs, tasks, time-use, opportunities and hindrances between men and women imply that women and men are affected differently by government fiscal policy and have different preferences concerning government expenditure. Hewitt and Mukhopadhyay (2002: 53) affirm that gender analysis helps to demonstrate the ways in which social institutions that seemingly appear “gender-neutral” do in fact bear and transmit gender biases. In a review of the opportunities that GRB initiatives present towards enhancing gender mainstreaming, Hewitt and Mukhopadhyay (2002) argue that GRB analysis permits an objective determination of the real value of resources targeted to women, men, boys and girls through mainstream core government programmes, as gender-specific programme allocations rarely exceed one



<sup>65</sup> per cent of total government spending. They further note that GRB initiatives help to reveal unequal opportunities in the public service; provide an opportunity for key government officials to gain exposure to easily applicable gender training; and the GRB process uncovers the constraints of scarcity of gender disaggregated statistical data and information for effective programme design and implementation (Hewitt and Mukhopadhyay, 2002).

Considering real examples, the Australian and Philippine initiatives demonstrate conventional applications of GRB as a gender mainstreaming strategy (see details of the initiatives in boxes 1 and 2 in Annex 2). Both initiatives share common features of having originated from government and being located in the executive arm under a ministry in charge of coordinating women affairs, working in close collaboration with strategic entities such as the Finance Ministry, Budget Department and the Office of the Prime Minister. Both GRB initiatives started as top-down strategies aimed at fulfilling national policy statements and constitutional obligations relating to gender equality and women, as well as international commitments such as Beijing Platform for Action and/or CEDAW. The initiatives were implemented at national (federal) level with decentralised units at local government (state) levels covering all sectors of the economy. The main focus of both initiatives was to make all government agencies accountable for gender equality by requiring them to: (i) review and revise all programmes, projects and activities for gender-responsiveness and gender impact; (ii) allocate a percentage of resources towards promotion of gender equality; and (iii) make periodic submissions to the responsible authority (ministry or department) about the progress of implementation and achievements relating to gender equality.

In both cases, the processes adopted were quite technical and highly confined to inside government departments. The outputs produced were also not easy to read by outside government actors and, as in the case of Australia, were neglected by NGOs. The broad activities undertaken by the initiatives to integrate a gender perspective across policy processes and diffuse responsibility and knowledge about gender issues across the bureaucracy included: (i) collection of gender-disaggregated statistics and other indicators; (ii) gender training of personnel to build knowledge and capacity for mainstreaming gender into all programmes and policies; (iii) checklists, guidelines and 'gender-proofed' official documents to direct executives with limited experience in gender mainstreaming; and (iv) provision of monitoring and evaluation tools to ensure compliance and assess effectiveness of a given policy or method (Hafner-Burton and Pollack, 2002: 352-353).

Overall, authors such as Holvoet and Inberg (2008), Holvoet (2007), Budlender (2005), International Labour Organisation (2006) and Budlender and Buenenaobra (2001) attest to limitations in the implementation of GRB as a gender mainstreaming strategy to achieve gender equality. Reflecting on the performance of GRB initiatives in achieving the three interrelated hierarchical goals articulated by Sharp (2003), Sharp remarks that while successes have been registered in promoting a better understanding of the gender impacts (goal 1),

“[GRB initiatives] have been limited in achieving both accountability (goal 2) and change to policies and resource allocations (goal 3).” She concludes that “GRB initiatives are weakened as a strategy for imbedding gender into mainstream policy and budgetary processes and outcomes” (Sharp, 2003: 10). Similarly, International Labour Organisation (2006) citing Budlender (2005) and Budlender et al. (2005), suggests that GRB initiatives have generally not been successfully applied to mainstream budgets (which comprise 90 per cent of government expenditure) and have instead tended to concentrate on allocations that specifically target women and girls (which comprise a small proportion of national budgets).

Several factors have been advanced to explain the limited performance of GRB initiatives as a strategy to mainstream gender into government policies and budgets. The common factors across countries, especially in relation to inside government initiatives, include lack of political will among government officials and elected representatives to make institutional changes; poor appreciation and understanding of gender issues by planning and budget officers; conceptual problems with the construct of gender mainstreaming among government departments; inadequate technical capability to integrate a gender perspective into policies, planning and budgeting processes; low levels of staff and budgets allocated towards GRB implementation and gender mainstreaming in general; and the absence of clear operational indicators, measures and monitoring and evaluation standards (Jahan, 1996; Budlender and Buenenaobra, 2001; Holvoet, 2007; Combaz, 2013). In an assessment of the integration of GRB into the aid effectiveness agenda in Mozambique, Holvoet and Inberg (2008) draw attention to the failures of national gender machineries in mainstreaming gender into economic sectors owing to their limited capacity to influence priorities of other ministries. As a crucial solution to integrating “transversal issues (such as gender)” into vertically organised bureaucracies, the authors recommend that “a gender dimension” should be integrated in planning and budgetary guidelines with an orientation towards all line ministries (Holvoet and Inberg, 2008: 37).

Different authors allude to the limitations of civil society GRB initiatives to influence gender responsive policies and budgets as being a result of lobbying actors with insufficient power to amend policies and budgets (Budlender, 2005; Krafchik, 2002); aiming too wide; or focusing on “targeted allocations for women rather than considering how to make all government policies and allocations gender-sensitive” (Budlender 2005: 7). GRB initiatives have largely focused on the supply side of service delivery. With the goal of gender mainstreaming being to achieve gender equality, however, it becomes essential for GRB initiatives to equally focus on interventions that target the demand-side, such as the inclusion of unpaid labour in policies and budgets, as well as advocacy to transform norms and relations that perpetuate gender inequalities at household and community level (Budlender, 2005). Budlender (2005) further contends that the diversity in GRB initiatives with regard to actors, goals, understanding of GRB and activities undertaken, similarly implies that GRB is implemented differently, at different stages of the policymaking and budgetary process, by different players, thereby

<sup>67</sup>resulting in different outcomes at different levels, which may not include gender equality in the final outcomes.

To sum up the debate, despite the limitations encountered, GRB initiatives present great potential to promote gender mainstreaming objectives by raising awareness and understanding of existing gender inequalities, informing gender-responsive policy formulation and resource allocation, and providing feedback on the impacts of fiscal policies on women and girls compared to men and boys. GRB, however, should not be considered as an ultimate solution that will lead to gender equality, as it needs to be combined with other gender mainstreaming strategies as well as more demand-side focused interventions to be effective. The next section examines GRB used as a tool to promote transparency and accountability of budgets and public service delivery.

### **3. GENDER RESPONSIVE BUDGETING AS A TRANSPARENCY AND ACCOUNTABILITY INITIATIVE**

McGee and Gaventa refer to transparency and accountability initiatives (TAIs) as:

“[...] initiatives that attempt to improve standards of accountability and transparency either as ends in themselves or as a means towards democracy- and development-oriented outcomes” (McGee and Gaventa, 2010: 5).

TAIs in most states emerged in the late 1990s amidst the wave of democratic transition and participatory development (Malena et al., 2004). Stirred by the limited successes of the ‘supply-side’ systems of good governance – notably political checks and balances, administrative rules, auditing requirements and formal law enforcement – the international community shifted focus to the ‘demand-side’ of good governance, with the goal of strengthening the voice and capacity of mostly poor citizens to directly demand greater accountability and responsiveness from public officials and service providers (Malena et al., 2004). As a result, most TAIs are demand-driven, led by civil society organisations and citizens and operate from the bottom-up (Malena et al., 2004). A few TAIs, such as the participatory budgeting experiment in Porto Alegre in Brazil, were initiated and are directly supported by government.

TAIs are quite diverse with wide-ranging agendas, assumptions, values and purposes (McGee and Gaventa, 2010). They include, among others, initiatives focusing on service delivery; budget processes; freedom of information; natural resource governance; and aid transparency (McGee and Gaventa, 2010). According to Malena et al. (2004), TAIs have three general aims, namely to improve the quality of governance, increase development effectiveness, and empower citizens – particularly the poor and disadvantaged.

The underlying argument for TAIs is that they help to repair the ‘leaky-pipes’ of corruption and inefficiency, thereby ensuring that aid is channelled more effectively and development initiatives produce greater and more visible results (McGee and Gaventa, 2010). Advocates advance that TAIs increase the chances of effecting positive changes in state responsiveness by providing citizens – especially the poor and disadvantaged – with the opportunity to articulate their demands and engage directly with bureaucrats and politicians in a more informed, organised, constructive and systematic manner (Malena et al., 2004; McGee and Gaventa, 2010). It is argued that increased transparency in public decision-making informs better policy design and promotes the effectiveness of service delivery (McGee and Gaventa, 2010). Goetz and Jenkins (1999: 2) similarly assert that local planning and auditing “promotes citizen awareness of what their government is doing, equips citizens to judge the effectiveness of public policies, and allows people to participate in, and influence, the development process.”

Furthermore, TAIs are credited for empowering poor and disadvantaged groups “to exercise their voice effectively so that power relations are reconstituted to their advantage” (McGee and Gaventa, 2010: 7). Proponents of this view suggest that through the provision of critical information on rights and entitlements as well as solicitation of feedback, the poor and disadvantaged are enabled to increase and aggregate their voice to demand for policy changes in their favour (McGee and Gaventa, 2010).

Narrowing down to budget process initiatives, transparency and accountability is identified as core to initiatives engaged in participatory budgeting, sector-specific budget monitoring (such as gender budgeting), public expenditure monitoring and tracking, as well as social auditing (McGee and Gaventa, 2010). Robinson (2008) argues that the immediate goals of GRB initiatives – which include ensuring that government budget priorities are consistent with declared policy objectives, reflect the preferences of the poor, and allocated financial resources are fully and appropriately expended – already justify the need for improving budget transparency. He alludes to GRB as having a wider purpose, which is “to contribute to democracy-building in developing and transitional societies where state capacity is weak and formal political institutions remain unconsolidated” (Robinson, 2008: 2). Consequently, GRB initiatives are seen to have the potential to strengthen accountability of state actors responsible for formulating and implementing budgets; reduce the scope for diversion of public resources; and promote more efficient and transparent budgetary processes (Robinson, 2008).

Çağatay et al. (2000) observe that in addition to ensuring that financial resources are channelled to socially equitable ends, transparency and accountability of budgets are important for government’s ability to raise revenue. They argue that the willingness of citizens to increase their tax contributions, and external actors to provide financial support, is more probable in cases where governments are transparent, accountable and use resources effectively to meet the stated needs of the citizenry (Çağatay et al., 2000).

Additionally, Goetz and Jenkins (1999) point out that local-level budget analysis and auditing draw attention to the differential impact of public spending patterns on different social groups; the differences in time-use patterns and associated constraints of different social groups; and cases of corruption or miss-spending on non-priority areas. They conclude that local-level budget analysis and auditing contribute to more gender- and poverty-sensitive development planning and policy implementation (Goetz and Jenkins, 1999).

Illustrative examples of GRB initiatives with a focus on transparency and accountability include the South African Women’s Budget Initiative and the Mazdoor Kisan Shakti Sangathan (MKSS) social initiative in Rajasthan, India (see details of initiatives in boxes 3 and 4 in Annex 2). While the South African initiative represents a combination of inside and outside

government actors, the MKSS is an outside government initiative led by a local NGO working with citizens at grassroots level. Both initiatives aim for distributive justice, increased citizen participation in budgetary processes, transparency and accountability of government spending and the effective and efficient use of public resources. The inside government South African initiative is undertaken as an internal monitoring measure to ensure gender-responsiveness and impact of fiscal policies. Both outside government initiatives in South Africa and India, however, scrutinise government budgets for coherence with government policies and the priorities and preferences of the citizenry.

Other similarities between the initiatives include a focus on multiple themes (gender, poverty and social inequalities such as racial discrimination) across diverse sectors of national and/or local government budgets; and the concentration on monitoring, audit and evaluation phases of the budget cycle. McGee and Gaventa (2010: 11) affirm the “most of these [TA] initiatives focus downstream on how public funds are prioritised and used.” A notable distinction, however, is that whereas civil society-led (outside government) initiatives use more technical approaches to collect and analyse budgetary information – such as gender-aware policy appraisal and beneficiary assessments – citizen-led (grassroots) initiatives adopt simpler and largely participatory approaches, such as public commissions or hearings and citizen oversight committees at village level, to gather evidence and demand for accountability from government officials. Both initiatives rely on civic engagement and public pressure to influence responsiveness and exact accountability from public executives.

Typical activities undertaken by GRB initiatives engaged in transparency and accountability include: (i) appraisal of government policies for gender sensitivity and responsiveness; (ii) gender and poverty impact analyses; (iii) training of executives, legislatures and citizens on gender analysis and budgeting; (iv) simplification of budget information for the benefit of the less literate citizens; (v) gender budget advocacy; and (vi) mobilisation and empowerment of grassroots citizens to participate in planning and budget processes. Robinson (2008: 10) particularly highlights two indirect approaches through which GRB initiatives engage citizens in the budget process. The first approach involves enhancing the capacity of elected representatives to participate more effectively in the budget process through trainings in fiscal literacy and equipping them with independent sources of data and information (Robinson, 2008). The second approach involves providing voice to the socially excluded and marginalised citizens, to ensure that their priorities are taken into account during budget debates and while reviewing budget implementation (Robinson, 2008).

Although a group of studies point out a range of developmental and democratic outcomes, such as increased state or institutional responsiveness, reduced corruption, enhanced democratic spaces for citizen engagement, better budget utilisation and improved service delivery; other studies have also noted contradictory results (Mc Gee and Gaventa, 2010). The limited success of GRB initiatives as TAIs is particularly noted in their inability to impose

<sup>71</sup>sanctions or force compliance in cases of corruption or ineffective service delivery owing to the absence, ineffectiveness or inadequacy of institutionalised mechanisms to do so (Malena et al., 2004). Another limitation relates to the fact that the budget process in many countries is still characterised by executive dominance and secrecy, especially at the budget formulation stage where expenditure decisions are determined (Robinson, 2008). Houtzager and Joshi (2008) emphasise that the likelihood of social accountability substantially increases when actors representing the poor and disadvantaged participate in the formulation of policies, as their capacity to monitor implementation is enhanced.

International Labour Organisation (2006) further highlights that the impact of GRB initiatives on budgets is affected by the under-expenditure of governments, unstable budgetary planning processes, lack of political support from Finance Ministers, limited commitment on the part of government officials, and the absence of data and transparency of government. Çağatay et al. (2000) additionally note that the challenges of inadequate literacy skills, numeracy skills and technical knowledge of budgets among ordinary citizens limit their participation in budgetary processes.

In summary, despite the limitations with regard to imposing sanctions and forcing compliance, GRB initiatives with a focus on transparency and accountability can be instrumental in improving state responsiveness to gender and poverty issues, enhancing citizen participation in planning, budgeting and monitoring processes, and promoting efficient use of limited public resources for better service delivery by putting pressure on relevant duty bearers to conform accordingly.

#### **4. SUPPORTIVE CONDITIONS FOR GENDER RESPONSIVE BUDGETING INITIATIVES**

Having distinguished the different kinds of GRB initiatives and reviewed the evidence of implementation and limitations encountered, this section now examines the contexts in which different GRB initiatives have been successfully implemented. The objective is to identify the supportive conditions that enhance the establishment, implementation and impact of GRB initiatives. The identified conditions are to be used in theorising and explaining the necessary scope conditions underlying the causal mechanism linking outside government GRB initiatives to improvements in maternal health service delivery and the use of maternal health services by rural women, discussed in chapter 5 of this thesis.

A review of the implementation and sustainability of GRB initiatives reveals a strong link to their origin. As already mentioned in Section 1.1 of this chapter and affirmed by Çağatay et al. (2000), some of the present day successful initiatives took advantage of the new democratic spaces that were created as a result of larger transformations – such as the South African initiative that emerged soon after the apartheid era. Other initiatives are linked to fiscal decentralisation, devolution practices and social movements – such as the Porto Alegre, India, Uganda and Bangladesh GRB initiatives.

Decentralisation of governments is intended to open up the planning, budgeting and monitoring processes to civil society and citizen participation, thereby providing operative ground for GRB initiatives. The extent of devolution of powers to lower levels of government, however, affects the kind of initiatives that will be implemented and the degree of impact expected. In a review of transparency and accountability initiatives, McGee and Gaventa (2010: 35) observe that the operative context of the initiatives is particularly important, as it determines “which transparency and accountability objectives are feasible or desirable in the first place and the interactions the initiatives will have with broader external factors.”

Goetz and Jenkins (1999) similarly reviewed experiments in local-level service delivery audits in India and concluded that the extent of participation of citizens, particularly women, in local-level planning and auditing was dependent upon the institutional setup and priorities of the decentralised government. They identified the determinant factors as being: (i) the nature of powers devolved to local government for development planning; (ii) the size of local budgets for development work; (iii) the extent of powers for budgetary oversight and audit given to elected representatives and citizen forums; (iv) the constitution of formal opportunities for citizen’s participation – especially for women and other excluded groups; (v) the strength of the civil society; and (vi) the extent to which local government actors (politicians and bureaucrats) are sympathetic and open to efforts to increase local government transparency (Goetz and Jenkins, 1999: 3-4).



<sup>73</sup>International Labour Organisation (2006) credits the relative success and sustainability of the South African Women's Budget Initiative to the involvement of a wide range of actors, notably NGOs, parliamentarians, government and the international community (mainly Commonwealth Secretariat). In contrast, International Labour Organisation attributes the downturn of the Australian initiative during the late 1990s to the lack of involvement of the civil society, which would have challenged the subversion of Women's Budget Statements with the change in political regimes (International Labour Organisation, 2006). They conclude that the collaboration of civil society with government in advocacy work is necessary to promote accountability of governments.

Categorising the necessary conditions and context for the implementation of TAIs into supply-side and demand-side factors, McGee and Gaventa (2010) highlight that the implementation and impact of TAIs (the supply-side) depend on the level of democratisation; the level of political will and overall political environment; and the existence of broader enabling legal frameworks, political incentives and sanctions. The demand-side factors, on the other hand, comprise the capabilities that citizens and civil society organisations have to take up the opportunities offered by the TAIs; the degree to which TAIs interact with other mobilisation and collective action strategies – such as advocacy, litigation, electoral pressure or protest movements; and the engagement of citizens in 'upstream' and 'downstream' stages of the TAI processes (McGee and Gaventa, 2010). McGee and Gaventa (2010) emphasise that the contexts of demand- and supply-side factors differ across countries and will, thus, result in varying degrees of impact.

Malena et al. (2004) identify the critical success factors for the sustainability of social accountability initiatives to be: (i) a democratic political regime that guarantees basic political and civil rights, with a culture of political transparency and probity; (ii) availability and accessibility of reliable public documents and data; (iii) an independent and pluralistic media; (iv) capacity of civil society in terms of technical, advocacy and mobilisation skills; (v) state-civil society synergy; and (vi) institutionalisation of social accountability mechanisms.

From the foregoing observations, it can be deduced that the key supportive factors for sustainable and impactful GRB initiatives fall into five broad categories, namely:

- i. *Conducive political environment:* GRB initiatives thrive in political contexts characterised by democracy, effective devolution of decision-making and oversight powers to the legislature and citizen forums, and political will and commitment among the bureaucrats and politicians towards gender, poverty issues and government transparency.
- ii. *Involvement of a range of actors:* Enhanced results are more likely in contexts where a range of actors are involved in implementing GRB initiatives including bureaucrats,

politicians, civil society organisations, the media, legal experts and citizens. Effective synergy between state and civil society actors is also important.

- iii. *Enabling institutional and legal frameworks:* The impact of GRB initiatives is enhanced by the existence of formal spaces for citizens and civil society participation alongside institutional mechanisms to enforce compliance among bureaucrats. The existence of laws such as the right to information, freedom of the press and provisions for participation of women and other disadvantaged groups in decision making processes are also key factors for successful implementation of GRB initiatives.
- iv. *State capacity and effectiveness:* GRB initiatives are also more effective in instances where public administration is well-functioning, with horizontal accountability mechanisms, the ability to produce timely and reliable records and accounts and the capacity to respond to citizen's demands.
- v. *Engagement and capability of civil society and citizen actors:* The willingness and capability of civil society and citizen actors to take advantage of opportunity spaces created by government and GRB initiatives to participate in the various stages of the budgetary process is also essential for GRB implementation and sustainability.

## <sup>75</sup>5. CONCLUDING REMARKS

This chapter has presented the origin and evolution of GRB initiatives and distinguished the different kinds of initiatives in terms of origin, political location, actors, goals, focus, coverage, processes and outputs. Through the discussion of GRB initiatives as gender mainstreaming strategies and transparency and accountability initiatives respectively, the chapter has revealed that GRB initiatives have a much wider purpose beyond promoting equity in budget policy formulation, resource allocation and implementation. The added purpose includes enhancing democracy and good governance; empowering citizens – especially women and excluded groups – to participate in decision-making and budgetary processes; ensuring transparency and efficiency of public service delivery; and monitoring and reporting the actions of governments to fulfil national policy statements and international commitments regarding gender equality. The chapter has also demonstrated the possibility of similar initiatives yielding different outcomes and/or effects depending on the operational context and political environment. Key supportive conditions for implementation and sustainability of GRB initiatives have also been identified as: a favourable political environment; involvement and synergy of a wide range of actors inside and outside government; enabling institutional and legal frameworks; state capacity and effectiveness; and active engagement and capability of civil society organisations and citizen representatives.

Generally, GRB initiatives worldwide have concentrated their efforts on the expenditure side of budgets. They have also tended to focus on specific sectors and stages of the budget process in accordance with their objectives and focus. The next chapter explores the maternal health sub-sector as one of the aspects of the budget and service delivery that some GRB initiatives have targeted.

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## ANNEX II.

### ***Box 1: The Australian Women's Budget Initiative***

The Federal Government of Australia, elected in 1972, had an election commitment to make government more responsive women. Feminists – known as ‘femocrats’ were recruited with the task of developing a model women’s policy machinery that emphasized the importance of mainstreaming gender analysis into central policy processes. With the clear perception that mainstream policies, such as tariffs, industry policy and industrial relations, had more impact on women’s lives than the relatively small programme expenditures on women’s or children’s services or equity programmes in education and employment, the femocrats distinctively focused on policy monitoring and policy audit.

By the mid-1970s, the hub of Australian women’s policy machinery – the Office of the Status of Women (OSW) – was situated in the chief policy coordinating arm of the Federal Government, the Department of Prime Minister and Cabinet. The OSW had the responsibility to analyse all Cabinet submissions for gender impact, regardless of the area of government from which they came. Decentralised units of this machinery were established in line departments of government with the intention of detecting and reporting on gender impact before proposals reached the stage of Cabinet submission.

In line with their commitment to mainstreaming, the femocrats became increasingly concerned with the need for an effective way to mainstream gender perspectives and gender accountability into budgetary processes. This led to the invention of the women’s budget process referred to as the “women’s budget programme” in 1984. The women’s budget programme mandated all government agencies to audit all their activity for its impact on women, not just programmes specifically targeted at women. By 1985, the women’s budget programme covered all departments and portfolio agencies and was subsequently replicated at state level. From 1987, the women’s budget programme was renamed the women’s budget statement and given more formal status. It covered all federal government activity and became a substantial document up to 1994.

Overtime, however, the original purpose of the women’s budget process became eroded and it became a form of public relations rather than an analytic report. While it was originally intended to highlight the differential impact on women of ‘mainstream’ budgetary allocations, as well as to highlight expenditures targeted to women, the latter function had become dominant by the time of its demise. In 1993, a review recommended that it be replaced by two accountability mechanisms, one of which was the inclusion of gender reporting in the programme statements provided annually by departments for scrutiny by parliamentary estimates committees and the integration of gender equity criteria into programme targets.

*Adapted from* (Sawer, 2002)



<sup>81</sup>**Box 2: The Gender and Development (GAD) Initiative in the Philippines**

The GAD initiative was designed, by the Government of the Philippines, to implement the constitutional recognition of the fundamental equality of men and women and the role of women in nation building, as well as government commitments to women through international agreements such as CEDAW and the Beijing Platform for Action. The GAD strategy started with an enactment of the Women in Development and Nation Building Act (RA 7192) in 1992, which mandated the review and revision of all government regulations and procedures to remove gender bias, and the active participation of women and women's organisations in development programmes. It also specified that a certain percentage of official development assistance be allocated to women's concerns.

Following a presidential directive in 1993, a provision was included in the General Appropriations Act (GAA) mandating all government agencies to allocate a percentage of their budgets to GAD programmes. In 1995, this allocation was fixed at 5 percent and was intended for projects designed to address gender issues and a reporting mechanism was provided to the National Commission on the Role of Filipino Women (NCRFW) to monitor its compliance.

The implementation of GAD programmes, projects and activities follows Guidelines which were formulated by the National Economic and Development Authority (NEDA) and the Department of Budget and Management (DBM) in collaboration with the NCRFW. Implementation is both at national and local government levels and follows GAD Plans which must be formulated in consistency with the respective agency's mandate and objectives and the Philippine Plan for Gender-Responsive Development, 1995-2025. GAD Plans refer to a set interventions systematically designed and implemented by the agencies over a period of time to address the gender issues in their respective sectors, and can be either input/start-up activities or mainstream activities over a given period of time. The Philippine Plan for Gender-Responsive Development 1995-2025 seeks to address the concerns of women for equality and development across six major spheres, namely individual, family, socio-cultural, economic, political and legal. Three basic goals cut across these spheres, namely (i) establishment of mechanisms for gender-responsive policy and programme formulation and implementation; (ii) attention to women on special circumstances and how these circumstances are impacted by other national policies and programmes; and (iii) consciousness-raising, advocacy and affirmative action.

Compliance with the GAD policy was initially slow, partly as a result of resistance owing – in part – to lack of capacity on the part of planning and budgeting officers. NCRFW held meetings with planning and budget officials in each ministry to clarify the concept and methods and continually pressed for monitoring and evaluation at critical points of the process. In an analysis conducted almost a decade later, Budlender and Buenaobra (2001) as cited in Reyes (2002) affirm that GAD budgeting was not integrated into overall planning and budgeting cycles of government agencies due to lack of technical skill and limited understanding of gender, as well as lack of political will.

*Adapted from* (Reyes, 2002)

**Box 3: The South African Women's Budget Initiative**

South Africa has two GRB initiatives – one involves NGOs and parliamentarians (outside-government), the other within government is led by the Ministry of Finance. These initiatives illustrate the different roles of inside and outside government exercises. For instance, the applied gender budget analysis internal to government is primarily for management and accountability: it involves government monitoring the impact of its fiscal policies and reporting its activities to parliament and civil society. The outside government initiative involves citizens in overseeing and critiquing the budget. In this sense, the civil society exercise is bringing the voices of those affected by fiscal policies but normally excluded from discussions of policy formulation, into the discussion.

The outside government initiative is older – it has been underway since 1996 – and has served the dual purpose of spreading the concept of gender budget analysis and widening the expertise of those who can undertake such an analysis. It started as a research and advocacy initiative, with the NGO partners conducting the research to reveal gender aspects of policy and related budgets, and the parliamentarians using the findings to advocate for better policies and budgets. The South African Government started a parallel initiative in 1997 as a Pilot Project of the Commonwealth Gender Budget Initiative aimed at promoting gender-sensitive macro-economic policies.

The outside-government initiative has published analyses of the sectoral budgets of the national government, as well as some analyses of provincial budgets. The sectoral analyses involve four steps. To start with, an examination of the position of women and men and boys and girls in each sector is made, with the data disaggregated by gender, age, race, location and class. This is followed with an analysis of whether government policies adequately address problems identified in the first step. The third step looks at whether adequate resources have been allocated to implement gender-sensitive policies, while the fourth step investigates the effectiveness of the use of the resources in reaching the intended targets and goals. In order to reach the grassroots activists and a wider spectrum of the citizenry, the outside-government initiative also publishes simplified versions of the Women's Budget volumes as a book called *Money Matters: Women and the Government Budget*, whose target audience is people with at least ten years of education. Additionally, the initiative has focused on developing training modules on budgets, budget-related advocacy and public participation.

The government-led initiative includes activities such as input on gender at meetings, training in one of the provinces and preparation of a discussion on gender responsive budgeting. At present, however, the government-led initiative is less active, partly owing to the departure of supportive key players during the early months of 2000.

The South African Initiative is widely credited for strengthening advocacy around gender equality issues, with the main outcome having been the inclusion of studies on gender issues within sectoral reports tabled on the Budget day.

**Adapted from** (Bakker, 2002; Çağatay et al., 2000; & Budlender D, 2002)

<sup>83</sup>**Box 4: The Mazdoor Kisan Shakti Sanghathan (MKSS) Initiative in India**

The MKSS, literally translated as the Movement for Empowerment of Peasants and Workers, is a mass-based grassroots organisation that operates in Rajasthan, one of the poorest areas of India. With a membership of about 1000 people, 60 percent of who are women, the MKSS focuses on addressing issues of concern to the poorer sections of local society through mass action and strategic confrontation with the state administration.

The MKSS's interest in the direct audits of government accounts arose from its work in the late 1980s and early 1990s on livelihood issues, particularly the failure of the state government to enforce minimum-wage regulations on drought-relief works. Discrepancies had constantly arisen between the experiences of the villagers hired in these projects or supposedly benefiting from them and the government's claims. In 1990, MKSS began to take up the more general issue of government's transparency and accountability. It took four years for the MKSS to get the right to view bills, vouchers and employment rolls of development projects from the government at the lowest unit of local government level, and another three years to get the right to copy documents – which was key since certified copies were needed to use as evidence when registering *prima facie* cases of corruption. MKSS was active in cross-checking stories told in official documents with villagers' own experiences as labourers on public-works projects, as applicants for anti-poverty schemes, and as consumers in ration shops.

Starting in December 1994, the MKSS began to hold public hearings (*jan sunwayi*) where detailed accounts derived from official expenditure records and other supporting documentation were read aloud to assembled villagers for them to testify to any discrepancies with their own experiences. The meetings were held in attendance of elected representatives and local government officials. Through this direct form of audit, estimates of missing funds were painstakingly assembled, and people who were never paid their due for their work were able to protest authorities as a group. The public hearings exposed the misdeeds of local politicians, government engineers and private contractors – in a number of cases leading to confessions of corruption by local officials and promises of restitution. In other cases, *prima facie* evidence of corruption was presented to the police and officials of the local government department. MKSS also attempted to use public pressure to force government and elected officials to return the amount they had embezzled to the same village and use public humiliation as a future deterrent to future corruption.

*Adapted from* (Goetz & Jenkins, 1999; Çağatay et al., 2000)



## INTRODUCTION

This chapter puts maternal health in perspective as a gender and poverty issue that calls for targeted intervention. In an attempt to link maternal health to the core themes of GRB initiatives, I begin the chapter with an exposition of maternal health, discussing it as a gender concern and poverty issue respectively. Next, I explore specific health system-related factors (supply-side) and user health seeking behaviour (demand-side) factors that affect access and use of maternal health care and ultimately maternal health outcomes. I follow this with a review of existing literature on GRB initiatives in maternal health, where I discuss the objectives, focus, activities and results of different GRB initiatives. I conclude the chapter with a justification of the importance of GRB initiatives in realising improved maternal health outcomes.

### 1. MATERNAL HEALTH AND GENDER

Maternal health refers to “the health of a woman during pregnancy, child birth and the postpartum period” (World Health Organisation, 2013). Conversely, maternal death refers to “the death of a woman while pregnant or within 42 days of termination of a pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes” (World Health Organisation, 2012: 4).

The World Health Organisation asserts that the overall MMR of developing regions is “roughly 20 times higher than that of developed regions”, with the most affected regions being Sub-Saharan Africa followed by Southern Asia. The majority of deaths occur during or immediately after childbirth and the common direct causes are “bleeding, high blood pressure, prolonged and obstructed labour, infections and unsafe abortions” (The Partnership for Maternal, Newborn and Child Health, 2011).

Until the mid-1980s, global interest in maternal health mainly focused on women’s fertility behaviour as a means of curbing population growth and the effects of maternal health on child welfare (Buvinić et al., 2006). During the 1980s, activism for the adoption of a woman-centred perspective into policies and programmes led to the awareness of how the lower status of women in society affected health delivery and health seeking behaviours, and how women’s time burdens in poor households affected child health (Buvinić et al., 2006). Building on this awareness, the World Bank, alongside partners such as WHO and the United Nations Population Fund (UNFPA), launched the Safe Motherhood Initiative at the UN ICPD in Nairobi in 1987 (Bale et al., 2003). The conference raised awareness of the problem of maternal morbidity and mortality – especially in developing countries – and ended with an ambitious goal to reduce maternal mortality worldwide by half within a decade (Bale et al. 2003). Subsequent focus on maternal health took place at the 1994 UN ICPD in Cairo, where women’s

reproductive health and rights formed a central part of the population and development debate and member states were called upon to design reproductive health care programmes that served the needs of women (United Nations, 1994). The 1995 Fourth World Conference on Women in Beijing further placed emphasis on promoting women's rights and the incorporation of a gender perspective into health policies and programmes (Buvinić et al., 2006). Present day global efforts to improve maternal health mainly stem from its incorporation as MDG 5 at the UN Millennium Summit of 2000 and subsequently Goal 3.1 of the 2030 Agenda for Sustainable Development.

Various authors suggest that the low status of women relative to men is responsible for gender differentials in health, including maternal health. Referring to gender as "structural inequalities marked by unequal relations of power between women and men to material and non-material resources", Sen et al. (2002: 6) point out that girls and boys, women and men within households receive unequal recognition and treatment with regard to health. In many societies, preference is given to the health needs of boys and men relative to girls and women. Women have less decision-making power in the allocation of household and community resources, rest and health care, which may prevent them from seeking care for their health problems (Sen et al., 2002; Vlassoff, 1994). Furthermore, community norms and values regarding women's and men's sexuality, reproduction and rights reinforce gender biases that put women's lives at risk (Sen et al., 2002). Citing research by Royston and Armstrong (1989), Shen and Williamson (1999: 199) assert that in societies where the status of women is low, "women have too many children, start childbearing too early, end childbearing too late and the children are close together." They stress that, given the poor socioeconomic conditions; such women are more vulnerable to health risks caused by childbearing resulting in high maternal mortality (Shen and Williamson, 1999).

The low status of women in households and communities is also reflected in their limited access to formal education and information. Bale et al. (2003) suggest that female literacy is a strong predictor of family size and birth spacing, both of which significantly influence birth outcomes. Formal and health education of girls tends to delay the age of marriage and first pregnancy and may guide women of reproductive age to seek preventive services, increase food intake during pregnancy, understand the danger signs during labour and delivery and seek referral care for obstetric and new born complications (Bale et al., 2003). Extensive literature has also shown that women's education increases the use of maternal health services independent of related factors such as urban or rural residence and socioeconomic status (Gill et al., 2007; Ensor and Cooper, 2004; Thaddeus and Maine, 1994). Conversely, Vlassoff (1994: 1249) asserts that women's limited access to education and information influences their failure to recognise early symptoms of infection and disease and to "suffer from chronic problems because they are accustomed to viewing these as normal female complaints."

Related to the low status of women in households is their lack of control of the timing and number of children to have. A review of evidence by USAID and the Interagency Gender Working Group noted that women are in a weak position in negotiating the timing and circumstances of sexual intercourse; are often blamed for unplanned pregnancies; and – in some settings – “would rather undergo unsafe abortions than risk repeated conflicts with their male partners over contraceptive use” (Interagency Gender Working Group, 2011: 5). Furthermore, gender based violence, which is a prevalent and socially accepted form of gender inequality, affects women’s health and may deter them from seeking professional health care services outside the home (Shaw, 2006).

Vlassoff (1994) further suggests that gender roles in most cultures, which place women as the primary providers of health and care in the family, imply that women will neglect seeking help for their illnesses (or pregnancy), as this would make them seem dependent and unable to perform their roles competently. Research conducted by Li (2004) in Yunnan Province, China found that gender inequality, rooted in the division of labour within the family, impeded maternal health. Highlighting the dual role of women as farm labourers and housewives – even late into the pregnancy – Li asserts that women were often left exhausted and with little time for personal health and hygiene (Li, 2004). Li concluded that women’s lack of control over their lives, coupled with lack of access to material resources and restrictions on their freedom of movement, reduced their chances of receiving necessary antenatal and postnatal health care and increased the risk of maternal and infant mortality (Li, 2004).

While gender norms in many societies ascribe pregnancy and childbirth to be the domain of women, diverse studies have found that male involvement in maternal health has the beneficial effects of increasing the uptake and continuation of family planning methods among families (Hartmann et al., 2012; Sternberg and Hubley, 2004); increasing acceptability of interventions to prevent mother to child transmission of HIV (PMTCT) (Delvaux et al., 2009; Ditekemana et al., 2012 ); and increasing chances of women delivering with the assistance of skilled birth attendants (Mangeni et al., 2012; Terefe and Larson, 1993; Tweheyo et al., 2010). Given that men are the main decision makers in the home, the studies argue that educating men on maternal health and the risk factors and danger signs associated with pregnancy and childbirth enhances their support for women to attend antenatal care and deliver from health facilities.

The key issues emerging from the foregoing discussion are that gender relations and roles at household level, reinforced by gender norms and cultures at community level play a significant role in determining women’s health seeking behaviour for maternal health care and other health services in general. Gender inequality at household level is perpetuated through inadequate representation of women in decision-making positions at community and policy-making levels, which potentially results in the design of policies and programmes that do not effectively address women’s health needs. Education and exposure of women outside the

household, however, provides opportunities to enhance women's autonomy over childbearing and their decision to seek maternal health care during pregnancy, with the positive effect of improving maternal health outcomes. The next section explores the link between maternal health and poverty.



## 2. MATERNAL HEALTH AND POVERTY

Joint estimates – by World Health Organisation, United Nations Children’s Fund (UNICEF), UNFPA, the World Bank and United Nations Population Division – for the year 2015 indicate a wide disparity in maternal health indicators between developed and developing regions. Whereas developed regions account for only 1 per cent of maternal deaths worldwide, developing regions account for 99 per cent, with Sub-Saharan Africa accounting for 66 per cent of the global burden alone (World Health Organisation, 2015). Furthermore, the adult lifetime risk<sup>5</sup> in developing regions is 1 in 150, compared to 1 in 4,900 in developed regions; and the highest adult lifetime risk is still found in Sub-Saharan Africa (1 in 36) as summarised in Table 3 below (World Health Organisation, 2015). The prevalence of high maternal deaths and adult lifetime risk in low-income developing countries is evidence of a possible link between poverty and poor maternal health.

**Table 3: Estimates of MMR, number of maternal deaths and adult lifetime risk by region in 2015**

Region	MMR <sup>6</sup>	Number of maternal deaths	Adult lifetime risk
World	216	303,000,	1 in 180
Developed regions	12	1,700	1 in 4,900
Developing regions	239	302,000	1 in 150
Sub-Saharan Africa	546	201,000	1 in 36
Southern Asia	176	66,000	1 in 210
Western Asia	91	4,700	1 in 360
Northern Africa	70	3,100	1 in 450
Latin America	67	7,300	1 in 670
Eastern Asia	27	4,800	1 in 2,300

Source: Excerpt from summary table in World Health Organisation (2015: 17).

Extensive literature exists to explain the wide disparities in maternal health between high income (developed) and low income (developing) countries. At country level, Bale et al. (2003) propose that weak national and local economies have limited resources, which typically reduce the availability of good quality health services, including obstetric and neonatal care. Low income countries are predisposed to having low health budgets that do not favour investment in public health care infrastructure and, as stated by Ensor and Cooper (2004: 1), “traditional investments in public sector health care infrastructure have not primarily benefited the most vulnerable in society.”

Sen et al. (2002) further suggest that health policies and promotion strategies in developing countries do not adequately respond to women’s specific needs and concerns. They argue that health policies are often based on male perspectives, focus primarily on women’s

<sup>5</sup> The adult lifetime risk is the probability that a 15 year old woman will die of a maternity cause.

<sup>6</sup> MMR is the number of maternal deaths during a time period per 100,000 live births during the same period.

reproductive function while neglecting other functions, and view women as ideal and willing health care providers in the home with no consideration for their own social constraints and health (Sen et al., 2002). Buvinić et al. (2006), on the other hand, attribute the near elimination of the burden of disease from maternal conditions in high income countries to advances in medical technology with a focus on effective family planning methods and the provision of quality emergency obstetric care to prevent maternal health complications. Seen in this way, it can be said that developed countries have a clearer focus on addressing women's medical health needs compared to developing countries.

Within developing countries, evidence had been found of wide disparities in maternal health outcomes between the richest and poorest quintiles of the populations. To illustrate this, Paruzzolo et al. (2010: 7) cite a six-fold difference between the MMR among the richest and poorest quintiles in Peru of 130 deaths per 100,000 live births, compared to 800 deaths per 100,000 live births; and "a 3 to 4 times greater risk of maternal death among the poorest groups of Indonesia compared to the richest groups." Graham et al. (2004: 25) also analysed demographic and health surveys of 10 developing countries and established that "with increasing poverty, the proportion of women dying of non-maternal causes generally increased, and the proportion dying of maternal causes increased consistently."

Numerous studies have attributed the disparities in maternal health outcomes within countries to differences in access and use of maternal health care services among women from different socioeconomic categories. Ensor and Cooper (2004: 1) contend that "access to health services and the distribution of public services favour richer, urban dwellers over generally poorer, rural inhabitants." Reviewing a study conducted by the World Bank on socioeconomic differences in health, nutrition and population in 45 countries, Gill et al. (2007) similarly affirm that the poorest women in the poorest regions of the world have the lowest coverage of maternal health services, represented by an average of 34 per cent having their births attended by a medically trained person compared to 80 per cent of the births attended for women in the richest quintile. Birth outcomes are profoundly affected by exposure to infectious diseases, malaria and poor nutrition, which are more prevalent among the poor than the rich (Bale et al., 2003). Ogunjuyigbe and Liasu (2007) further explain that the convergence of absence of several factors and conditions needed to maintain life at an appropriate level causes poor people to suffer from diseases that either do not, or hardly affect those at the top of the social ladder. Moreover, when the illnesses become protracted, the poorest are less likely to afford treatment, thus resigning themselves to faith and death (Ogunjuyigbe and Liasu, 2007).

At community and household levels respectively, poverty equally manifests itself in poor maternal health conditions and outcomes. Linked to gender relations and unequal division of labour at household and community level, already discussed in section 3.2, women's health

experience is the summation of their caring work, paid or unpaid work, and the conditions under which they carry out their work (Payne, 1991). According to Payne,

“[...] poverty makes demands on women’s time and energy, both physical and emotional, and the draining effect of guilt and worry about meeting the needs of other members in the household, in particular the needs of children, creates a climate of health costs for women” (Payne, 1991: 152).

Payne argues that the resolution of women’s competing demands at household and community level results in a compromise, where their health is traded off against the health and wellbeing of other family members. Impoverished women are more likely to be malnourished, increasing their chances of getting complications or death from pregnancy and childbirth (Bale et al., 2003). Poor women are also inclined to bear children with low birth weight or malformations, resulting in higher rates of disease and early death, all of which impose added costs on the household (Bale et al., 2003).

Taking a different viewpoint, Gill et al. (2007) note that women’s economic opportunity – displayed through gainful or paid employment, the type of occupation, status at work, sector of activity, work effort and wage rate – could pose physical burdens, hazards, or stress which negatively affect maternal health. They, however, maintain that gainful employment empowers women to increase control over resources and decision-making about health care by availing them with the ability to access and pay for maternal and other health care services (Gill et al., 2007). Empirical evidence from China, the Philippines and Cameroon confirms an association between employment and reduced maternal mortality, morbidity, and the increased use of maternal health services (Anson, 2004; Miles-Doan and Brewster, 1998).

From the above discussion, the link between poverty and maternal health becomes clear. There is also evidence of a reverse causal link between poverty and maternal health. Supporters of this view argue that poor maternal health can perpetuate ill health to new born children, drain family resources and savings, change household consumption patterns and reduce households to debt and poverty (Gill et al., 2007). Peters et al. (2008: 166) suggest that the economic consequences of paying for health services include “spending high proportions of household finances (catastrophic spending), [...] borrowing money or selling assets (distress financing), both of which push people into deeper poverty and longer-term debt.”

Death or illness from childbirth may also reduce household productivity through loss of the woman’s paid and unpaid economic contributions. Meyerhoefer and Sahn (2006) argue that maternal morbidity and mortality affect other household members by requiring pre-existing children – especially girls – to take over domestic and caretaking responsibilities, thereby restricting their attainment of education and future earning potential. The cycle of poverty and ill-health is also probably passed on to future generations, as the children who drop out

of school are more likely to marry early, have many children, and become engaged in low-skilled and low wage self-employment or home production (Meyerhoefer and Sahn, 2006). Finally, at a macro level, the large burden of disease caused by maternal morbidity and mortality can put a strain on human and financial resources for health and affect the nation's overall productivity and economic growth.

### 3. INFLUENCING FACTORS FOR MATERNAL HEALTH ACCESS AND USE

Having established the links between gender, poverty and maternal health outcomes, this section delves into specific factors that affect access<sup>7</sup> and use of maternal health services. A distinction is made between health system-related factors on the supply side and the health seeking behaviour of users on the demand side, while acknowledging mutual dependence between the two categories. Supply side factors are inherent in governance and policies, as well as the health system and may promote or hinder service uptake by individuals, households or the community (Jacobs et al., 2012). Demand side factors, on the other hand, influence the ability to access and use maternal health services at individual, household and community level (Jacobs et al., 2012).

Jacobs et al. (2012) propose that the use of health care services can be taken as an operational proxy for access to health care. This presumption suggests that the use of health care is conditional on access to health care services, thus any barriers to access consequently limit the effective use of maternal health care services. Adopting this view, this section concurrently analyses the barriers that affect access with those that hinder the effective use of maternal health care services.

Various authors consider access to health care to be inclusive of four dimensions, notably accessibility, availability, affordability and acceptability (O'Donnell, 2007; Jacobs et al., 2012). All four dimensions comprise factors (barriers) that are health system-related (supply side), as well as user behaviour-related (demand side) as summarised in Table 4 below. As already noted in the introduction chapter of this thesis, health system and household and community factors are shaped by structural factors in the economy and society. The respective barriers are discussed in more detail under sub-sections 3.3.1 and 3.3.2 of this chapter.

***Table 4: Supply- and demand-side barriers to access and use of health services along four dimensions of access***

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<sup>7</sup> Access here refers to the opportunity to use.

Supply- side barriers	Demand-side barriers
<b>Geographic accessibility</b>	
<ul style="list-style-type: none"> <li>• Service location</li> </ul>	<ul style="list-style-type: none"> <li>• Indirect costs to household (transport)</li> <li>• Means of transport</li> </ul>
<b>Availability</b>	
<ul style="list-style-type: none"> <li>• Unqualified health workers, staff absenteeism, irregular opening hours</li> <li>• Waiting time</li> <li>• Motivation of staff</li> <li>• Drugs and consumables</li> <li>• Non-integration of health services</li> <li>• Lack of opportunity (exclusion from services)</li> <li>• Late or no referral</li> </ul>	<ul style="list-style-type: none"> <li>• Information on health care services/ providers</li> <li>• Education</li> </ul>
<b>Affordability</b>	
<ul style="list-style-type: none"> <li>• Costs and prices of services, including informal payments</li> <li>• Private-public dual practices</li> </ul>	<ul style="list-style-type: none"> <li>• Household resources and willingness to pay</li> <li>• Opportunity costs</li> <li>• Cash flow within society</li> </ul>
<b>Acceptability</b>	
<ul style="list-style-type: none"> <li>• Complexity of billing system (out-of-pocket) and inability of patients to know prices beforehand</li> <li>• Staff interpersonal skills, including trust</li> </ul>	<ul style="list-style-type: none"> <li>• Low self-esteem and little assertiveness</li> <li>• Community and cultural preferences</li> <li>• Stigma</li> <li>• Lack of health awareness</li> <li>• Lack of male involvement</li> </ul>

Source: Adapted from Jacobs et al. (2012:290)

### 3.1. Health system related factors (supply side)

A health system is “the sum total of all the organisations, institutions and resources whose primary goal is to improve health” (World Health Organisation Website, 2005). This includes the entire network of agencies, facilities and providers of health care, along with the structures, procedures and regulations that guide health care provision. As shown in Table 4, common health system-related barriers to access and use of maternal health care services include inaccessible health facilities; shortages of skilled health personnel, inadequate health supplies and equipment; irregular and low quality health care delivery; high costs of health care services; and ill conduct of health staff towards maternal health care users.

Relating to accessibility, Peters et al. (2008) note that the absence of good roads coupled with poor communication services – especially in rural areas of low income countries – affects the distribution of drugs and other supplies to health facilities, the timely referral of patients in cases of emergencies, and adequate supervision of health workers by higher level health units. Owing to these problems, remote health care facilities are largely associated with poor quality of service. Golooba-Mutebi (2005: 172) found that the inaccessibility of rural health facilities

in Uganda caused health workers at lower level health units to have very little contact with their professional supervisors, which “created leeway for health workers to engage in unrestrained malfeasance.” In another study conducted in Uganda, Kiwanuka et al. (2008) found that users of health care in remote rural areas of Uganda often by-passed the nearest health facility, opting to travel longer distances in search of ‘perceived’ better quality services. These two studies suggest that geographic inaccessibility of health facilities affects both the quality of service delivery by the health providers and the use of health services by the local community, who expect to receive low quality treatment.

Another prevalent category of health system-related barriers to access and use of maternal health services relates to the dimension of availability. The shortage of qualified health staff (skilled birth attendants), blood, drugs and medical supplies at health facilities affects the delivery and effective use of maternal health care services. Inadequate staffing is compounded further by problems such as absenteeism, delayed and inconsistent opening hours and long waiting times at health facilities. Several studies attribute absenteeism and inconsistent operating hours (late opening and early closing of health facilities) to the dual practice of public health workers in private clinics as a result of low motivation, low and irregular pay from public practice, and an opportunity to make additional income from private practice (Golooba-Mutebi, 2005; Matsuoka et al., 2010; Parkhurst et al., 2005). The private-public dual practice by health workers may either take the form of levying informal user fees in public health facilities or providing maternal health services in private clinics and hospitals, both of which reduce service availability to the poor (Parkhurst et al., 2005). Parkhurst et al. (2005) argue that the ‘dual-practice’ of health workers often clashes with their formal responsibilities and unfairly disadvantages those who are unable to pay by redirecting resources to fee-payers. Mavalankar and Rosenfield (2005) further highlight that some institutional regulations, such as those that restrict lower level health units from offering maternal health services, often result in rural women either not following through with referrals to distant higher level health units, or arriving too late at the health facility to receive the needed lifesaving care.

Affordability, manifested in the cost of services and prices for medication at public health facilities, is also a major hindrance to the effective use of maternal health care services, especially among the poor. User charges for public health services are widespread in developing countries and, in most cases, coexist with informal fees that are often greater than the formal charges (O'Donnell, 2007). Poorly paid health workers and the absence of medical supplies in a health system riddled with limited control over pricing practices implies that poorer women will have limited access to skilled maternal health care. Many studies in diverse developing countries confirm that the introduction of user fees or increase in prices of health care decreased utilisation of health care services, with the effect having been larger among the poor (Peters et al., 2008). Ensor and Ronoh (2005: 55) also note that user chargers “may

influence delays in the decision to seek care and reach a facility, impacting significantly on utilisation of services.”

Under the dimension of acceptability, health system-related factors that restrict access to maternal health care include the complexity of the public health facility billing system, the inability of patients to know the prices of health care beforehand and poor interpersonal skills of health staff (Jacobs et al., 2012). Many developing countries lack public health insurance schemes and are thus heavily reliant on upfront lump sum payment of cash out-of-pocket by the users of health care services (Ensor and Ronoh, 2005; Matsuoka et al., 2010; O'Donnell, 2007). Access to skilled maternal health care services by poor women, therefore, becomes limited and is substituted with unskilled traditional birth attendants whose payment terms are more flexible. The absence of standardised rates and prices for services and medical supplies, as suggested by Peters et al. (2008), breeds misconception by women that governmental facility user fees are much higher than they sometimes are, thereby restricting access and use of maternal health services (Matsuoka et al., 2010).

Stringent public health system requirements in some countries also inhibit some women from accessing and utilising maternal health care during pregnancy. As a case in point, Golooba-Mutebi (2011) notes that the health system regulation in Uganda obliging pregnant women to report with their husband or the person responsible for the pregnancy at the first antenatal visit restricts the women who are unable to be escorted by their partners from attending antenatal care.

With regard to interpersonal skills of maternal health staff towards patients, various studies from developing countries cite impoliteness, hostility and even at times violence towards pregnant mothers as one of the dominant health system hindrances to accessing maternal health care. Grossman-Kendall et al. (2001), in a study conducted in Benin, affirm that the behaviour of health personnel in antenatal clinics and hospital centres was the object of many complaints by women, with the common occurrences being lack of space for communication with patients, impersonal treatment during antenatal consultations, and being brushed off for asking questions or complaining about health problems. Matsuoka et al. (2010) correspondingly found that women in rural Cambodia preferred traditional birth attendants to skilled birth attendants because they were kind and friendly to their clients, although not necessarily skilled in midwifery. Traditional birth attendants were also found to have convenient operating hours and locations, available drug stocks, fewer social barriers with their fellow villagers, as well as helpful attitudes and longstanding relationships with their clients (Peters et al., 2008).

Related to ill-treatment by health staff are delays in receiving care while at the health facility. Cham et al. (2005) found that women who were able to reach health facilities on time also faced delays in receiving prompt and adequate obstetric care from medical workers, which in some cases resulted in maternal and infant deaths. The poor conduct of workers and delays



in receiving care at health facilities are partly explained by shortages of staff; overcrowded maternity and antenatal wards; lack of essential equipment, supplies, blood and drugs; and poor internal management of the health facility (Wallace, 2002; Thaddeus and Maine, 1994).

From the preceding discussion, an interrelationship between structural and health system-related factors can be identified. Inadequate financing of the health sector affects the recruitment, retention and motivation of skilled health workers, as well as the investment in suitable infrastructure, equipment and supplies to ensure the provision of quality maternal health care. Poor management and supervision of health workers and health facility operations also affect service quality; promote absenteeism, dual practice, and other malpractices such as pilferage of public health equipment and supplies to private practice and the charging of high informal user fees. All these factors restrict access and use of maternal health services by the poor.

### **3.2. User health seeking behaviour (demand side)**

The users of maternal health care are women of reproductive age (15-49 years), and more specifically, pregnant women and women in the postpartum period (42 days after child birth). Maternal health seeking behaviour among women in developing countries is largely influenced by distance, quality of care, cost and socio-cultural factors (Thaddeus and Maine, 1994). As shown in Table 4, distance influences the decision to seek maternal health care through the consideration of factors such as transportation and other indirect costs associated with travelling to the health facility. Women's level of education and the availability of information about maternal health care services and providers also affect the use of skilled maternal health care, while socio-cultural factors such as community and cultural preferences and women's status play a role in determining what is deemed an acceptable procedure during pregnancy and childbirth. Affordability relates to household resources and willingness to pay, the opportunity costs of accessing maternal health care outside the home and the regularity of cash flows within a particular society; all of which influence the decision to access and use maternal health care.

Thaddeus and Maine (1994) argue that distance to the health facility has a dual influence on the decision to access and use maternal health care. The long distance may be an obstacle to seeking care, and when combined with lack of appropriate transportation and poor roads, the disincentive becomes stronger (Thaddeus and Maine, 1994). Studies conducted in developing countries have shown that inhabitants of remote rural locations commonly have to walk long distances or improvise transportation with bicycles or mules over rugged terrain in order to reach the health care facility (Cham et al., 2005; Golooba-Mutebi, 2011; Thaddeus and Maine, 1994). Furthermore, women in many parts of the developing world often have to be accompanied by other adults and at times by children who cannot be left at home without caretakers (Odaga and Cattaneo, 2004; Thaddeus and Maine, 1994). This increases the costs

of transportation, accommodation and food, and can be a deterrent to seeking skilled maternal health care (Odaga and Cattaneo, 2004). Ensor and Cooper (2004: 16) summarise that “women living farther away are less likely to choose a health facility for delivery, although their inferior access makes them the most vulnerable group in case of emergency.”

As already highlighted under section 3.1, women’s level of education and access to information about health services and appropriate health service providers influence the decision to seek skilled maternal health care. Proponents argue that education – measured by the individual’s years of schooling – increases their knowledge, awareness, access to information, as well as self-confidence, respect and influence (Thaddeus and Maine, 1994). Ensor and Cooper (2004) propose that education raises the appreciation of the benefits of seeking skilled health care and hence the demand for it. Matsuoka et al. (2010) additionally point out that women’s decision to seek antenatal care and maternal health care services is influenced by their knowledge of the availability of such services at health facilities in their communities. In the absence of information, Cham et al. (2005) highlight that women tend to use previous uncomplicated pregnancies as a risk predicting tool for the current pregnancy. Matsuoka et al. (2010) similarly found that women in rural Cambodia believed that if they were healthy during the pregnancy, they were most likely going to have a healthy birth and that skilled birth attendants were only needed for abnormal or complicated deliveries. Furthermore, where women are availed with information about the medical procedures that may be carried out during pregnancy and childbirth, the possible complications associated with pregnancy and childbirth and the purposes of the treatment they receive, women are able to make informed decisions and may be influenced to seek skilled maternal health care (Grossman-Kendall et al., 2001).

In relation to affordability, Jacobs et al. (2011) suggest that the household’s economic status and willingness to pay for health care services are a key factor in determining the use of maternal health care. The economic status of a household and community is, to a great extent, determined by the type of economic activity from which the main source of income is derived. Cash flows of households in rural agrarian communities are more intermittent than those of households engaged in other economic activities such as trade and service provision. Thaddeus and Maine (1994: 1009) cite studies conducted in Ethiopia by Kwast et al. (1984) and Kwast et al. (1985), which found that the utilisation of health care increased with increasing economic status, and that “the lowest rates of prenatal clinic attendance and highest rates of home delivery were found among women from the lowest economic status groups.” Household willingness to pay for maternal health care services is also influenced by the fact that in many rural societies of developing countries, pregnancy and delivery is considered “natural normal work for women” that does not justify medical expenditure (Thaddeus and Maine, 1994: 1097). In such cases, death during labour and delivery may also be considered normal or inevitable and therefore not amenable to treatment (Thaddeus and Maine, 1994).

Unequal relations of power in the household that give preferences to the needs of men and boys over women and girls, already discussed under section 3.1, also influences women's access and use of maternal health care. In households where resources are scarce, the low priority assigned to women's health needs may inhibit the decision to seek maternal health care until extreme complications with the pregnancy or childbirth arise (Thaddeus and Maine, 1994). Furthermore, access to maternal health care involves opportunity costs relating to the time spent getting to, waiting for and receiving maternal health services. Competing demands on women's time to perform routine tasks such as farming, fetching water, collecting wood for fuel, trading and cooking may affect their decision to seek maternal health care, especially when they are unable to find substitutes for the chores, or during peak seasons of economic activity, such as the harvest (Ensor and Cooper, 2004; Matsuoka et al., 2010; Thaddeus and Maine, 1994).

Regarding acceptability, bad past experience with accessing skilled maternal health care – such as impolite health staff, long waiting times, misdiagnosis, ineffective treatment, lack of necessary supplies and unfavourable health facility procedures – may affect the decision of women to seek maternal health care services. Additionally, low self-esteem and limited assertiveness of women – resulting from wide differences in social status between the health workers and the women, as well as communication barriers between lay people's concepts and those of professional care providers – may influence women's decision to resort to home delivery assisted by traditional birth attendants (Cham et al., 2005; Ensor and Cooper, 2004). Research from countries as diverse as Nigeria, Ethiopia, Tunisia, India and Korea also indicates that women's decision to seek maternal health care is influenced by others, including their spouse or senior family members, and access to maternal health care is minimal in communities where women's mobility outside the household is restricted (Thaddeus and Maine, 1994).

Community and cultural preferences, as well as religious beliefs, may similarly influence health seeking behaviour and the effective use of maternal health care. In a study conducted in rural Gambia, Cham et al. (2005) reveal that older women in their menopause are seen as the 'experts' in pregnancy and childbirth and are often consulted if a complication is noticed during pregnancy, labour or childbirth. Once consulted, their advice is often taken as correct and final (Cham et al., 2005). Ensor and Cooper (2004: 21) also cite one study in Uganda that found that women of the Alur people do not seek help during delivery for fear of being thought of as weak. Cultural beliefs associated with traditional birth practices, however, greatly reduce as societies change through urbanisation, which possibly explains the higher use of modern health care in urban locations of developing countries (Thaddeus and Maine, 1994).

Lastly, the use of maternal health care may also be hindered by stigma associated with fear of social or legal sanctions. Thaddeus and Maine (1994: 1097) suggest that women suffering from

a condition viewed by society as shameful, such as venereal diseases, vesicovaginal fistula, or complications arising from induced unsafe abortion, may restrain from accessing appropriate maternal health care for fear of legal punishment or ostracism.

Broadly, the evidence shows that health seeking behaviour for skilled maternal health services is largely influenced by the household's economic status, socio-cultural norms and preferences, women's level of education and knowledge about maternal health care facilities, and perceptions about the cost and quality of health care at health facilities. The household's economic status, however, is fundamental in that it may overcome or be frustrated by barriers related to distance, indirect costs of accessing care and the opportunity costs of the time spent accessing maternal health care. Education and access to information are also important determinants, as they increase health awareness and understanding of the importance of seeking skilled maternal health care during the pregnancy and after childbirth, and may boost women's assertiveness and self-esteem to have control over their health needs.

## **4. LINKING GENDER RESPONSIVE BUDGETING TO MATERNAL HEALTH OUTCOMES**

The preceding three sections of this chapter have reviewed existing studies on maternal health and ascertained that the causal factors that influence access and the use of maternal health care are largely related to poverty and gender. Underscoring poverty and gender as core themes of GRB initiatives, this section draws on existing literature to explore the experiences of GRB initiatives in maternal health. It concludes with a justification for GRB as a necessary intermediate tool to achieve better maternal health outcomes.

### **4.1. Reviewing the literature: GRB and maternal health**

Keith-Brown (2004) notes that the entry point for most budget initiatives is creating budget literacy by demystifying budget processes and budget information for citizens. Many GRB initiatives have concentrated on applying gender analysis to past and current budgets to assess the appropriateness and trends of expenditure allocations to the health sector relative to other economic sectors (Budlender, 2005; International Labour Organisation, 2006). Some GRB initiatives have moved beyond gender budget analysis to building capacities of women leaders in gender analysis and budgets at local and/or parliamentary level (Mexico, Uganda); promoting gender-responsiveness of budgetary processes (Mexico, South Africa, United Kingdom); developing guides for the formulation of gender responsive health budgets (Mexico); developing toolkits on gender analysis and monitoring in health (Argentina, Mexico, Tanzania, Brazil); and advocating for increases in budget allocations – or budget reallocations – to the health sector (Mexico, Indonesia), among others (Budlender, n.d.; Fundar, n.d.; International Labour Organisation, 2006; International Labour Organisation, n.d) .

Available literature indicates that very few GRB initiatives explicitly target the maternal health sub-sector and that this group of initiatives are predominantly located outside government, led by civil society organisations (Keith-Brown, 2004; Semillas, 2012). According to Budlender (2005: 14), GRB initiatives in maternal health, such as Mexico, grew out of activism relating to the ICPD. Some rights-based civil society organisations are increasingly implementing GRB initiatives – mostly gender analysis of budgets followed by advocacy – as an additional tool to advance their objectives of holding governments to account for commitments to the reduction of maternal mortality and fulfilment of women's rights to safe motherhood (Budlender, 2005; Hofbauer and Garza, 2009; Keith-Brown, 2004; Semillas, 2012). Such initiatives view gender budgeting as a mechanism of ensuring that government policy statements regarding maternal health are backed with adequate funding for successful implementation.

The activities undertaken by GRB initiatives in maternal health are largely technical in nature, and have included “monitoring government spending on maternal health and documenting government's changing strategies, programmes and budgets”(Hofbauer and Garza, 2009: 9);

monitoring budgets and the implementation of specific government programmes on reproductive health for efficiency and accountability (Hofbauer and Garza, 2009; Semillas, 2012); and tracking the flow of funds allocated for maternal health across different levels of government to “uncover leakages that can eventually affect service delivery” (Hofbauer and Garza, 2009: 15). Other initiatives, such as Tanzania and Mexico, have additionally offered trainings to government executives, civil society and staff of international NGOs (UNFPA and UN Women) on how to practically apply GRB to reproductive health (UN Women, 2012b).

Renowned examples of civil society GRB initiatives in maternal health, according to various authors, include Fundar, Centre for Analysis and Research in Mexico, Women’s Dignity in Tanzania, and the Centre for Budget and Governance Accountability in India.

Fundar, Centre for Analysis and Research partnered with three state-based civil society organisations to monitor Mexico’s spending on maternal health since the year 2000 at national, subnational and local levels (Hofbauer and Garza, 2009). Fundar and its partners focused on the health component of the Coverage Extension Programme – one of Mexico Government’s strategies to provide basic health services to the unemployed and informally employed – and examined the proportion of programme funds that were directed towards maternal health (Hofbauer and Garza, 2009). The findings, which were disseminated to relevant stakeholders, revealed that maternal health budgets were insignificant and inadequate to improve health infrastructure and provide emergency obstetric care (EmOC) (Hofbauer and Garza, 2009). With the subsequent launch of ‘Popular Health Insurance’ for the unemployed by the Mexican Government in 2003, Fundar and its partners in the coalition working on maternal mortality noted that EmOC had been excluded from the scheme (Hofbauer and Garza, 2009). The Coalition undertook a costing exercise for the provision of basic and comprehensive EmOC, demonstrated its financial viability and justified its relevance in reducing maternal mortality in Mexico (Hofbauer and Garza, 2009). The result of this advocacy was the government’s inclusion of EmOC-related services under the scheme (Hofbauer and Garza, 2009). Budlender (2005: 10) also highlights that, on the basis of civil society GRB analysis in Mexico, the Commission of Gender Equality of the Chamber of Deputies succeeded in lobbying for “a 40% increase in the amount allocated to reproductive health.” Fundar’s GRB work is also credited for demystifying maternal mortality in Mexico by making it “an issue of social justice, class and race”, which is now given due consideration during congressional budget discussions (Hofbauer and Garza, 2009: 10).

The second renowned example of GRB initiatives in maternal health is Women’s Dignity NGO in Tanzania. On the basis of a government policy to provide free delivery kits<sup>8</sup> to expectant mothers, Women’s Dignity first engaged in “a basic costing exercise to assess how much the

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<sup>8</sup> Delivery kits, also known as mama kits, contain basic supplies (soap, a plastic sheet, a razor blade, umbilical tape and cotton wrap for the new-born) used by midwives and health workers when assisting a delivery (Hofbauer and Garza 2009: 12).

government would have to invest in order to provide free delivery kits to women in vulnerable situations” (Hofbauer and Garza, 2009: 12). Following a study which revealed that delivery kits were lacking at some health facilities and were at times not free; Women’s Dignity engaged in analysis of the national health budget to trace the funds that were allocated for delivery kits, as well as track the flow of these resources from the national level to the point of availability of drugs and supplies at public health facilities (Hofbauer and Garza, 2009). The budget tracking exercise, however, did not succeed, owing to inadequate transparency of health budget information; but paved way for advocacy by Women’s Dignity for “more precise information regarding the funding and availability of the delivery kit and the overall flow of resources from the national level all the way to the health facilities” (Hofbauer and Garza, 2009: 13).

The Centre for Budget Governance and Accountability (CBGA) GRB initiative in India focused on the maternal health component of India’s Reproductive and Child Health Programme. CBGA engaged in “tracking the flow of funds for maternal health from the central government to the district level, scrutinising the national budget, the state budget, and the district implementation plans” in the two states of Uttar Pradesh and Chhattisgarh (Hofbauer and Garza, 2009: 14). The objectives of the initiative were to analyse whether any gaps existed in the transfer of funds from central government to the states and to determine what the funds were actually spent on (Hofbauer and Garza, 2009). The findings of this analysis revealed “a mismatch between what is allocated, what is released, and what is spent”, which led to CBGA’s conclusion that any additional budget allocations to combat maternal mortality need to be backed by “an efficient spending scheme that, in turn, should be based on the actual needs of the targeted population” (Hofbauer and Garza, 2009: 15-16).

The foregoing three illustrations of GRB initiatives in maternal health point towards a shared view that any efforts by governments to reduce maternal mortality must be inclusive, with a focus on meeting the health needs of the poor who are the most affected. As summarised by Hofbauer and Garza (2009: 4-5), “the health of the poor, understood in its widest definition, depends greatly upon the services and attention that the government is *able* or *willing* to provide.” The review of literature also suggests that the success of GRB initiatives in maternal health heavily depends on access to information about maternal health policies, programmes and budgets, which should be specific and transparent about the objectives, activities, funds allocated, implementation procedures, targeted beneficiaries, expected outputs and outcomes. GRB initiatives in maternal health also appear to be successful in cases where there is political support from government to accept and implement suggestions made by civil society activists. Other enabling factors put forward by Keith-Brown (2004) include coalition amongst civil society organisations, strong alliances with oversight institutions, and commitment and sustainability of civil society GRB initiatives.

The technical nature of GRB, however, potentially impedes its adoption by many rights-based civil society organisations that dominate advocacy work related to maternal health. Budlender (2005: 9) affirms this view, with her ‘crude’ categorisation of those who work on budgets as “techninists [who] tend to argue in terms of ‘prioritisation’ and choices within a given budget ceiling” and the rights advocates, who are more of “idealists” and “are more inclined to argue for ‘more for everyone’.” Keith-Brown (2004: 17) further highlights that applied budget work requires a mastery of “public finance techniques, as well as policy and advocacy skills”, which are not often entirely present in civil society budget activist groups.



## 5. SUMMING UP

This chapter has discussed maternal health from a gender and poverty perspective and related maternal health to GRB initiatives. By presenting evidence of wide disparities in maternal health outcomes between developed and developing countries (macro level), and in the access and use of maternal health care between the richest and poorest quintiles within developing countries (micro level); this chapter has ascertained a link between maternal health and poverty. The chapter has demonstrated that other socio-cultural factors, related to gender relations, norms and cultural practices concerning pregnancy and childbirth, as well as the acceptability of the quality of maternal health services at health facilities may hinder access and effective use of maternal health care. Linking maternal health to GRB initiatives, the chapter explored experiences of GRB initiatives in maternal health.

I conclude by reiterating that GRB initiatives in maternal health do not, by themselves, lead to gender equity in health and improved maternal health outcomes, but are necessary as a complementary measure to ensuring that government policies and programmes effectively and explicitly address maternal health needs and government commitments to women's rights to health; that adequate resources are allocated to implement the devised government programmes, and that the allocated resources are spent equitably and efficiently on the intended beneficiaries so as to accomplish programme objectives. GRB initiatives should be combined with other gender mainstreaming efforts in order to realise gender equity in health. A complementary focus of GRB initiatives on the demand side of maternal health care is also envisaged to enhance improvement in maternal health outcomes.

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## **CHAPTER 4**

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### **RESEARCH DESIGN AND METHODOLOGY**



## INTRODUCTION

This chapter elaborates the approach that was used to answer the research questions posed in this study, taking into consideration the issues of validity and reliability. It starts with a review and critical assessment of previous methods that have been applied to evaluate the impact of GRB initiatives and introduces and justifies the methods adopted for this study. Next, the chapter presents an overview of mixed methods research designs and explains the sequential exploratory mixed methods research design adopted for this study. This is followed by a description of the qualitative and quantitative methods and procedures that were undertaken to answer the research questions. The chapter concludes each research phase (qualitative and quantitative) with a discussion of how the issues of validity and reliability were dealt with in the study.

### 1. REVIEWING METHODS USED TO EVALUATE THE IMPACT OF GRB INITIATIVES

As highlighted in the introductory chapter of this thesis, very few empirical studies have examined the effectiveness and impact of GRB initiatives. Combaz (2013: 3), cited in Bamanyaki and Holvoet (2016), attributes the limited evidence base to complexities involved in assessing and interpreting impact, notably: varying definitions and scope of GRB; diversity and unevenness of GRB implementation; the fact that “causalities are complex, multiple and difficult to establish”; and GRB effects may take considerable time to emerge. The available literature on the impact of GRB initiatives is mostly policy- or practitioner-oriented, largely descriptive and has concentrated on evaluating the supply-side effects of GRB initiatives at country/national level (McGee and Gaventa, 2010; Bamanyaki and Holvoet, 2016).

Widely accessed impact studies originate from international organisations (Commonwealth Secretariat, International Labour Organisation, UN Women); policy research institutions (Institute of Development Studies– IDS, United Nations Research Institute for Social Development – UNRISD, Governance and Social Development Resource Centre– GSDRC); individual experts and few academics. These studies have extensively applied case study research methods to document experiences of GRB initiatives (objectives, activities, actors, processes, outputs, short- and medium-term outcomes) in single countries (Bolthale, 2011; Holvoet, 2007; Muchabaiwa, 2010; Sharp and Broomhill, 2002) or multiple countries (Budlender, 2001; Budlender, 2009; International Labour Organisation, 2006; Sugiyama, 2002 UN Women, 2010a).

A review of the approaches that were used to evaluate the effects/impact of GRB initiatives broadly categorises the available case studies into two sets. One set of studies – comprising the majority – provides narrative descriptions of the context and implementation of different GRB initiatives, along with anecdotal evidence of their effects/impact on government policies, budgets, planning and budgetary processes, as well as service delivery. Another set of studies

(UN Women, 2010b; UN Women, 2012a; UN Women, 2012b) consists of evaluations commissioned by practitioners and international organisations – mainly UN Women – to assess the implementation of (supported) GRB initiatives and their “progress towards achieving GRB programming outputs and outcomes” (Bamanyaki and Holvoet, 2016: 73). The latter set of studies, while also descriptive, employs logical framework approaches and theory-based evaluation to explicate the programme theory of the GRB initiatives under evaluation, and utilises the programme theory as a basis to assess programme implementation, effectiveness and impact.

In applying case study research methods, both sets of studies acknowledge the diversity of GRB initiatives and have provided useful insight of the contribution of different GRB initiatives towards promoting gender equality at different stages of the budgetary process (planning, budgeting, implementation/service delivery and audit). Although the latter set of studies attempts to add rigour to the evaluation process, both sets of studies, however, fall short of explaining – in explicit detail – how the observed outcomes were produced, and how strongly the pieces of evidence that manifest the outcomes can be used to infer that the GRB initiative in fact contributed to producing the outcomes (Bamanyaki and Holvoet, 2016). Moreover, the prime focus of previous studies on examining the supply-side effects of GRB initiatives at the national level leaves us in the dark about real impacts of GRB initiatives at lower levels of government, as well as at the household level (Bamanyaki and Holvoet, 2016).

In consideration of these gaps, the present research uses a case study of Kabale District, Uganda and adopts theory-based evaluation and process tracing methodology to evaluate the effects of an outside government (FOWODE) GRB initiative on maternal health service delivery at local government level; as well as a quasi-experiment to determine the effects of the outside government GRB initiative on knowledge of maternal health services, rights and entitlements among rural women at household level. Logistic regression is also applied to examine the influence of knowledge of maternal health services, rights and entitlements on the utilisation of skilled maternal health care among rural women. The next two sections of this chapter elaborate the research design and methodology applied in the study.

## 2. THE RESEARCH DESIGN

This study has the core objective to explore the supply-side and demand-side effects of local-level outside government GRB initiatives in maternal health. In Section 1.3 of the introduction chapter, three central questions were posed to accomplish this core objective. An exploratory mixed methods research design has been chosen as the most appropriate to facilitate the answering of the three central questions. The next section introduces research designs and methods and explains the purposes of mixing methods in research. It also presents a typology of mixed methods research designs and justifies the adoption of the sequential exploratory mixed methods research design for this study, including its strengths and challenges.

### 2.1. Definitions and key attributes of research designs and methods

Research designs refer to “procedures for collecting, analysing, interpreting and reporting data” (Creswell and Clark, 2011: 53). The procedures of data collection and analysis involve the use of different research methods, which Rallis and Rossman (2003: 494) describe as “ways, techniques or tools for generating thoughtful, accurate and ethical data about a program, and also ways, techniques or strategies for manipulating those data.” Research methods are broadly categorised into qualitative approaches, quantitative approaches or mixed methods approaches.

Qualitative approaches stem from a social constructivist, often combined with an interpretivist, worldview that seeks to explore the understanding and meaning that individuals ascribe to a social or human problem (Creswell, 2009). Qualitative research is inductive in nature and involves the use of strategies of inquiry such as narrative research, case studies, phenomenology, ethnography, grounded theory, participatory action research and discourse analysis, among others (Creswell, 2014). When using qualitative methods, the researcher: relies as much as possible on the participant’s view of the situation being studied; typically collects data in the participant’s setting; and analyses the data inductively, building from particular to general themes, before making interpretations of the meaning of the data (Creswell, 2009).

Quantitative approaches derive from a post-positivist worldview, which has a determinist philosophy that “causes (probably) determine effects or outcomes” (Creswell, 2014: 7). Quantitative research is deductive in nature and seeks to test objective theories of identified causes that influence outcomes by examining the relationship among variables (Creswell, 2009). In quantitative research, numeric measures are assigned to variables; data is collected on individual observations; and analysis is done using statistical procedures to enable the generalisation of findings to a given population (Creswell, 2009). Quantitative strategies of inquiry include experimental research (true experiments or quasi-experiments) and surveys (cross-sectional or longitudinal) (Creswell, 2014).

Mixed methods approaches combine or associate qualitative and quantitative approaches in a single study or programme of inquiry (Creswell, 2009; Rallis and Rossman, 2003). According to Creswell (2014: 11) mixed methods research adopts a pragmatic worldview, which puts more emphasis on the research problem rather than research methods and uses “pluralistic approaches to derive knowledge about the problem.” Other authors such as Biesta (2010), Greene and Hall (2010) and Mertens and Wilson (2012), propose that mixed methods should be viewed in terms of “epistemologies, methodologies, designs and ontological assumptions that are associated with different research frameworks (Mertens, 2012: 256). Three paradigmatic stances are advanced, namely dialectic pluralism (a nexus of social constructivist and post-positivist paradigms); pragmatism (involving the use of different methods to fit different research questions) and the transformative stance (where different methods are used to “support enhancement of human rights and social justice” (Mertens, 2012: 256). The stance adopted in this research has elements of dialectic pluralism, but differs to the extent that social constructivist and post positivist stances are not applied concurrently throughout the study, rather are applied for separate research questions and linked in the final stage of interpretation of results.

A range of reasons exist to justify the mixing of methods in research. Greene et al. (1989) put forward a typology of five reasons for mixing methods in research, notably triangulation, complementarity, expansion, development and initiation. Table 5 below summarises the description and rationale for each of the five reasons respectively.

**Table 5: Purposes for mixed methods evaluation designs**

Purpose and description	Rationale
TRIANGULATION seeks convergence, corroboration and correspondence of results from different methods.	To increase the validity of constructs and inquiry results by counteracting and maximising the heterogeneity of irrelevant sources of bias attributable, especially, to inherent method bias, but also to inquirer bias, bias of substantive theory and biases of inquiry context.
COMPLEMENTARITY seeks elaboration, enhancement, illustration and clarification of the results from one method with the results from the other method.	To increase the interpretability, meaningfulness and validity of constructs and inquiry results by both capitalising on inherent method strengths and counteracting inherent biases in methods and other sources.
EXPANSION seeks to extend the breadth and range of inquiry by using different methods for different inquiry components.	To increase the scope of inquiry by selecting the methods most appropriate for multiple inquiry components.
DEVELOPMENT seeks to use the results from one method to help develop or inform the other method, where	To increase the validity of constructs and inquiry by capitalising in inherent method strengths.

Purpose and description	Rationale
development is broadly construed to include sampling and implementation, as well as measurement decisions.	
INITIATION seeks the discovery of paradox and contradiction, new perspectives of frameworks, the recasting of questions or results from one method with questions or results from the other method.	To increase the breadth and depth of inquiry results and interpretations by analysing them from the different perspectives of different methods and paradigms.

Source: Excerpt from table in Greene et al. (1989: 259).

In choosing an appropriate mixed methods design, Creswell and Clark (2011) further recommend the consideration of the following four factors:

- 1) the level of interaction between the quantitative and qualitative stands, referred to as the extent to which the two strands are kept independent or interact with each other;
- 2) the priority of the quantitative and qualitative strands, referred to as the relative importance or weighting of the quantitative and qualitative methods for answering the questions;
- 3) the timing of the quantitative and qualitative strands, defined as the temporal relationship between the two strands in terms of data collection and the order in which the results from the two data sets are used within a study; and
- 4) where and how the quantitative and qualitative strands are mixed, referred to as the point of interface in the research where the quantitative and qualitative strategies are mixed (interpretation, data analysis, data collection or design stages); and the associated mixing strategies (merging the two data sets; connecting from analysis of one set of data to the collection of a second set of data; embedding one form of data within a larger design or procedure; or using a framework [theoretical or programme] to bind together the data sets).

Depending on the nature of the research problem, combined with a consideration of the above four factors, Creswell and Clark (2011) suggest six major prototypical mixed methods research designs that a researcher may choose from, namely convergent parallel design, explanatory sequential design, exploratory sequential design, embedded design and transformative multi-phase design. While this study adopts the exploratory sequential mixed methods design, a summary of the characteristics of the six prototype designs is presented in Table 9, Annex 3 of this chapter. The next section discusses the exploratory sequential mixed methods design in more detail.

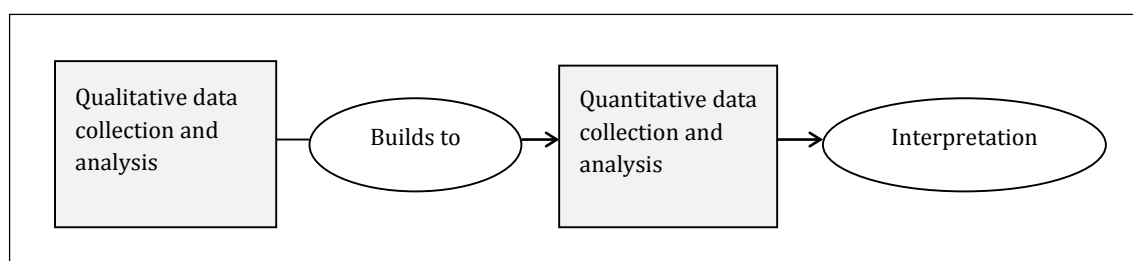
## 2.2. The exploratory sequential mixed methods design

[Creswell and Clark define the exploratory sequential mixed methods design as one in which

“[the researcher] begins with and prioritises the collection and analysis of qualitative data in the first phase. Building from the exploratory results, the researcher conducts a second, quantitative phase to test or generalise the initial findings. The researcher then interprets how the quantitative results build on the initial qualitative results.” (Creswell and Clark, 2011: 71)

In this type of research design, the qualitative phase takes greater priority or emphasis compared to the quantitative phase, notated as QUAL-quant (Creswell and Clark 2011; Morse, 1991). A graphic illustration of the exploratory sequential mixed methods design is depicted in Figure 2 below.

**Figure 2: An illustration of the exploratory sequential design**



Source: Excerpt from Creswell and Clark (2011: 69).

The research design for this study consists of two distinct phases starting with an exploratory qualitative phase and ending with a second quantitative phase. In the first phase, qualitative data is collected and analysed to understand the context, activities, outputs and expected outcomes of the outside government GRB initiative (FOWODE) in the maternal health sub sector, along with the change process and mechanism through which the GRB initiative influences gender responsive maternal health service delivery and the utilisation of maternal health services among rural women at local government level. The quantitative phase follows second in the sequence with the aim of testing and expounding on selected qualitative results of the first phase. The quantitative and qualitative strands of the research design are connected through an intermediate phase in which the qualitative results are used to make decisions about specific research questions, relevant variables and sampling strategies for data collection in the second quantitative phase. The two strands of the research design are also connected at the stage of interpretation of the overall study findings (see flow chart in Table 10, Annex 3 of this chapter).

The rationale for choosing the exploratory sequential design is three-fold: foremost, there is scant academic literature and no established guiding theory or framework of how to evaluate GRB initiatives in the health sector at local government level; secondly, the relevant variables and associated measures of outcomes and impact of GRB initiatives in the maternal health



sub sector are unknown; and thirdly, a mixed methods approach provides a better understanding of the research problem as compared to the use of either a qualitative or quantitative approach alone (Creswell and Clark, 2011). Relating to the typology suggested by Greene et al. (1989) presented in Table 7, the exploratory sequential design aids the purposes of expansion – by offering a broad range of inquiry methods for different inquiry components; complementarity – by affording the elaboration, enhancement and clarification of qualitative results with quantitative findings; development – by informing research questions, sampling and measurement decisions for the quantitative phase; and triangulation – through the corroboration of the results from the two phases. Furthermore, the quantitative survey enables us to obtain the perspectives of rural poor women regarding the changes that have resulted from the outside government GRB intervention at personal, household, community, and health facility levels.

### **2.3. Strengths and challenges of the exploratory sequential mixed methods design**

In addition to enabling a better understanding of the research problem that the study seeks to accomplish, the exploratory sequential mixed methods research design has the following other strengths. First, it is straightforward to describe, implement and report, owing to the separation of the qualitative and quantitative phases (Creswell and Clark, 2011). Second, it appeals to both qualitative- and quantitative-based audiences by using the two methods to evaluate the construct of outside government GRB initiatives in the maternal health sub sector (Creswell and Clark, 2011). Third, the second quantitative phase builds on the findings of the initial qualitative phase, consequently enabling the identification of relevant variables and the minimisation of erroneous attribution of effects. The fourth strength relates to its ability to enhance the utility of the evaluation findings by GRB practitioners, as it provides a broader perspective of the effects of GRB implementation at different stages.

The strengths of the exploratory sequential approach notwithstanding, this research design also does pose some challenges, which have been noted and addressed accordingly. First, the approach requires considerable time to implement, including the time to develop the quantitative instrument mid-way the study. This problem was addressed by drafting and following a work plan, early enough in the study, with specific timelines for the research activities (see flowchart in Annex 2 of this chapter). The second problem relates to the sequential phases of inquiry in the same study sites, which could bias the responses of the second quantitative phase in the event that some of the participants are interviewed twice. This problem was addressed by choosing a small purposeful sample for interview in the first phase, followed by a larger sample constituting different participants during the second phase.

## **3. QUALITATIVE RESEARCH METHODOLOGY**

With the exploratory sequential mixed methods research design understood, this section elaborates on the research methodology adopted for the initial qualitative phase of the study. The qualitative phase had two specific objectives. The first objective was to gain an in-depth understanding of the objectives, activities, processes and the causal mechanism through which outside government GRB initiatives in health may influence gender-responsive maternal health service delivery (the supply side) and the utilisation of maternal health services by rural women (the demand side) at local government level. The second objective of the qualitative phase was to analyse whether and how the outside government GRB initiative (FOWODE) has influenced gender responsive maternal health service delivery and the use of maternal health care services in Kabale District. In doing so, the qualitative phase answers *central question 1* and *central question 2* of this research.

The main strategy of inquiry for this qualitative phase is a case study (Creswell, 2014). According to Gerring (2007: 10) a case refers to “a spatially delimited phenomenon (a unit) observed at a single point in time or over some period of time. It comprises the type of phenomenon an inference attempts to explain.” Case study research, therefore, involves an in-depth analysis of a case (or number of cases) using qualitative, quantitative or mixed methods (Creswell, 2014; Gerring, 2007). There is no general consensus on the definition of case studies; however, some authors have proposed the description of case studies according to the purposes or research objectives of the study (Levy, 2008). Gerring (2006: 170) offers a distinction between narrowly-scoped case studies whose inferences are intended to reflect upon a larger population and “studies that investigate a bounded unit in an attempt to elucidate a single outcome occurring within that unit.” In line with the research objectives of this qualitative phase, and given the fact that GRB initiatives are diverse across and within countries (as already discussed in Chapter Two), the focus of the present case study is to investigate the bounded unit (the FOWODE GRB initiative in maternal health in Kabale District) and make inferences of effects that apply to the specific case. Theory-based evaluation is combined with process tracing methods to aid within-case qualitative analysis of the case study as described next in 3.1.

### **3.1. Overview of theory-based evaluation and process tracing methods**

Theory-based evaluation and process tracing are theory-centred approaches that seek to explain how and why a programme achieves (or fails to achieve) results (Birckmayer and Weiss, 2000 cited in Bamanyaki and Holvoet, 2016). This section gives an overview of theory-based evaluation, process tracing and the integration of theory based evaluation and process tracing.

#### **3.1.1. Theory-based evaluation**

Various authors define theory-based evaluation differently. According to Rogers et al. (2000: 5) theory-based evaluation refers to “an explicit theory or model of how the programme causes the intended or observed outcomes and an evaluation that is at least partly guided by the model” Another definition by Van Der Knaap (2004: 17) describes theory-based evaluation as “the analysis and valuation of the contribution of intervention strategies to resolving or controlling social problems.”

Theory-based evaluation essentially involves two key components: a conceptual component, which articulates the programme theory (theory of change), and an empirical component, which tests the theory to investigate whether, why and how the programme caused the intended or observed outcomes (Leeuw, 2012). The programme theory is a description of the cause-and-effect sequence through which an intervention is expected to bring about changes in the social conditions that it seeks to address, along with the necessary requirements (underlying assumptions) that will bring about the intended effects (Rossi et al., 2004; White, 2009).

Theory-based evaluation has been applied in diverse ways by different authors, depending on the evaluation purpose (Bamanyaki and Holvoet, 2016). Weiss (1997) identifies two types of theory-based evaluation approaches that vary on the basis of how the programme theory is used. The first type, referred to as implementation theory, articulates the programme theory and uses it to evaluate programme implementation and success (Bamanyaki and Holvoet, 2016; Weiss, 1997). Rossi et al. (1999: 161) define implementation theory (or process theory) as “an account of how the program intends to bring about the desired interactions with the target population and provide the planned services.” The second type, referred to as programmatic theory, utilises the programme theory to analyse mechanisms or “the responses that activities generate between the delivery of the programme service and the occurrence of the anticipated outcomes” (Weiss, 1997 cited in Bamanyaki and Holvoet, 2016: 74). Programme theory, also known as programme impact theory, “delineates the cause-and-effect sequence through which the programme is expected to bring about change in the social conditions it addresses” (Rossi et al., 1999: 161). The latter type of evaluations is more concerned with causal attribution of programme interventions.

The existing studies concerned with making causal attribution have widely used the programme theory in experimental and quasi-experimental designs “to identify and measure intermediate steps of programme implementation and proximal outcomes so as to make judgements about programme success” (Bamanyaki and Holvoet, 2016: 74; Rogers et al., 2000; Stern et al., 2012). In more recent years, the increasing complexity of evaluating the efficacy or effectiveness of real-world interventions using experimentalist designs (Blamey and Mackenzie, 2007) has seen the rise of non-counterfactual designs being used in ‘small-n’ studies to evaluate the impact of interventions (Bamanyaki and Holvoet, 2016; Befani and Mayne, 2014; Stern et al., 2012). In the latter studies, implicit programme theories are used

“to establish beyond reasonable doubt how an outcome or set of outcomes occurred” (White and Phillips, 2012: 7). White and Phillips (2012) draw attention to four non-counterfactual approaches that have been used in theory-based evaluations, namely realist evaluation (Pawson and Tilley, 1997); contribution analysis (Mayne, 2012); general elimination method or modus operandi (Scriven, 2008); and process tracing (Beach and Pedersen, 2013; George and Bennet, 2005).

Realist evaluation regards programme interventions being implemented in particular contexts as a manifestation of a given underlying programme theory, referred to as the middle range theory (White and Phillips, 2012). In realist evaluation, the programme theory is made explicit to explain the nature of a particular programme, the target population, the precise circumstances in which the programme is introduced (context), and how the programme will function in the given context to produce the outcome (White and Phillips, 2012). The implementation of the programme and subsequent evaluation then test the validity of the programme theory, with the objective of updating the middle range theory or establishing a new middle range theory of “what works for whom, in what circumstances and in what respects and how” (Pawson and Tilley, 1997: 2).

Contribution analysis underlines that a single programme intervention does not work in isolation to produce a particular outcome; rather, it operates alongside other influences to produce the observed outcome (Befani and Mayne, 2014; White and Phillips, 2012). Consequently, contribution analysis has the objective to establish the “contribution story” of an intervention on an outcome, while taking note of the relative importance of other influences (White and Phillips, 2012: 42). Contribution analysis uses the programme theory as a framework upon which evidence is gathered to establish whether the activities, processes, mechanisms and results postulated in the programme theory actually occurred, as well as the extent to which observed outcomes “can be attributed to the programme in light of other factors” (White and Phillips, 2012: 42). In contribution analysis, multiple causal strands are permitted, resulting in the possibility of multiple contribution stories to explain the outcome (White and Phillips, 2012).

General elimination method sets out to validate causal claims beyond reasonable doubt by “systematically identifying then ruling out causal explanations of observed results” (White and Phillips, 2012: 38). General elimination method starts with the listing of potential causes or alternative competing explanations for an observed outcome or event, followed by the theorising of the modus operandi (similar to a programme theory) that details “a sequence of intermediate or concurrent events, a set of conditions or chain of events that has to be present when the cause is effective” (Scriven, 2008: 21). From an examination of the facts of a particular case, causes whose modi operandi are not present in the case are systematically eliminated to “leave a dominant cause or set of causes that explain how the outcome resulted” (Scriven, 2008 cited in Bamanyaki and Holvoet, 2016: 75).

All the preceding three approaches utilise the programme theory (or some variant) as a basis for collecting evidence of causal chain events and underlying assumptions in order to substantiate causal claims in a given case. The three approaches, however, are not explicit about “causal links in causal processes” (the underlying mechanisms) and either ignore their importance (general elimination method); treat them as unobservable (realist evaluation); or regard them as “assumptions instead of vital parts of the causal mechanism that should be studied empirically” (Schmitt and Beach, 2015: 430-431; Bamanyaki and Holvoet, 2016). Moreover, the three approaches neither prescribe the kinds of evidence that should be collected to validate the (programme) theory, nor the criteria for judging the strength of the evidence that supports causal claims made in the given case (Befani and Mayne, 2014; Schmitt and Beach, 2015; Bamanyaki and Holvoet, 2016). Process tracing methodology offers an alternative solution to the aforementioned challenges, and is increasingly gaining popularity as an evaluation approach that enables “stronger causal inferences to be made about complex interventions” (Bamanyaki and Holvoet, 2015: 75). Process tracing methodology is the analytical approach adopted for the qualitative phase of this study and is discussed in more detail in the next sub section.

### **3.1.2. Process tracing methodology**

The thrust of process tracing methodology, which distinguishes it from other theory-based non-counterfactual evaluation approaches, is its focus on the causal mechanisms that underpin causal theories. Unlike other approaches that focus on validating events and assumptions in the cause-and-effect sequence of the programme theory; process tracing methodology (or process tracing) places emphasis on analysing the theoretical process whereby the cause (programme intervention) “transmits causal forces through a series of interlocking parts of a mechanism” to produce the outcome (Beach and Pedersen, 2013: 13). Collier (2011: 823) defines process tracing as “the systematic examination of diagnostic evidence selected and analysed in light of research questions and hypotheses posed by the investigator.” Process tracing has three variants which differ according to the research purpose (Beach and Pedersen, 2013). The three variants include two theory-centric approaches – theory-testing process tracing and theory-building process tracing– and one case-centric approach – explaining outcome process tracing (Beach and Pedersen, 2013).

Explaining outcome process tracing is concerned with “crafting a minimally sufficient explanation for a particular outcome” in a given case (Beach and Pedersen, 2013: 18). The researcher starts with a puzzling or interesting outcome in a case and then theorises and combines multiple mechanisms into a conglomerate mechanism that accounts for the outcome (Beach and Pedersen, 2013). The conglomerate mechanism is systematically traced to build the best possible explanation for the particular outcome, and the inferences that are made are delimited to the specific case (Beach and Pedersen, 2013).

Theory-building process tracing starts with factual “empirical material and uses a structured analysis of this material to detect a plausible hypothetical causal mechanism whereby X [the hypothesised cause] is linked to Y [the outcome]” (Beach and Pedersen, 2013: 16). Theory-building process tracing is used to investigate known correlations between X and Y that are present across a population of cases, with the ambition of building a mid-range theory (causal mechanism) that is generalizable beyond the individual case to a temporal or spatial bounded context of cases (Beach and Pedersen, 2013: 16).

The third variant, which is adopted for this study, is theory-testing process tracing. Theory-testing process tracing is applied when the researcher has knowledge of both X and Y and either has “existing conjectures about a plausible causal mechanism” or is “able to use logical reasoning to formulate a causal mechanism from existing theorisation” (Beach and Pedersen, 2013: 14). In theory-testing process tracing, a plausible causal mechanism is hypothesised and empirically tested to confirm or disconfirm whether each part of the causal mechanism was present in the case and whether the causal mechanism functioned as a whole (or just parts of it were present) to contribute to producing the outcome (Beach and Pedersen, 2013). Theory-testing process tracing does not make claims of the mechanism being the only cause of the outcome; neither does it “test the relative explanatory power of competing mechanisms against each other” (Beach and Pedersen, 2013: 15). The inferences made from theory-testing process tracing relate to the specific case, although the theorised causal mechanism can be generalised to other cases with a similar context (Beach and Pedersen, 2013).

Theory-testing process tracing methodology proceeds in three steps. Step 1 involves conceptualising the causal mechanism between X and Y and explicitly describing the context within which the causal mechanism functions (Beach and Pedersen, 2013). Step 2 follows with the operationalisation of the causal mechanism by “translating theoretical expectations into case-specific predictions of what observable manifestations each of the parts of the mechanism should have if the mechanism is present in the case” (Beach and Pedersen, 2013: 14). Step 3 involves collecting empirical evidence for each part of the mechanism and testing it using Bayesian logic to update our confidence in the causal mechanism having been present in the case and functioned accordingly to link with the outcome (Beach and Pedersen, 2013). The elaboration of the theory-testing process, along with its application for this case study is made in Chapter 5 of this thesis.

### **3.1.3. The integrated approach: theory based evaluation and process tracing methodology**

The integrated approach employs theory based evaluation and process tracing to answer the research questions for the qualitative phase (Bamanyaki and Holvoet, 2016). On an account of the absence of established theories linking GRB initiatives to specific outcomes (such as gender-responsive maternal health service delivery and the use of maternal health care), combined with the diverse nature and unevenness of implementation of GRB initiatives worldwide (Combaz, 2013); theory-based evaluation principles were employed to explicate a programme theory that links local-level outside government GRB initiatives to the outcomes of gender responsive maternal health service delivery and the use of maternal health services by rural women (Bamanyaki and Holvoet, 2016). The development of the programme theory and underlying assumptions was informed by reviews of existing relevant policy, academic and practitioner literature; interviews held with GRB architects, managers and practitioners in Uganda; as well as site visits to Kabale District to “observe and understand the context of programme implementation” (Bamanyaki and Holvoet, 2016: 77). The Programme theory (Figure 5) is presented and discussed in detail in Chapter 5.

Following the development of the programme theory, a case-specific causal mechanism was logically deduced, informed by the presumed links in the cause-and-effect sequence of the programme theory, as well as existing theoretical explanations of how social accountability initiatives (including GRB) may bring about gender accountability in maternal health (Bamanyaki and Holvoet, 2016). The three steps of theory-testing process tracing (as described above) were applied to test the presence and functioning of each (and all) part(s) of the hypothesised causal mechanism in Kabale District, so as to strongly confirm or disconfirm the contribution of the FOWODE GRB initiative towards gender responsive maternal health service delivery. Section 3.2 discusses the researcher’s role in the study, followed by the procedures that were undertaken for qualitative data collection, preparation and analysis in sub sections 3.3 and 3.4 respectively.

### **3.2. The researcher’s role**

Qualitative research constitutes interpretive research, whereby “the inquirer is typically involved in a sustained and intensive experience with participants” (Creswell, 2014: 187). This interaction between the inquirer and research participants creates ethical, personal and strategic issues which could bias the research process as well as the interpretations formed during the study (Creswell, 2014). With the researcher considered as a human instrument in qualitative research, it becomes useful to reflexively identify and report personal biases, values and experiences that may shape the interpretations of the findings in the study (Creswell, 2014).

The inquirer in this study has an academic background in economics, accounting and development studies and has no prior practical experience working with civil society organisations, and much less with women activist organisations. At the start of field research (August to October 2013), the inquirer undertook a three-month's internship with FOWODE at the national office (under the Gender and Economic Policy Programme) with the objective of acquainting herself with outside government GRB interventions in the Uganda context and understudying civil society operations and challenges. During the internship period, the inquirer participated in programme activities, including the internal monitoring of GRB interventions at local government level in five districts (including Kabale). This enabled the inquirer to witness, first hand, some GRB activities being implemented at district and grassroots level, as well as establish good relations with district officials, Kabale field office programme staff, local leaders and grassroots community group leaders. The relations established while at FOWODE facilitated easy access to the district local government offices and communities in the study locations one year later (October 2014 to January 2015); as well as access to relevant, and at times sensitive documents needed for the research.

The inquirer's district of origin (Bushenyi) is in the same geographic region as Kabale, whereby the dialect spoken is very similar. The inquirer was able to fluently communicate with all the research participants interviewed, which encouraged them to be open and provide detailed responses to the open-ended interview questions. The inquirer obtained official permissions to conduct interviews in the district and always introduced the study to all participants and obtained their consent to participate in the study, providing them with the assurance that their views would be kept confidential. Potential inquirer biases that may arise include the fact that the inquirer is a female who may be empathetic towards maternal health and gender equality issues faced by rural women. The inquirer was conscious of this fact and purposed to remain objective in handling responses throughout the research and conducted separate interviews for male respondents and female respondents.

### **3.3. Procedures for qualitative data collection**

As already mentioned, the research site for the qualitative phase of the study is Kabale District located in South Western Uganda (latitude 1°14'31.04"S; longitude 29°59'8.22"E). Kabale was purposefully selected as the research site because it is one of the five pilot districts of the FOWODE GRB initiative at local government level in Uganda (started in 2000), and among the five pilot districts, Kabale has the most significant results in as far as influencing gender-responsive maternal health service delivery is concerned. The choice of the district was informed by a review of FOWODE programme reports and consultations with FOWODE staff at national level.

Data collection for the qualitative phase was conducted in only one district to aid the purposes of within-case analysis. The data was collected from September 2014 to January 2015. Within



Kabale District, the sub-research sites were Kabale District Local Government (for the district-level GRB intervention) and the two sub counties of Bubare and Kamwezi, where FOWODE had implemented the grassroots-level intervention as at the time of the data collection. FOWODE implemented two-year grassroots-level interventions and operated in Bubare Sub County from 2010 to 2012 and in Kamwezi Sub County from 2012 to 2014.

The research participants for the qualitative phase were purposively selected using maximal variation sampling strategy (Creswell and Clark, 2011), whereby diverse individuals were chosen so as to obtain diverse perspectives of the objectives, implementation and ensuing outcomes of the FOWODE GRB initiative in the health sector at local government level, with specific reference to maternal health. Information for the research drew from five sources. The first source was semi-structured interviews conducted with 32 individuals, 9 of who were technocrats in the district, 4 district councillors, 4 health workers at health facilities, 2 media (radio) journalists, 5 FOWODE staff at the field office and national level, 3 local leaders at sub county, parish and village level, and 5 staff from other NGOs with activities in the maternal health sector of Kabale. The second source was 4 focus group discussions held with 12 village budget club<sup>9</sup> (VBC) leaders and members (6 from Bubare and 6 from Kamwezi), and 20 expectant and/or or new mothers residing in villages in Bubare and Kamwezi sub county. The third source was document reviews of FOWODE programme documents, national and district policies, budgets, plans and reports. The fourth source was audio and visual material of FOWODE GRB activities implemented (particularly interface meetings and community meetings held to discuss maternal health service delivery and budget issues). The fifth source of information was observation of processes and physical outputs (where possible) to aid the corroboration of interview statements. All the interviews and focus group discussions were conducted by the inquirer and were recorded using audio equipment, as well as interview notes by two note takers.

### **3.4. Procedures for qualitative data analysis and interpretation**

All raw forms of data collected were first organised and then prepared for analysis. The audio-taped interviews were transcribed and field notes and documents were arranged into different types depending on the category and source of information. The transcribed interviews and other electronic data were imported into NVIVO 10 software for thematic content analysis.

Guided by the qualitative research objectives and questions, the data in NVIVO was first coded into seven organising categories, namely GRB objectives, activities, processes, outcomes, underlying assumptions, programme sustainability and work attributed to other players. The

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<sup>9</sup> Village budget clubs are parish-level community groups comprising of 20 members (12 women and 8 men) formed by FOWODE to implement grassroots-level GRB activities.

second level of coding involved the sub-division of the first six codes (objectives, activities, processes, outcomes, underlying assumptions, programme sustainability) according to respondent categories, notably district-level actors, grassroots level actors, health providers and rural women. The second level of coding was done in order to identify themes, patterns and meanings from the data across the different respondent categories. The code of outcomes was also further sub-divided into three levels, namely proximate, intermediate and distal across the different categories of the respondents. The qualitative data was interpreted in accordance with the key themes that emerged and the principles of Bayesian logic, as will be described in Chapter 5.

### **3.5. Dealing with validity and reliability**

This section discusses how the issues of validity and reliability were dealt with in the qualitative phase. Qualitative validity relates to the accuracy of the research findings, while qualitative reliability checks the consistency of the inquirer's approach across different researchers or projects (Creswell, 2014). In their book on naturalist inquiry, Lincoln and Guba (1985) propose alternative terminologies to validity and reliability that are more applicable to qualitative research, namely truth value, consistency/neutrality and applicability.

Truth value relates to the accuracy with which the inquirer interprets participant experiences and is partly influenced by the worldview and personal experiences of the inquirer (Jeanfreau and Jack, 2010; Noble and Smith, 2015). Truth value in this study has been addressed through the explicit reflexive statement of the researcher's role in sub-section 4.3.2. In addition, the use of audio-recording for all the interviews permitted the necessary revisiting of actual interviews to identify and reflect the participants' statements and triangulate the responses with other data sources accordingly.

Consistency, also known as auditability relates to "the 'trustworthiness' by which the methods have been undertaken and is dependent on the researcher maintaining a [clear and transparent] 'decision-trail'" (Noble and Smith, 2015: 34). This has been addressed through the explicit detail and a systematic application of the principles and methods prescribed for theory based evaluation and theory-testing process tracing.

Applicability is similar to generalisability and refers to the extent to which the findings of the research can be applied to "other contexts, settings or groups" (Noble and Smith, 2015: 34). This has also been considered by making the explicit statement that the inferences made in this study apply to the specific case, although the causal mechanism may apply to other cases with similar contexts as the present case.

The next section discusses the research methodology applied for the quantitative phase of the study.



#### **4. QUANTITATIVE RESEARCH METHODOLOGY**

The quantitative phase of this research is intended to answer central question 3 (To what extent have outside government gender budget initiatives influenced the use of maternal health care among rural women of Kabale District?). The specific objective of this phase is to examine the effects of outside government GRB initiatives on the demand for maternal health care services at local government level. As already discussed, this quantitative phase utilises the qualitative phase findings to identify relevant variables and frame specific research questions to evaluate the effects of the outside government GRB initiative at individual/household level. Specifically, the research questions examine the extent to which selected cause-and-effect claims posited in the programme theory manifest at household/individual level.

The quantitative phase investigates three research questions outlined as follows:

- 1) What is the effect of the exposure to outside government gender budget initiatives on the knowledge of maternal health services, rights and entitlements among rural women of reproductive age?
- 2) How does the knowledge of maternal health services, rights and entitlements associate with the utilisation of skilled maternal health care among rural women of reproductive age?
- 3) What is the relationship between exposure to the outside government gender budget initiative and perceptions about the quality of maternal health service delivery among rural women of reproductive age?

The strategy of inquiry for the quantitative phase is a quasi-experiment using a post-test treatment group and two sets of control groups to facilitate the assessment of the counterfactual in two scenarios. The treatment group comprises participants residing in villages that constituted the operational area of the grassroots-level FOWODE GRB initiative in Kamwezi Sub County, Kabale District. The two control groups comprise participants residing in villages that did not have the grassroots-level outside government GRB initiative. One control group scenario is a sub county within the same district (exposed to the outside government GRB initiative at district level) but without the grassroots level initiative, while the other control group is a sub county in a different district with no outside government GRB initiative present (neither at district- nor grassroots-level). The rest of this section proceeds with a description of the procedures that were undertaken for quantitative data collection, analysis and interpretation accordingly.

## 4.1. Procedures for quantitative data collection

Creswell and Clark (2011) emphasise that persuasive and rigorous quantitative data collection should involve the use of sampling procedures in determining the research location and site; the participants needed to provide the data in the study; the number of participants needed to answer the research questions; and the recruitment procedures for the participants. This section describes the research sites, participants and sampling strategy. The section also explains the types of data that were collected and the instrument that was used to collect the data accordingly.

### 4.1.1. The research sites and participants

The treatment location for the quantitative phase investigation is Kamwezi Sub County, Kabale District. Kamwezi Sub County was conveniently chosen as the research location based on the following reasons:

- Among the three sub counties that FOWODE had operated in<sup>10</sup>, Kamwezi was the only one that still had an active grassroots-level Village Budget Club at the time of conducting this research;
- Qualitative interviews widely cited Kamwezi Sub County as being renowned for advocacy related to gender-responsive maternal health service delivery and maternal health care utilisation; and
- The data required to answer the quantitative research questions constituted recall information, which was deemed to be more accurate in a location which had recently concluded (and still had traces) of the FOWODE GRB intervention.

The two control locations for this study are Nyamweru Sub County in Kabale District (scenario 1) and Mpungu Sub County in the neighbouring Kanungu District (scenario 2). The choice of the two control locations was informed by the FOWODE GRB programme placement criteria, as well as other characteristics of the treatment location. From qualitative interviews and document reviews, FOWODE's placement criterion for its GRB initiative is rural-poor and 'hard-to-reach' sub counties, either in terms of physical distance from the district headquarters or owing to poor transport and communication networks, which potentially affect effective public service delivery. Other selection criteria that were considered in the choice of comparable control locations included the coverage of maternal health services in the sub county, socio-economic conditions, ethnicity, topography, and transport and communication networks. Furthermore, FOWODE was in the process of setting up community structures to implement the grassroots-level GRB initiative in Nyamweru Sub County for the

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<sup>10</sup> As at the time of data collection, FOWODE had implemented and completed two-year cycle grassroots-level GRB initiatives in Bubare (2010 to 2012), Kamwezi (2012 to 2014) and Ikumba (2012 to 2014).

period 2015 to 2017 at the time of conducting this research. Mpungu Sub County in Kanungu District shares the similarity with Kamwezi of being located far from the district headquarters.

Within Kamwezi Sub County, FOWODE implemented the grassroots-level GRB initiative in two out of the six parishes, namely Kyabuhangwa and Kyogo. The two parishes are made up of 18 villages and constitute the catchment of one public health facility that offers maternal health services - Kyogo Health Centre III. The health facility is located in Kyogo Parish, while Kyabuhangwa Parish has a private not for profit health facility in the parish at the level of a health centre II. In comparison, Bwindi Health Centre III in Nyamweru Sub County serves a catchment of two parishes (Nyamweru and Kyokyezo) which comprise 20 villages. The health facility is located in Nyamweru Parish, while Kyokyezo also has a private not for profit health facility at health centre II level. In Kanungu District, Mpungu Health Centre III is located in the centre of the sub county and serves a catchment of four relatively small parishes (Bulemba, Mpungu, Muramba and Ngara) comprising a total of 14 villages. Mpungu Sub County also has one private not for profit health facility at the level of health centre II. All the three locations have the presence of White Ribbon Alliance and AMREF Health Africa as the only other NGOs with interventions in maternal health.

In view of the information required to answer the three research questions for this phase, the study population was restricted to women of reproductive age (15 to 49 years) who had delivered a live child or still birth within the three years prior to August 1, 2015. The three year period coincides with six months following the commencement of the grassroots-level GRB initiative in Kamwezi Sub County to the first day of data collection. The quantitative data was collected during the months of August to October 2015.

#### **4.1.2. The sampling strategy**

Quantitative data collection commenced with the treatment sub county, Kamwezi. Due to resource constraints, it was impractical to conduct research in all the 18 villages of the GRB intervention in the sub county. A feasible representation of half of the villages in each parish (9 villages) was conveniently chosen. The initial qualitative phase had established that the villages within respective parishes were quite similar with regard to socio-economic status, ethnic groupings and the factors that would influence access and use of maternal health services by women. Accordingly, a two-stage sampling design was adopted to generate the study sample.

In the first stage, the village listing from the 2011 Uganda Bureau of Statistics (UBOS) Community Information System implementation report was used as the sampling frame (UBOS, 2011: 69-70). Each of the villages was assigned a number ranging from 1 to 10 for the villages in Kyabuhangwa Parish and from 11 to 18 for the villages in Kyogo Parish (see sampling frame in Table 9, Annex III). An online random numbers generator (Stat Trek) was then used

to randomly select, without duplication, the 9 sample villages (5 from Kyabuhangwa and 4 from Kyogo) for the treatment location. A similar approach was used to draw the sample villages in Nyamweru sub county, whereby 10 villages<sup>11</sup> out of 20 (5 from Nyamweru Parish and 5 from Kyokyezo Parish) were selected. Maintaining consistency with the criterion of selecting the sample villages from the catchment area of the health centre III in the sub county, combined with the fact that Mpungu Health Centre III is strategically located in the centre of the sub county, all the four parishes surrounding the health facility were considered for the sample. A similar approach of selecting half of the villages from each parish, as described above, was applied and 7 out of the 14 villages<sup>12</sup> (3 from Bulemba, 2 from Mpungu, 1 from Muramba and 1 from Ngara) were selected for the sample (see sampling frame in Table 9, Annex III). Table 6 below presents a summary of the first stage of sampling in the three sub counties

**Table 6: Summary of villages sampled in the three study locations**

Subcounty/district	Number of parishes	Villages in parishes	Villages sampled
Kamwezi, Kabale	2	18	9
Nyamweru, Kabale	2	20	10
Mpungu, Kanungu	4	14	7
Total	7	52	26

Source: Author's own table

In the second stage, village population lists of women fitting the eligibility criteria for the study (women aged 15 to 49 years with a live or still birth delivery in the last 3 years) were compiled for all the 26 selected villages in the three sub counties using updated Village Health Team (VHT) household records<sup>13</sup>. The village population lists were used as the sampling frame for the households within the respective villages. Specific households were randomly selected from the respective household lists using systematic random sampling.

As already highlighted, the sample size that was used in the three locations was determined in the first (treatment) location. The following formula was used to calculate the sample size:

$$(Z^2 * p * (1-p))/c^2$$

where  $Z$  = Z-value (1.96 for a 95 per cent confidence level)

$p$  = percentage of the sample that picks a particular answer (set at 0.5)

<sup>11</sup> Bwindi Health Centre III has a catchment of 20 villages in two parishes.

<sup>12</sup> Bulemba Parish has 5 villages, Mpungu Parish has 4 villages, Muramba Parish has 3 villages and Ngara Parish has 2 villages, making a total of 14 villages.

<sup>13</sup> A recently concluded national mass polio immunisation had facilitated the updating of household records by VHTs.

c = confidence interval ( $\pm 5$ ).

Given the study population of 279, the sample size was calculated as 162 respondents at a 95 per cent confidence level and margin of error of  $\pm 5$ . The 162 respondents per Sub County (486 in total) were proportionately distributed according to village sizes within the parishes which ensured that more responses were obtained from the villages with larger representation (see sampled households in Table 10 in Annex III). For each village, however, the enumerators were each given an extra five names as alternative respondents to be interviewed in the event that the enumerator was not able to find the principal respondent at home. This resulted in the enumerators interviewing more than 162 respondents in some villages, leading to the final total of 500 respondents (168 from Kamwezi, 162 from Nyamweru and 170 from Mpungu). All completed questionnaires were included in the dataset for analysis.

#### **4.1.3. Instrumentation**

A structured questionnaire was designed for the study and administered through face-to-face interview. The questionnaire included five sections, namely:

- a) Demographic information – individual and household characteristics;
- b) Social status in the household and community – to establish participation in decision-making and control of household resources at household level, as well as participation in community-level activities;
- c) Knowledge of maternal health services, rights and entitlements – a simple knowledge test;
- d) Use of maternal health care services – particularly prenatal care, delivery care, delivery assisted by a skilled birth attendant and postnatal care;
- e) Rating of maternal health service quality at public health facilities – to corroborate qualitative findings and determine the perception that rural women have about the gender-responsiveness of maternal health care.

#### **4.1.4. Pre-testing and field research**

The questionnaire was pretested in Nyaruhanga Parish, Ikumba Sub County. Ikumba Sub County was chosen because FOWODE concurrently implemented the grassroots-level GRB initiative in Ikumba and Kamwezi. The pre-test was preceded by a one-day training of 4 enumerators (2 male and 2 female university graduates) on the study objectives and proper administration of the questionnaire. Each question was first interpreted in English and then translated into Rukiga (the local dialect) to ensure that it was correctly and consistently understood. Each enumerator interviewed 8 respondents during the pre-test making a total of 32 households. Pre-test experiences were shared amongst the team and the questionnaire was refined to the final version. The pre-test findings facilitated the identification of common



responses, which enabled the refinement of the questionnaire to have more close-ended questions and an option of 'other' for responses that did not fit the available options.

#### **4.2. Procedures for quantitative data preparation and analysis**

The data from the three sub counties was entered in Excel and then exported to Stata 14 and SPSS 23 for analysis. Descriptive analysis of the data was conducted for the independent and dependent variables to examine the characteristics of the sample. Propensity score matching was used to estimate the effects of the outside government GRB initiative on the knowledge of maternal health services, rights and entitlements among rural women of Kabale (question 1). Bi-variate logistic regression analysis was used to determine the association between of knowledge of maternal health services, rights and entitlements and the utilisation of skilled maternal health care (prenatal, delivery at a health facility, delivery assisted by a skilled birth attendant and postnatal) among rural women (question 2). For research question 3, exploratory factor analysis, followed by Kruskal-Wallis H and Mann-Whitney U tests were conducted to examine the relationship between exposure to the outside government gender budget initiative and perceptions about the quality/responsiveness of maternal health service delivery among rural women of reproductive age. The description and application of each of these methods will be explained in more detail in Chapter 6.

#### **4.3. Dealing with reliability and validity threats**

With regard to quantitative applications in the social sciences, Carmines and Zeller (1979: 11) define reliability as "the extent to which an experiment, test or any measuring procedure yields the same results on repeated trials." Validity, on the other hand, refers to "the extent to which any measuring instrument measures what it is intended to measure" (Carmines and Zeller, 1979: 17).

The reliability of the survey questionnaire was handled by conducting a pre-test and re-testing the same individuals shortly (switching interviewers) to determine consistency of the results. A reliability test (Cronbachs alpha) was also conducted to determine the internal consistency of the scale items used in factor analysis (question 3), as will be presented in Chapter 6.

Regarding validity, the questions asked in the survey primarily drew from actual qualitative findings relating to the activities of the outside government GRB in maternal health at grassroots level. The objectives and interpretation of each question were discussed amongst the research team (researcher and four enumerators) prior to conducting field research, which enabled a unified understanding of what each question sought to measure. Analysed pre-test results as well as experiences of the enumerators during the pre-test were discussed, which enabled appropriate refinement (rephrasing of questions) to suit the understanding of the participants.



## 5. CONCLUDING REMARKS

This chapter has elaborated the research design and methodologies that were applied to investigate the effects of outside government GRB initiatives on the supply of and demand for maternal health services at local government level. The chapter started by highlighting the void in literature that evaluates the effects of GRB initiatives and reviewed the approaches that have been used in existing studies that discuss the effects/impact of GRB initiatives. Noting deficiencies, such as the lack of systematic procedures to evaluate impact and the lack of criteria with which to judge the weight of evidence used to infer impact, the chapter has advanced and briefly discussed the use of theory based evaluation and theory-testing process tracing to empirically evaluate the effects of GRB initiatives and other gender-focused interventions.

The chapter also introduced the sequential exploratory mixed methods design that was adopted for this study. The mixed methods design starts with a qualitative phase that applies theory-based evaluation and process tracing and ends with a quantitative phase that employs propensity score matching, binary logistic regression and factor analysis methods to investigate the effects of outside government GRB initiatives in maternal health at district and grassroots levels. The sequential exploratory mixed methods design was deemed most appropriate because it offers a broad range of inquiry methods for different inquiry components, and elaborates, enhances and clarifies qualitative findings with quantitative results. The chapter has elaborated the procedures that were undertaken for sampling, data collection and analysis in the two study phases and discussed how the issues of reliability and validity of findings have been dealt with.

The next two chapters present and discuss the research findings starting with the qualitative phase results in Chapter 5 and the quantitative phase results in Chapter 6 respectively.

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## ANNEX III.

**Table 7: Prototypical characteristics of the major types of mixed methods designs**

Prototypical characteristics	Convergent design	Explanatory design	Exploratory design	Embedded design	Transformative design	Multi-phase design
Definition	Concurrent quantitative and qualitative data collection, separate quantitative and qualitative analyses of the merging of the two data sets	Methods implemented sequentially starting with quantitative data collection and analysis in Phase 1 followed by qualitative data collection and analysis in Phase 2, which builds on Phase 1	Methods implemented sequentially starting with qualitative data collection and analysis in Phase 1 followed by quantitative data collection and analysis in Phase 2, which builds on Phase 1	Either concurrent or sequential collection of supporting data with separate data analysis and use of supporting data before, during or after major data collection procedures	Framing the concurrent or sequential collection and analysis of quantitative and qualitative data sets within a transformative theoretical framework that guides the methods designs	Combining the concurrent and/or sequential collection of quantitative and qualitative data sets over multiple phases of a program of study
Design purpose	<ul style="list-style-type: none"> <li>• Need a more complete understanding of the topic</li> <li>• Need to validate or corroborate quantitative scales</li> </ul>	<ul style="list-style-type: none"> <li>• Need to explain quantitative results</li> </ul>	<ul style="list-style-type: none"> <li>• Need to test or measure qualitative exploratory findings</li> </ul>	<ul style="list-style-type: none"> <li>• Need preliminary exploration before an experimental trial (sequential/before)</li> <li>• Need a more complete understanding of an experimental trial, such as the process and outcomes (concurrent/ during)</li> <li>• Need follow-up explanations after an experimental trial (sequential/after)</li> </ul>	<ul style="list-style-type: none"> <li>• Need to conduct research that identifies and challenges social injustices</li> </ul>	<ul style="list-style-type: none"> <li>• Need to implement multiple phases to address a programme objective, such as for development and evaluation</li> </ul>



<b>Prototypical characteristics</b>	<b>Convergent design</b>	<b>Explanatory design</b>	<b>Exploratory design</b>	<b>Embedded design</b>	<b>Transformative design</b>	<b>Multi-phase design</b>
Typical paradigm foundation	<ul style="list-style-type: none"> <li>• Pragmatism as an umbrella philosophy</li> </ul>	<ul style="list-style-type: none"> <li>• Post-positivist in Phase 1</li> <li>• Constructivist in Phase 2</li> </ul>	<ul style="list-style-type: none"> <li>• Constructivist in Phase 1</li> <li>• Post-positivist in Phase 2</li> </ul>	<ul style="list-style-type: none"> <li>• Worldview may reflect the primary approach (e.g. post-positivist or constructivist) or pragmatism if concurrent</li> <li>• Constructivist for the qualitative component and post-positivist for the quantitative component if sequential</li> </ul>	<ul style="list-style-type: none"> <li>• Transformative worldview as an umbrella philosophy</li> </ul>	<ul style="list-style-type: none"> <li>• Pragmatism if concurrent</li> <li>• Constructivist for the qualitative component and post-positivist for the quantitative component if sequential</li> </ul>
Level of interaction	Independent	Interactive	Interactive	Interactive	Interactive	interactive
Priority of the strands	Equal emphasis	Quantitative emphasis	Qualitative emphasis	Either quantitative or qualitative emphasis	Equal, quantitative, or qualitative emphasis	Equal emphasis
Timing of the strands	Concurrent	Sequential: quantitative first	Sequential: qualitative first	Either concurrent or sequential	Either concurrent or sequential	Multi-phase combination
Primary point of interface for mixing	<ul style="list-style-type: none"> <li>• Interpretation if independent</li> <li>• Analysis if interactive</li> </ul>	<ul style="list-style-type: none"> <li>• Data collection</li> </ul>	<ul style="list-style-type: none"> <li>• Data collection</li> </ul>	<ul style="list-style-type: none"> <li>• Design level</li> </ul>	<ul style="list-style-type: none"> <li>• Design level</li> </ul>	<ul style="list-style-type: none"> <li>• Design level</li> </ul>
Primary mixing strategies	Merging the two strands: <ul style="list-style-type: none"> <li>• After separate data analysis</li> <li>• With further analysis (e.g. comparisons or transformation) of separate results</li> </ul>	Connecting the two strands: <ul style="list-style-type: none"> <li>• From quantitative data analysis to qualitative data collection</li> </ul>	Connecting the two strands: <ul style="list-style-type: none"> <li>• From qualitative data analysis to quantitative data collection</li> </ul>	Embedding one strand within a design based on the other type <ul style="list-style-type: none"> <li>• Before, during or after major component</li> <li>• Use secondary results to enhance planning, understanding or explaining of primary strand</li> </ul>	Mixing within a theoretical framework: <ul style="list-style-type: none"> <li>• Merging, connecting or embedding the strands within a transformative theoretical lens</li> </ul>	Mixing within a programme-objective framework: <ul style="list-style-type: none"> <li>• Connecting and possibly merging and/or embedding within a programmatic objective</li> </ul>

Prototypical characteristics	Convergent design	Explanatory design	Exploratory design	Embedded design	Transformative design	Multi-phase design
		<ul style="list-style-type: none"> <li>• Use quantitative results to make decisions about qualitative research questions, sampling and data collection in Phase 2</li> </ul>	<ul style="list-style-type: none"> <li>• Use qualitative results to make decisions about quantitative research questions, sampling and data collection in Phase 2</li> </ul>			
Common variants	<ul style="list-style-type: none"> <li>• Parallel databases</li> <li>• Data transformation</li> <li>• Data validation</li> </ul>	<ul style="list-style-type: none"> <li>• Follow-up explanation</li> <li>• Participant selection</li> </ul>	<ul style="list-style-type: none"> <li>• Theory development</li> <li>• Instrument development</li> </ul>	<ul style="list-style-type: none"> <li>• Embedded experiment</li> <li>• Embedded correlational design</li> <li>• Mixed methods case study</li> <li>• Mixed methods narrative research</li> <li>• Mixed methods ethnography</li> </ul>	<ul style="list-style-type: none"> <li>• Feminist lens</li> <li>• Disability lens</li> <li>• Socioeconomic class lens</li> </ul>	<ul style="list-style-type: none"> <li>• Large-scale programme development and evaluation projects</li> <li>• Multi-level state-wide studies</li> <li>• Single mixed methods studies that combine both concurrent and sequential phases</li> </ul>

Source: Creswell and Clark (2011: 73-76)

**Table 8: Flow chart of procedures and timelines followed in implementing the sequential exploratory design**

Phase	Activity details	Timescale
Qualitative	Design and implement the qualitative strand of the study <ul style="list-style-type: none"> <li>• State qualitative research questions and research approach</li> <li>• Identify qualitative sample</li> <li>• Collect open-ended data using interview and observation protocols</li> <li>• Analyse the qualitative data using procedures of theme development and in relation to the qualitative research question</li> <li>• Identify relevant information to inform the next quantitative phase of the study</li> </ul>	October 2014 to January 2015  February to April 2015
Intermediate	Use strategies to build on qualitative results <ul style="list-style-type: none"> <li>• Refine the quantitative research questions</li> <li>• Determine the selection strategy of participants for the quantitative sample</li> <li>• Design and pilot test the quantitative data collection instrument (survey) based on the qualitative results</li> </ul>	May to June 2015
Quantitative	Design and implement the quantitative strand of the study <ul style="list-style-type: none"> <li>• Reformulate quantitative research questions that build on the qualitative results and determine the quantitative approach</li> <li>• Select a quantitative sample that will test or generalise key qualitative results</li> <li>• Collect close-ended data with survey instrument designed for quantitative results</li> <li>• Analyse quantitative data using descriptive statistics, inferential statistics and effect sizes to answer the quantitative and mixed methods questions</li> </ul>	July 2015 to May 2016
Mixed	Interpret connected results <ul style="list-style-type: none"> <li>• Summarise and interpret qualitative results</li> <li>• Summarise and interpret quantitative results</li> <li>• Discuss to what extent and in what ways the quantitative results generalise the qualitative results</li> <li>• Submit first complete draft of the thesis</li> </ul>	June to July 2016

Source: Author's own table

**Table 9: Village sampling frames for Kamwezi, Nyamweru and Mpungu Sub Counties**

Kabale District			
Kamwezi Sub County		Nyamweru Sub County	
Kyabuhangwa Parish	Villages	Nyamweru Parish	Villages
	1. Nyakabungo		1. Nyamweru
	2. Karere		2. Rwanshunju
	3. Kanyerere		3. Rwamugasha
	4. Kankiro		4. Rwabanyerere
	5. Nyakeina		5. Bwindi
	6. Rweikonko		6. Kihengamo
	7. Rwandamira		7. Kintokoori
	8. Butare		8. Ikore
	9. Kabira		9. Nyakasazi
	10. Kamutungu		10. Mugoongo
Kyogo Parish		Kyokyezo Parish	
	11. Rwamasyazo		11. Nyamirima
	12. Nyarurigata		12. Butaturwa
	13. Nyamabare		13. Butambi
	14. Kateramabare		14. Kashambya
	15. Nango		15. Kitengure
	16. Nyabyondo		16. Rwaruchenchuka
	17. Kijongo		17. Rwenkuba
	18. Karushaya		18. Mutaaba
			19. Kirwaa
			20. Kyokyezo
Kanungu District - Mpungu Sub County			
Bulemba Parish	Villages		
	1. Bweyongyezo		
	2. Hakikome		
	3. Karukara		
	4. Katunda		
	5. Rukungwe		
Mpungu Parish			
	6. Kanyanshogi		
	7. Murukore		
	8. Murushasha		
	9. Nyamizo		
Muramba Parish			
	10. Karambi		
	11. Kibingo		
	12. Kyambeja		
Ngara Parish			
	13. Kigaga		
	14. Kyogo		
Total			

Source: Author's own table

**Table 10: Village populations and sampled households in Kamwezi, Nyamweru and Mpungu Sub Counties**

Kamwezi Sub County			
	Village	Village population	Sample households
Kyabuhangwa Parish	1. Rweikonko	30	18
	2. Butare	27	16
	3. Kamutungu	40	23
	4. Nyakeina	30	17
	5. Karere	24	14
Kyogo Parish	6. Rwamasyazo	42	24
	7. Kateramabare	33	19
	8. Nyamabare	25	15
	9. Nyabyondo	28	16
	Total	279	162
Nyamweru Sub County			
Nyamweru Parish	10. Rwamugasha	36	25
	11. Ikore	25	17
	12. Nyamweru	17	12
	13. Mugoongo	24	17
	14. Kihengamo	14	10
Kyokyezo Parish	15. Butambi	16	11
	16. Kitengure	13	9
	17. Kashambya	26	18
	18. Mutaaba	33	22
	19. Nyamirima	34	23
	Total	238	162
Mpungu Sub County			
Bulemba Parish	20. Hakikome	170	43
	21. Katunda	50	13
	22. Rukungwe	86	22
Mpungu Parish	23. Kanyanshogi	58	15
	24. Murukore	42	11
Muramba Parish	25. Kibingo	154	40
Ngara Parish	26. Kyogo	73	19
	Total	633	163

Source: Author's own table



## **CHAPTER 5**

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### **THE CONTRIBUTION OF OUTSIDE GOVERNMENT GRB TO MATERNAL HEALTH IN KABALE DISTRICT**

Note: Part of this chapter has been published in Bamanyaki and Holvoet (2016) and reference to the publication is made where applicable.





## INTRODUCTION

This chapter applies theory based evaluation and process tracing to investigate the contribution of the outside government GRB initiative towards gender-responsive maternal health service delivery and the use of maternal health care services among rural women in Kabale District. The chapter answers the first two central questions:

- How may outside government gender budget initiatives influence gender-responsive maternal health service delivery and the use of maternal health services by rural women at local government level? and
- How have outside government gender budget initiatives contributed to gender-responsive maternal health service delivery and the use of maternal health care services by rural women in Kabale District?

As explained in Chapter 4, the focus of this chapter is not to make substantive claims about the magnitude of impact of the outside government GRB initiative; but rather to confirm or disconfirm that the outside government GRB initiative played a more than trivial role, alongside other influences, to produce the observed maternal health outcomes in Kabale District (Beach and Pedersen, 2013). Maternal health outcomes are used in this sense to denote improved and gender-responsive maternal health service delivery (on the supply-side) and the utilisation of maternal health care among rural women (on the demand side). To accomplish this task, the chapter first explicates the programme theory of outside government GRB initiatives in maternal health and uses it as a basis to theorise a causal mechanism explaining how the anticipated maternal health outcomes may be produced as a result of the outside government GRB intervention (*central question 1*). The causal mechanism is then tested using Bayesian logic to update our confidence in its presence and functioning in Kabale District to produce the observed outcomes accordingly (*central question 2*).

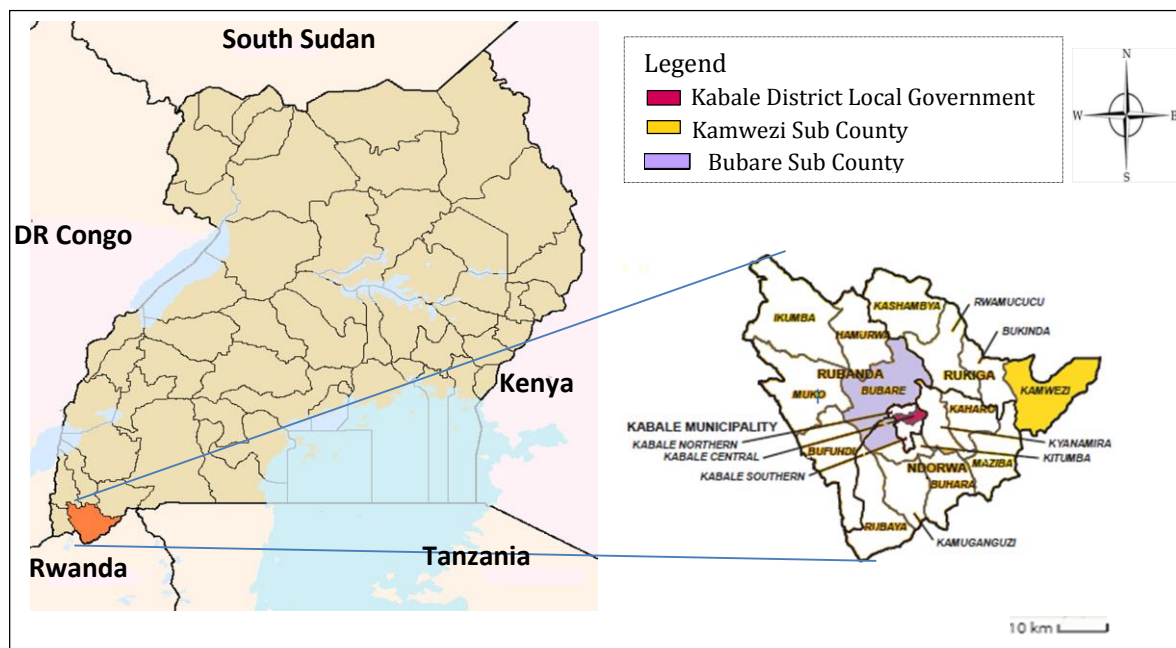
The chapter proceeds as follows: first, an exposition is made of Kabale District to describe the context of the case; next the programme theory is developed and explained, followed by the theorisation, operationalisation and evaluation of the underlying causal mechanism respectively. The chapter concludes with a discussion and verdict of the contribution of the FOWODE GRB initiative towards maternal health outcomes in Kabale District, as proven by the observed evidence.

### 1. ABOUT KABALE DISTRICT: SETTING THE CONTEXT

Kabale District is one of the 112 districts of the Republic of Uganda and is located in the south-west of the country. Historically, Kabale was formerly the Kigezi District Administration from the time Uganda was a British Protectorate in 1896 (Kabale District Council, 2015). Over the years, as a result of decentralisation, Kigezi District has been divided into the present four districts, namely Kabale, Kisoro, Rukungiri and Kanungu (Kabale District Council, 2015). At present, Kabale District shares its

borders with Kisoro District to the West, Kanungu District to the North-West, Rukungiri District to the North, Ntungamo District to the East and the Republic of Rwanda to the South. Figure 3 shows the map of Kabale District, highlighting its location in Uganda, and the location of the research sites for this study, notably Kabale District headquarters and the two sub counties of Kamwezi and Bubare respectively.

**Figure 3: Map of Kabale District showing the District Headquarters, Bubare and Kamwezi Sub Counties**



Source: Author's own construction based on google maps

Kabale is a highland district, with a relief ranging from 1,219 metres (3,999 feet) to 2,347 metres (7,700 feet) above sea level (Kabale District Council, 2015). The relief structure makes Kabale colder than other districts in the country, with year-round temperatures averaging 18°C (64°F) during the day and 10°C (50°F) at night (Kabale District Council, 2015). The topography of Kabale is mostly green, made up of “interlocking and heavily cultivated hills with spectacular valleys” and high altitude forests (Kabale District Council, 2015: 8). The total area of Kabale District is 1,864 square kilometres, which includes 1,695 square kilometres of arable land, 48.5 square kilometres of water body, 79.4 square kilometres of swamps/wetlands and 41.1 square kilometres of marginal land (Kabale District Council, 2015). The district has two rainfall seasons which are typically from March to May and October to December.

### 1.1. Demographics, socio-economic and cultural characteristics

Kabale is the ninth most populous district in Uganda, with a population size of 528,231 inhabitants (254,414 males, 273,817 females) and an annual population growth rate of 1.2 per cent (Uganda Bureau of Statistics, 2016). The population density of the district is 314 persons per square kilometre and 86 per cent of the inhabitants reside in rural areas, while only 14 per cent reside in the urban area (Kabale District Council, 2015). The average household size in Kabale is 4.4 persons and the sex ratio is 89.4 males to 100 females (Uganda Bureau of Statistics, 2016). According to the 2012 statistical abstract for Kabale, the total fertility rate for women, is 6.9, implying that each woman has an average of seven births during her childbearing years (Kabale District Local Government, 2012). In comparison, the national averages, according to the 2014 national population and housing census, are: a population density of 173 persons per square kilometre; an average household size of 4.7 persons, a total fertility rate of 5.8 children per woman and a sex ratio of 94.6 males to 100 females (Uganda Bureau of Statistics, 2016).

Kabale District is predominantly inhabited by the Bakiga tribe. Other tribes include the Batwa<sup>14</sup>, Banyarwanda and Bahororo (Kabale District Council, 2011). The main source of livelihood for households in Kabale is agriculture, particularly the cultivation of crops such as “maize, irish potatoes, sweet potatoes, bananas, beans, tobacco, arabic coffee, fruits [apples, pears, peaches, avocados], peas, sorghum, finger millet, wheat and vegetables” (Kabale District Council, 2011: 9). Livestock rearing is limited to a few animals per household, and includes indigenous and improved cattle, “goats, sheep, poultry, rabbits and pigs that often graze in free range” (Kabale District Council, 2015: 21). The bulk of agricultural production (82 per cent) is subsistence, with only eight per cent of the farmers practicing semi-commercial agriculture (Kabale District Council, 2015). Other sources of livelihood are salaried employment, business income, the sale of livestock (among the rich households), the sale of surplus food, crafts, firewood and casual labour (among the poor households) (Kabale District Council, 2015). The labour for agriculture is mainly provided by women who use rudimentary agricultural tools for cultivation (Kabale District Council, 2015). As a result of the high population, the land is heavily fragmented and a typical household owns six to seven small plots of land, which are scattered in different locations across the villages (Kabale District Council, 2015).

Customarily, women in Kabale “lack control over assets such as land, livestock and other resource means” and, as such, “lack influence on how cash income generated from those assets is used” (Kabale District Council, 2015: 80). Access to education is also unequal between males and females in Kabale, with preference being given to the education of boys (Kabale District Council, 2015). Although high enrolment rates are registered for girls compared to boys at primary level, fewer girls than boys attain post-primary education (Kabale District Council, 2015). The gender disparity in education is also reflected by the high levels of illiteracy among women compared to men.

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<sup>14</sup> The Batwa are a pygmy tribe that lives in the Echuya Forest Reserve along the Kabale-Kisoro border.

According to the 2002 national population and housing census, the literacy<sup>15</sup> rate of Kabale is 72.4 per cent and 67.4 per cent of the illiterate population are females (Kabale District Local Government, 2012). The high school dropout among the girls is mainly attributed to early marriages and the need to attend to household domestic and productive activities, especially among the poor households (Kabale District Council, 2015).

Relating to poverty, the district five year development plan 2015/2016 to 2019/2020 specifies “geographical pockets” of high poverty in the district, among which include the two sub counties of Kamwezi and Nyamweru which are the research sites for this study (Kabale District Council, 2015: 67). The common characteristics of these locations are highlighted to include: “poor productivity of land and human resources; unemployed youth and elderly; very poor housing conditions; soil and environmental degradation; absence of efforts to seek basic medical care; domestic violence; ignorance and poor hygiene at household level; [and] poor sanitary and environmental health” (Kabale District Council, 2016: 67)

## **1.2. Health structure and maternal health status**

Kabale District has a total of 124 health units (95 publicly owned and 29 privately owned), which include two hospitals, eight health centres IV, 22 health centres III and 92 health centres II as illustrated in Table 13 in Annex IV (Kabale District Council, 2015). In addition to the 124 health units are 35 licensed clinics, five pharmacies and 90 drug shops which are distributed throughout the district, but mainly located in towns and trading centres (Kabale District Council, 2015). At the lowest level of the district public health structure are the village health teams (VHTs), which comprise volunteers who are selected by community members at village level (Ministry of Health, n.d.). The role of the VHTs is to provide accurate health information to village members; maintain registers of all village inhabitants; mobilise village members for health activities; and liaise the villages with health workers at the nearest health units (Ministry of Health, n.d.).

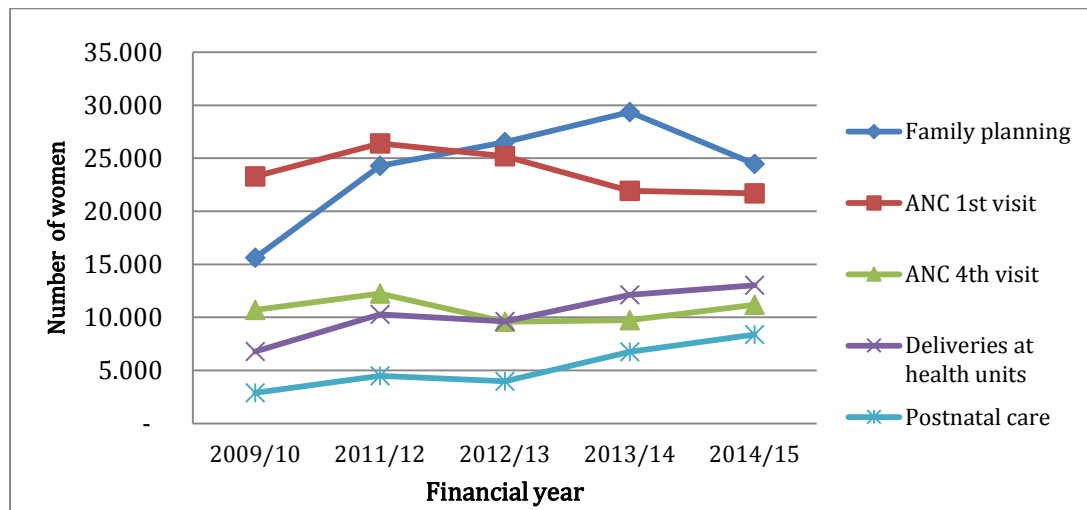
The district has a relatively good coverage of health facilities compared to other districts in the country, demonstrated by 87.3 per cent of the population residing within a five kilometre radius from a health facility (Kabale District Council, 2015). Human resources for health, however, remain a challenge in the district as only 59.6 per cent of the approved posts for health workers were filled as at financial year 2013/2014 (Kabale District Council, 2015). The critical staff lacking are “doctors, midwives, nurses anaesthetists and managers at Health Sub-Districts and Health facilities” (Kabale District Council, 2015: 27). Other challenges affecting Kabale’s health sector include inadequate structures and equipment at health facilities and lack of accommodation for health workers, especially in remote-rural locations (P. Tusiime, personal communication, December 5, 2014).

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<sup>15</sup> Literacy is defined as one’s ability to read with understanding and to write meaningfully in any language (Kabale District Local Government, 2012: 13).

Regarding maternal health care, Kabale District has prioritised equitable distribution of maternal health services in all villages and sub counties by offering maternal health care at all public health facility levels (Kabale District Council, 2015). Services including family planning, antenatal care and uncomplicated deliveries are provided at the level of Health Centre II, with referrals being made to higher level health facilities for complicated deliveries. Despite this measure, the utilisation of maternal health care in the district as a whole is still low, represented by 49 per cent of the expectant mothers delivering from health facilities compared to the national average of 52.7 per cent; 29 per cent attending up to the fourth antenatal care (ANC) visit compared to the national average of 36.6 per cent; and 25 per cent attending postnatal care as at financial year 2013/2014 (Kabale District Council, 2015; Republic of Uganda, 2015). Figure 4 below summarises the trend of maternal health care indicators for Kabale District over the six year period from 2009/2010 to 2014/2015<sup>16</sup>.

**Figure 4: Maternal health service utilisation by financial year in Kabale District**



Source: Author's own compilation from Kabale District Health Office records

From Figure 4, it can be seen that the most utilised maternal health care services in the district are family planning and the attendance of the first antenatal care visit. The less utilised services are delivery at health facilities, attendance of the fourth antenatal care visit and postnatal care respectively. The graph, however, shows a slow, but growing trend in the attendance of the fourth antenatal care visits, deliveries at health facilities and postnatal care attendance over the period 2012/13 to 2014/15 respectively.

### 1.3. Administrative and leadership structure

<sup>16</sup> The graph omits figures for 2010/2011, which were missing from district health office records.

Administratively, Kabale is made up of three rural counties (Ndorwa, Rubanda, Rukiga) and one urban area (Kabale Municipality) (Kabale District Council, 2011). The three rural counties are divided into three town councils and 19 sub counties, while Kabale Municipality is made up of three divisions (Kabale District Council, 2015). Below the sub county and division level are parishes/wards, which are further sub-divided into villages/ cells respectively. The rural sub counties and town councils in Kabale comprise a total of 119 parishes and 1,345 villages, while the three divisions of Kabale Municipality are made up of 12 wards and 74 cells respectively (Kabale District Council, 2015).

In accordance with the Local Governments Act 1997, the political head of the district is the District Chairperson, who was elected by universal adult suffrage (Local Governments Act, 1997). The District Chairperson heads the District Council (higher local government), which is made up of one councillor per electoral area of the district; two youth councillors (one of who is female); two councillors for persons with disabilities (one of who is female); and women councillors representing the electoral areas (Local Governments Act, 1997). Altogether, Kabale District had 48 councillors (31 males and 17 females) during the five-year political term of 2011 to 2016<sup>17</sup> (Kabale District Local Government, 2012).

Within the District Council is a District Executive Committee made up of five members, two of who are women (Kabale District Local Government, 2012). The District Executive Committee has the functions of initiating and formulating policy for approval by the Council; overseeing the implementation of national and Council's policies in the district; monitoring and coordinating the operations of NGOs operating in the district; and monitoring the implementation of the District Council's programmes in the district (Local Governments Act, 1997). Other roles of the District Executive Committee include recommending (to the District Council) the appointment of persons to serve in the district committees and commissions and resolving any problems or disputes that may be forwarded to the District Council from lower level local government councils (Local Governments Act, 1997). At the level of lower local government, a similar leadership and administrative structure is maintained, with the difference being that the functioning of the committees at lower local government level is on a part-time basis (Local Governments Act, 1997).

#### **1.4. Planning and budgeting**

In accordance with Section 35(1) of the Local Governments Act 1997, the District Council is the planning authority for the district. Five-year district development plans are prepared in accordance with guidelines provided by the National Planning Authority (Local Governments Act, 1997). As already explained in Chapter 1 of this thesis, the local government planning process follows a bottom-up approach, whereby plans originate from lower local government (villages, parishes and

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<sup>17</sup> The present study was conducted during the political term of 2011 to 2016.

sub counties) and are integrated into a comprehensive district plan that encompasses all lower local government plans for the different sectors (Local Governments Act, 1997).

The preparation and coordination of the district development plan is the responsibility of the District Technical Planning Committee, which reports to the District Council. The District Technical Planning Committee is headed by the Chief Administrative Officer and consists of the heads of departments in the district (Local Governments Act, 1997). Kabale District Local Government has eight administrative departments/directorates, namely management support services; finance and planning; production and marketing; education and sports; technical services and works; natural resources; public health; and community based services (Kabale District Council, 2011). The mandate and objectives/responsibilities of the respective departments are summarised in Table 15 in Annex 4. Lower local governments also have technical planning committees, which are chaired by the respective sub county chief/ town clerk and consist of the heads of departments or sectors at sub county/division level (Local Governments Act, 1997).

District plans are developed to feed into national priorities for each sector, as stated in the national development plan. The formulation of district plans is preceded by a Planning Call Circular from the National Planning Authority which highlights the national development vision, objectives and strategies (Government of Uganda, 2014). Upon receipt of the Planning Call Circular, a task force is formed by the District Planning Unit to collaborate with the District Technical Planning Committee to formulate the local government development plan (Government of Uganda, 2014). The district planning task team consults with lower local governments, ministries, departments and agencies, civil society organisations and other stakeholders to obtain data that will inform the formulation of the local government development plan (Government of Uganda, 2014).

Accordingly, the district planning process starts in the month of July with the sensitisation of local communities about “the decentralisation planning process, roles and responsibilities and some elements of resource mobilisation and community participation” (Kabale District Council, 2015: 6). Circulars are sent from the District Planning Unit to lower local governments, disseminating the outcomes of the consultative meetings at district level and communicating the policy and planning guidelines (along with timeframes) for all stakeholders to be involved in the lower local government planning process (Kabale District Council, 2015).

The collection of data from lower local governments follows pre-designed formats by the District Planning Unit, to ensure that adequate “socio-economic and demographic information is captured to inform evidence-based planning” (Kabale District Council, 2016: 6). Village data is collected during the month of August by Local Council I (village/cell) chairpersons (Kabale District Council, 2015). The data is intended to be collected through village planning meetings, where village members come up with action plans of “village investment proposals to be implemented at village level with village resources”, as well as investment proposals that are forwarded to be considered at parish level (Kabale District Council, 2015: 6). In practice, however, national priorities take precedence over

specific community needs, given that district local governments predominantly rely on conditional grants from the centre to fund their budgets. During the month of October, the Parish Development Committee consolidates all village plans and, with the help of sub county technical staff, generates and submits a consolidated analysis of poverty issues, gender issues and development proposals to the Parish Council (Kabale District Council, 2015). The Parish Council prioritises proposals from the villages and submits its recommendations to the sub county chief/town clerk, taking into consideration the availability of resources at village, parish and sub county levels respectively (Kabale District Council, 2015).

All selected proposals from the parishes in a given sub county are integrated into a draft sub county plan by the sub county technical staff. The draft plan is then presented at a budget conference, which normally takes place during the month of November, involving diverse stakeholders (village and parish representatives, civil society organisations, development partners, community members) to discuss and agree on priorities for the lower local government plan (Kabale District Council, 2015). The agreed upon priority plans from the sub county budget conference are then submitted to higher local government (district level) for consideration in the district local government development plan (Kabale District Council, 2015).

At district level, all lower local government development plans are compiled and discussed at the district budget conference, which involves district councillors, technical staff, civil society organisations and other stakeholders. The output of agreed upon priorities from the district budget conference is incorporated into a budget framework paper that is appraised by the District Technical Planning Committee and circulated to departmental heads for costing of priorities (Kabale District Council, 2015). The costed priorities are then appraised by the District Executive Committee and relevant District Standing Committees, before being “incorporated into the district development plan and the annual budget for approval by the District Council” (Kabale District Council, 2015: 7). The planning and budget process at higher local government level (from the stage of holding the district budget conference up to the approval of the final district plan and budget) normally takes four months from December to March of the following year (Kabale District Council, 2015). The district plans are then forwarded to the national level, for approval and the disbursement of funds accordingly<sup>18</sup>. Over the five-year period from 2010/11 to 2014/15, an average of 96 per cent of the district budget was funded by the central government, two per cent was funded by donors/non-government organisations, and the remaining two per cent was funded by district revenue.

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<sup>18</sup> The planning and budgeting process described here was followed in the preparation of the five year district development plan (2015/16 to 2019/20).



## **2. THE PROGRAMME THEORY: OUTSIDE GOVERNMENT GRB IN MATERNAL HEALTH**

Various authors (White, 2011; McGee and Gaventa, 2010; Bamanyaki, 2014) suggest that the context/setting of a programme intervention shapes, among other things, the implementation of the programme theory; the interactions that the programme will have with other external factors; and the outcomes that can be feasibly achieved by the programme intervention. The foregoing section has described the geographic, historic, social, economic, and political/administrative context of Kabale District. Details have also been provided about the planning and budgeting processes, and the maternal health status and trends in the district. This section now develops the programme theory of outside government GRB initiatives in maternal health and highlights underlying assumptions that are expected to enhance programme success.

The development of the programme theory utilised existing literature on GRB, local-level civil society budget initiatives (McGee & Gaventa, 2010; Robinson, 2008) and social accountability initiatives (Kim & Schachter, 2013; Ahmad, 2008; Forbes, 2013; Malena & McNeil, 2010) to explicate an implicit theory of how outside government GRB initiatives may influence gender-responsive maternal health service delivery and maternal health care utilisation (Bamanyaki and Holvoet, 2016). The implicit theory was then adapted to suit the specific case under evaluation, by drawing on information from FOWODE programme documents, interviews held with GRB functional experts, programme architects and practitioners at national and local level in Uganda, as well as FOWODE programme stakeholders in Kabale District (Bamanyaki and Holvoet, 2016). The programme theory was also validated through site visits that were conducted to observe programme implementation in Kabale District during 2013 (Bamanyaki and Holvoet, 2016).

The programme theory depicts a programmatic theory (Weiss, 1997), as it elaborates the causal chain of events from the inputs and activities of the outside government GRB initiative to the anticipated outcomes of improved and gender-responsive maternal health service delivery and the utilisation maternal health care among rural poor women respectively (Bamanyaki and Holvoet, 2016). In mapping out the programme theory, White (2011) proposes that the founding principle should be a clear identification of the programme intervention, including its objectives and anticipated outcomes, followed by the change process through which the intervention inputs and activities will lead to the outcomes (Bamanyaki, 2014). Chapter 2 of this thesis presented an overview of the FOWODE GRB initiative in Uganda at national and local government level. Section 2.1 narrows the focus down to the FOWODE GRB intervention in Kabale District.

### **2.1. FOWODE Gender Budget Initiative in Kabale**

FOWODE started its GRB intervention in Kabale District in the year 2000, making it one of the five pilot districts of the FOWODE GRB project at local government level (FOWODE, 2001). The objective of the local-level FOWODE GRB initiative is “to achieve gender balanced district budgets that address the needs of poor women and men, girls and boys equitably and give full attention to

marginalised groups such as People with Disabilities (PWDs).” (FOWODE, 2001: 1). In Kabale District, FOWODE concentrates on the sectors of health and education and targets to influence gender-responsive policies, plans, budgets and service delivery.

Given its status as a women-activist NGO, FOWODE’s preoccupation at local government level has been advocacy to address critical issues that directly affect rural poor women. With specific regard to health, FOWODE has focused on maternal and child health care, with the objective of ensuring that women needs are given due consideration in plans and budgets and that public service delivery deficiencies as well as gender-related issues that affect women’s access to skilled health care (at household, community and health facility levels) are addressed.

In order to achieve its objectives, FOWODE operates a double-pronged strategy involving stakeholders at district level (the supply side) and at parish/grassroots level (the demand side) (Bamanyaki and Holvoet, 2016). At the district level, FOWODE targets to build the capacities of technocrats (departmental planners) and politicians (elected women councillors) to prepare and implement/oversee gender-sensitive policies, plans and budgets (FOWODE, 2001). At the parish level, FOWODE targets to empower grassroots women leaders (organised in village budget clubs) to participate in political and budgetary processes so as “to demand greater gender accountability of government budgets” (FOWODE, 2009a: 15) and to track local government budgets so as to ensure transparency and accountability, and “the efficiency and effectiveness of government programmes” (FOWODE, 2009a: 16). In FOWODE’s philosophy, the village budget clubs act as pressure groups and “provide space for women to develop agendas for influencing the local government budget process” (FOWODE, 2009a: 15).

FOWODE relies on donor funding to support its local-level GRB initiative. From 2000 to 2006, the FOWODE GRB initiative in Kabale exclusively targeted district-level stakeholders, notably technocrats, district councillors (including some male representatives), the media and leaders of faith-based organisations involved in community mobilisation (FOWODE, 2009a). From 2006 to date, FOWODE’s district-level GRB intervention has mainly focused on developing the capacities of women councillors, while providing occasional refresher trainings for selected technocrats.

The grassroots-level GRB intervention commenced in 2010 and is implemented in cycles of one to two years (depending on funding availability) in different sub counties of the district. At the time of conducting this research, FOWODE had implemented the grassroots level GRB initiative in four sub counties, namely Bubare (2010 to 2012), Kamwezi (2012 to 2014), Ikumba (2012 to 2014), and was concluding in Maziba (2014 to 2015). Grassroots-level village budget clubs are organised at parish level (normally one or two parishes per Sub County) and comprise mostly women representatives (12 women and 8 men) who were elected by community members from the villages of the corresponding parish. The village budget clubs have a 40 per cent male representation as a strategy to give credibility to women issues among the male population in the villages. Having described the

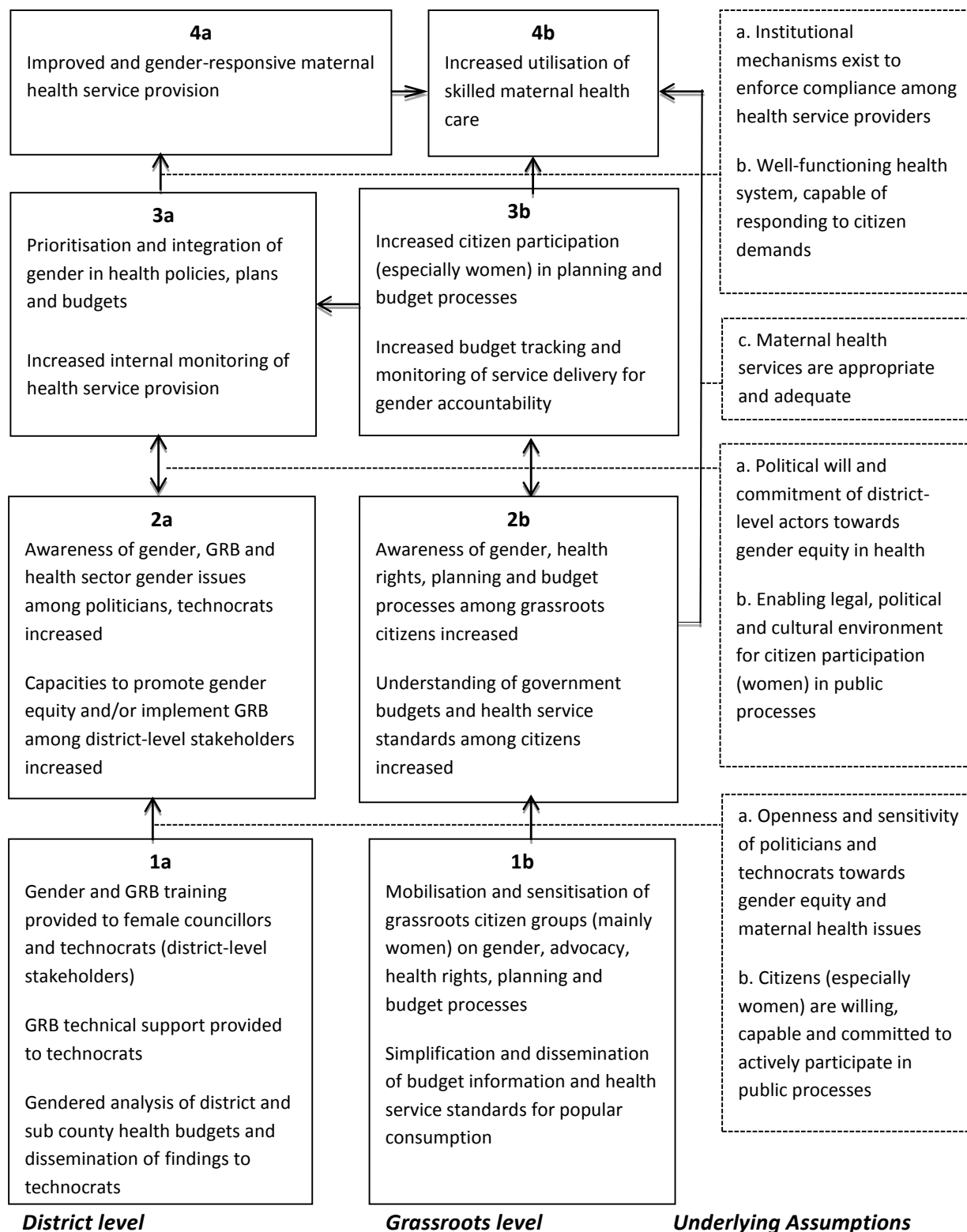
FOWODE GRB initiative in Kabale District, Section 2.2 elaborates the programme theory of outside government GRB initiatives in maternal health.

## **2.2. Explicating the programme theory**

The programme theory describes the cause-and-effect sequence through which the outside government GRB initiative (FOWODE) is expected to bring about changes in maternal health service delivery and the utilisation of maternal health care among rural women in Kabale, along with presumed necessary requirements that will enhance the intended effects (Rossi et al., 2004). The programme theory premises on the wide assumption that public health system deficiencies in the design and delivery of maternal health care affect access and use of skilled maternal health care by rural poor women. The lack of awareness among technocrats and legislators of gender-related maternal health issues affecting communities and GRB, coupled with inadequate participation of women in policy making, planning and budgetary processes “affects the development and implementation of responsive maternal health policies, budgets and services” (Bamanyaki and Holvoet, 2016: 79). In response to these gaps, the local-level outside government GRB initiative implements activities that target policy makers, policy implementers and maternal health service users (Bamanyaki and Holvoet, 2016). Figure 5 depicts the programme theory of local-level outside government GRB initiatives with district-level and grassroots-level interventions in maternal health.

The programme theory at district level is illustrated by boxes 1a, through 2a, 3a, to 4a, while the grassroots level programme theory is illustrated by boxes 1b, 2b, 3b (through 3a and 4a as well as directly) to 4b respectively. Additional links in the programme theory are inverse arrows from 3a to 2a and from 3b to 2b (represented by the double-headed arrows); as well as a direct link from 2b to 4b respectively.

**Figure 5: Programme theory for local-level outside government gender budget initiatives in maternal health**



Source: Author's own adaptation of Figure 1 in Bamanyaki and Holvoet (2016: 80)

At district level, the outside government GRB initiative trains female councillors and technocrats on the concept of gender and GRB (including gender analysis of the health sector); provides technical support to district technocrats on GRB; and conducts independent gender analyses of district and sub county health budgets and disseminates its findings to district-level stakeholders (mainly technocrats from relevant departments) (box 1a) (Bamanyaki and Holvoet, 2016). These three activities (box 1a) are expected to lead to increased awareness among district technocrats and councillors of GRB and the prevailing gender inequalities in the health sector, as well as enhance their capacities to promote gender equity and/or implement GRB principles in their respective mandates (box 2a) (Bamanyaki and Holvoet, 2016). The increased gender awareness and enhanced capacities in GRB among district technocrats and female councillors (box 2a) are expected to lead to the prioritisation and integration of a gender perspective in district health policies and budgets, and to stimulate increased internal monitoring of public health service delivery for gender responsiveness (box 3a) (Bamanyaki and Holvoet, 2016). “The latter two actions are expected to result in improved and gender-responsive maternal health service delivery” (box 4a), leading to the second outcome of increased utilisation of skilled maternal health care among rural poor women (box 4b) respectively (Bamanyaki and Holvoet, 2016: 79). As already highlighted, the processes of prioritising and integrating a gender perspective in health plans and budgets, as well as monitoring of health service provision for gender responsiveness (box 3a) are anticipated to have the inverse causal effect of further enhancing gender awareness and an understanding of GRB, as well as strengthening capacities of district technocrats and female councillors to implement a gender perspective in mandates (box 2a) (Bamanyaki and Holvoet, 2016).

At grassroots level, the outside government GRB initiative mobilises rural communities to elect representatives of mostly women leaders, who are formed into groups and trained on the concept of gender, gender advocacy, health rights and entitlements, and local government planning and budget processes (box 1b) (Bamanyaki and Holvoet, 2016). The outside government GRB initiative also simplifies health budget information and health service standards for popular consumption and disseminates this information to the community groups (box 1b) (Bamanyaki and Holvoet, 2016). These three activities at grassroots level (box 1b) are expected to lead to increased awareness, among grassroots citizen groups, of gender, health rights, local government planning and budget processes; and improve their understanding of health budget information and service standards (box 2b) (Bamanyaki and Holvoet, 2016). The increased awareness of gender and health rights, as well as improved understanding of budgets, planning and budget processes (box 2b) are further expected to lead to increased citizen participation (particularly women) in planning and budget processes, as well as in budget tracking and monitoring of public health service delivery for gender accountability (box 3b) (Bamanyaki and Holvoet, 2016).

The participation of women in planning and budget processes and in monitoring of health service delivery for gender accountability (box 3b) is expected to have three effects (Bamanyaki and Holvoet, 2016). First, the “interface between politicians, technocrats, health service providers and

grassroots level citizens in public decision-making arenas” (box 3b) is foreseen to influence the prioritisation and integration of gender-related maternal health needs in health policies, plans and budgets and increase internal monitoring of health service provision by district level actors (box 3a), consequently leading to improved and gender responsive maternal health service provision (box 4a) and increased utilisation of skilled maternal health services among rural poor women (box 4b) (Bamanyaki and Holvoet, 2016). Second, a direct effect of improved and gender responsive maternal health service delivery (box 4a) is expected to result from a better understanding of citizen needs by health providers, afforded by their direct interface with citizens during “citizen monitoring of health services at health facilities” (box 3b) (Bamanyaki and Holvoet, 2016: 80). Third, it is anticipated that citizen participation in planning and budget processes (box 3b) will provide information of the available maternal health services and the status and condition of maternal health service delivery, which, if deemed appropriate, would stimulate increased utilisation of skilled maternal health care among rural poor women (box 4b).

The participation of women groups in planning and budget processes, budget tracking and monitoring of health service delivery is additionally expected to have an inverse causal effect of increasing grassroots citizen awareness of gender, health rights, planning and budget processes, and deepen their understanding of health budgets and health service standards respectively (Bamanyaki and Holvoet, 2016). Lastly, it is also anticipated that the increased awareness of health budgets, health service standards, health rights and entitlements among the segment of rural poor women who do not actively participate in planning and budget processes or in monitoring of health service provision (box 2b), will lead to increased utilisation of skilled maternal health care (box 4b).

The programme theory in Figure 5 additionally depicts the underlying assumptions to enhance programme success along the different causal steps of the programme theory. Relating to the district level intervention, available literature on GRB and social accountability, backed with interviews with different stakeholders suggests that the key assumptions are openness, sensitivity, political will and commitment of politicians and technocrats towards gender equity in the health sector and maternal health issues; a well-functioning public health system that is capable of responding to citizen demands; and the existence of institutional mechanisms to enforce compliance of health service providers towards gender-responsive maternal health service provision (see Figure 5) (Bamanyaki and Holvoet, 2016). For the grassroots level intervention, the underlying assumptions to enhance programme success are that citizens (mostly women) are willing, capable and committed to actively participate in public processes; an enabling legal political and cultural environment exists for citizen participation (especially women) in public decision-making processes and that the maternal health services provided are appropriate and adequate for the respective communities (Bamanyaki and Holvoet, 2016).

In Chapter 4 of this thesis, it was underlined that the integrated approach of theory-based evaluation and process tracing utilises the programme theory as a guiding framework for the

theorisation of the causal mechanism that will be used to evaluate outside government GRB effects. Accordingly, Section 3 theorises the underlying causal mechanism linking outside government GRB initiatives to improved and gender-responsive maternal health service delivery and increased utilisation of skilled maternal health care respectively.

### 3. THEORISING THE CAUSAL MECHANISM

Chapter 4 of this thesis introduced and outlined the theory-testing process tracing procedure which is adopted for this study. To reiterate, theory-testing process tracing makes use of existing theorisation to formulate a plausible causal mechanism that links a hypothesised cause (or set of causes), X to a given outcome (or set of outcomes), Y (Beach and Pedersen, 2013; Bamanyaki and Holvoet, 2016). This section employs the programme theory developed in Section 2.2 as a foundation for theorisation of a case-specific causal mechanism that captures “the transmission of causal forces from the GRB intervention activities to the intended outcome[s] of improved and gender-responsive maternal health service delivery” and increased utilisation of skilled maternal health care (Bamanyaki and Holvoet, 2016: 81). The theorisation of the causal mechanism also utilises the underlying assumptions of the programme theory as a guide for identifying specific aspects about the context within which the causal mechanism is expected to function (Beach and Pedersen, 2013; Bamanyaki and Holvoet, 2016). The section proceeds with a review of process tracing principles for theorising causal mechanisms in Section 3.1, followed by the theorised causal mechanism for the FOWODE GRB intervention in the maternal health sub-sector of Kabale District presented in Section 3.2.

#### 3.1. Reviewing theory-testing process tracing principles

According to Beach and Pedersen (2013: 45), “causal theories need to be transformed so they offer a clear hypothesised mechanism describing how a type of outcome is produced.” George and Bennet (2005: 137) broadly define causal mechanisms as

“[...] ultimately unobservable physical, social or psychological processes through which agents with causal capacities operate, but only in specific contexts or conditions, to transfer energy, information or matter to other entities. In so doing, the causal agent changes the affected entity’s characteristics, capacities or propensities in ways that persist until subsequent causal mechanisms act upon it.”

A causal mechanism consists of a series of interlocking parts that are made up of *entities* – the factors or agents engaging in activities, and *activities* – the producers of change (Beach and Pedersen, 2013). “Each part of the causal mechanism is conceptualised as being individually insufficient but necessary, as it functions together with other parts of the mechanism to produce the outcome” (Bamanyaki and Holvoet, 2016: 75).

The first step to theorising causal mechanisms requires a clear definition of the central concepts that form the basis for theoretical propositions, notably the cause (or set of causes), X; the outcome (or set of outcomes), Y; and the theoretical process linking X to Y (Beach and Pedersen, 2013). Each of the central concepts is defined in set-theoretical terms, implying that the definition should state “the constitutive dimensions of a concept” and omit what the concept does not include for purposes of the study (Beach and Pedersen, 2014: 46 cited in Bamanyaki, 2014). Put differently, the concept



definition is systematised to “distinguish between what is included and what is not included” to enable us to make deterministic judgements about the presence or absence of the concept in the specific case (Beach and Pedersen, 2013: 46). Beach and Pedersen (2013: 46) further clarify that in process tracing studies; “context-specific contextual definitions” focus on the case being studied, and therefore “have a narrower scope than large-n studies.”

In addition to defining the central concepts, “the evaluator must decide on the appropriate level at which the causal mechanism should be conceptualised and tested” (Beach and Pedersen, 2013 cited in Bamanyaki, 2014: 14). Beach and Pedersen (2013: 54) distinguish four analytical levels, namely the macro level, macro-to-micro level, micro level, and micro-to-macro level; further emphasising that the choice of level should be guided by where “the empirical manifestations of the theorised mechanism are best studied”. Other considerations for theorising the causal mechanism include the type of theoretical explanation (structural, institutional, ideational or psychological), and the temporal dimension “of causal forces that produce the outcome and the time horizon of the outcome” (Beach and Pedersen, 2013: 54).

### **3.2. The theorised causal mechanism**

[For purposes of this study, the central concepts are defined in set-theoretical terms as follows:

- 1) *The set of causes (X)* denote the “FOWODE GRB advocacy and capacity building interventions at district level and grassroots level aimed at fostering gender accountability in the health sector” (Bamanyaki and Holvoet, 2016: 81). As elaborated in the programme theory (Figure 5), these activities include “training technocrats and female councillors on GRB; providing technical support to technocrats on GRB; and dissemination of independent gender analyses of district health budgets to stakeholders at district level ” (Bamanyaki and Holvoet, 2016: 81). At the grassroots level, FOWODE GRB activities include mobilising and sensitising “women-dominated citizen groups on gender advocacy, health rights and local government planning and budget processes; and simplification of budget information and health service standards for popular consumption” (Bamanyaki and Holvoet, 2016: 82).
- 2) *The Outcomes (Y)* denote the supply-side and demand-side effects of the FOWODE GRB initiative on maternal health in Kabale District. As illustrated in the programme theory (see Figure 5), the outcomes are “improved and gender-responsive maternal health service delivery” and increased utilisation of skilled maternal health care among rural poor women respectively (Bamanyaki and Holvoet, 2016: 22). Concerning the specific case under evaluation, “the causally relevant dimensions of improved and gender-responsive maternal health service delivery relate to local government responses to address gender-related challenges associated with accessibility (service location), availability (skilled birth attendants, medical supplies, round-the clock efficient services), affordability (costs) and acceptability (services and attitudes)” (Jacobs et al., 2012 cited in Bamanyaki and Holvoet, 2016: 82). On the demand side, the utilisation of

skilled maternal health care by rural poor women relates to their use of prenatal care, delivery at health facilities, delivery assisted by a skilled birth attendant and attendance of postnatal care respectively.

- 3) *The theoretical process linking X to Y* draws from existing literature on Social Accountability (World Bank, 2003; World Bank, 2005; Papp et al., 2013; Murthy, 2008;) and Citizen's Voice and Accountability (Bakker, 2002; Goetz and Jenkins, 2002). Principally, the causal mechanism adopts the Social Accountability theory as explained by the World Bank (2005; 2003). The theoretical explanation linking X to Y is summarised in Bamanyaki and Holvoet (2016: 82-83) as follows:

"[P]olicy makers, politicians, service providers and citizens are linked in relationships of power and accountability (World Bank, 2005). Citizens exercise *voice* over politicians and policy makers through formal mechanisms (political parties, elections) and through informal mechanisms (advocacy campaigns, public demonstrations and protests) (World Bank, 2005). Politicians and policy makers set directions and provide incentives for service providers to operate in a *compact* relationship. Where specified in the compact, politicians and policy makers also reward or penalise service providers depending on their services and output (World Bank, 2005). Organisation providers (ministries, departments or agencies in the various sectors) set internal policies and regulations specific to their organisation and manage the operations of frontline providers who provide services to citizens (World Bank, 2005). Lastly, citizens in their role as clients, exercise *client power* over frontline providers through their interactions [including utilisation of public services] and monitoring of frontline provider actions (World Bank, 2003)."

The theoretical explanation for the theorised causal mechanism is *institutional* in nature (Beach and Pedersen, 2013). An institutional causal mechanism presupposes that "institutions [formal or informal rules, conventions or practices together with the organisational manifestations these patterns of group behaviour sometimes take on] are man-made and thereby can be manipulated" (Parsons, 2007 cited in Beach and Pedersen, 2013: 53). By raising awareness among the various actors at local government level of gender inequity in the health sector, prevailing gender-related maternal health issues and gender-responsive budgeting, it is theorised that outside government GRB initiatives are able to channel actors to gradually transform existing institutions, which eventually leads to the achievement of the intended outcomes (improved and gender-responsive maternal health service delivery and the utilisation of skilled maternal health care among rural poor women). Furthermore the increased understanding of rights and entitlements is theorised to have the ability to transform maternal health seeking behaviour among rural poor women.

The analytical level at which the causal mechanism is theorised is *transformational* (micro-to-macro), "whereby 'individuals, through their actions and interactions, generate various intended

and unintended social outcomes at the macro level” (Beach and Pedersen, 2013: 42 cited in Bamanyaki, 2014: 17). The time dimension involved in the workings of the causal mechanism to produce the outcome is theorised as *incremental*, explained by causal impacts being expected to “become significant only after they have been in action over a long period” (Beach and Pedersen, 2013: 55). As noted by Beach and Pedersen (2013: 56), one should expect “small, almost unnoticeable empirical traces that will be apparent only if one knows what one is looking for” in an incremental mechanism.

- 4) *The scope conditions* refer to the context under which the mechanism is theorised as able to be activated (Beach and Pedersen, 2013; Bamanyaki and Holvoet, 2016). Falleti and Lynch (2009: 1152) define context as:

“[...] the relevant aspects of a setting (analytical, temporal, spatial or institutional) in which a set of conditions leads (probabilistically) to an outcome of a defined scope and meaning via a causal mechanism or set of causal mechanisms.”

The presence (or absence) of necessary scope conditions enables (or hinders) the mechanism from functioning. Relating to the specific context of Kabale District described in Section 1 of this chapter, combined with a consideration of the underlying assumptions posited in the programme theory, the necessary scope conditions are theorised to be “an enabling legal, political and cultural environment for citizen participation (especially women) in public decision-making processes” and “institutional mechanisms exist to enforce compliance among health service providers” (Bamanyaki and Holvoet, 2016: 83). Additionally, it is theorised that there is good collaboration between local government actors and the civil society and that political will and commitment towards gender equity and accountability exists to some degree among politicians and technocrats. As stated in Bamanyaki and Holvoet (2016: 83), “[t]he initial conditions preceding the causal mechanism are that the legislature, executives and health service providers in Kabale District lack awareness of GRB and gender-specific maternal health issues affecting the communities and there is lack of citizen participation (especially women) in public decision-making processes.”

The theorised causal mechanism sets out to “make more explicit the postulated links [represented by arrows] between the boxes in the programme theory” (see Figure 5 in Section 2.2) “by theorising a three-part case-specific causal mechanism” (Bamanyaki and Holvoet, 2016: 81). With reference to the programme theory in Figure 5, the three-part causal mechanism is theorised as follows: part 1 “theorises the causal link between the activities of the FOWODE GRB initiative and the proximate outcomes at district level (boxes 1a and 2a) and at grassroots level (boxes 1b and 2b)” respectively (Bamanyaki and Holvoet, 2016: 81). “Part 2 theorises the causal link between the proximate outcomes and intermediate outcomes at district level (boxes 2a and 3a) and at grassroots level (boxes 2b and 3b), as well as the horizontal causal link between intermediate outcomes at grassroots level and at district level (boxes 3b and 3a)” respectively (Bamanyaki and Holvoet, 2016:

81). Part 3 of the causal mechanism theorises the causal link between intermediate outcomes and distal outcomes at district level (boxes 3a and 4a); the link between grassroots level intermediate outcomes and distal outcomes at district level (boxes 3b and 4a) and the horizontal link between distal outcomes at district level and distal outcomes at grassroots level (boxes 4a and 4b) respectively (Bamanyaki and Holvoet, 2016). The causal mechanism omits the theorisation of causal links between the intermediate outcomes and distal outcomes at grassroots level (boxes 3b and 4b) and between the proximate outcomes and distal outcomes at grassroots level (boxes 2b and 4b), which are deemed to be best studied at household level using quantitative methods (a quasi-experiment), covered in Chapter 6.

With the central concepts defined, the causal mechanism is theorised as follows: the outside government GRB initiative (FOWODE) with interventions at district- and grassroots-level influenced maternal health service delivery and the utilisation of maternal health services in Kabale District through “a voice and accountability mechanism consisting of three parts [10 sub-parts], each of which is individually insufficient but a necessary part” for the whole mechanism” (Bamanyaki and Holvoet, 2016: 83). Logically, the causal mechanism is portrayed as:

$$X \rightarrow [(h_{11} \rightarrow) * (h_{12} \rightarrow) * (h_{13} \rightarrow) * (h_{21} \rightarrow) * (h_{22} \rightarrow) * (h_{23} \rightarrow) * (h_{24} \rightarrow) * (h_{31} \rightarrow) * (h_{32} \rightarrow) * (h_{33} \rightarrow)] Y$$

where: X refers to the set of causes;

$(h_{nn} \rightarrow)$  refers to a sub-part, consisting of the entity ( $h_{nn}$ ) and the activity ( $\rightarrow$ ) transmitting causal forces through the mechanism to produce the outcome.

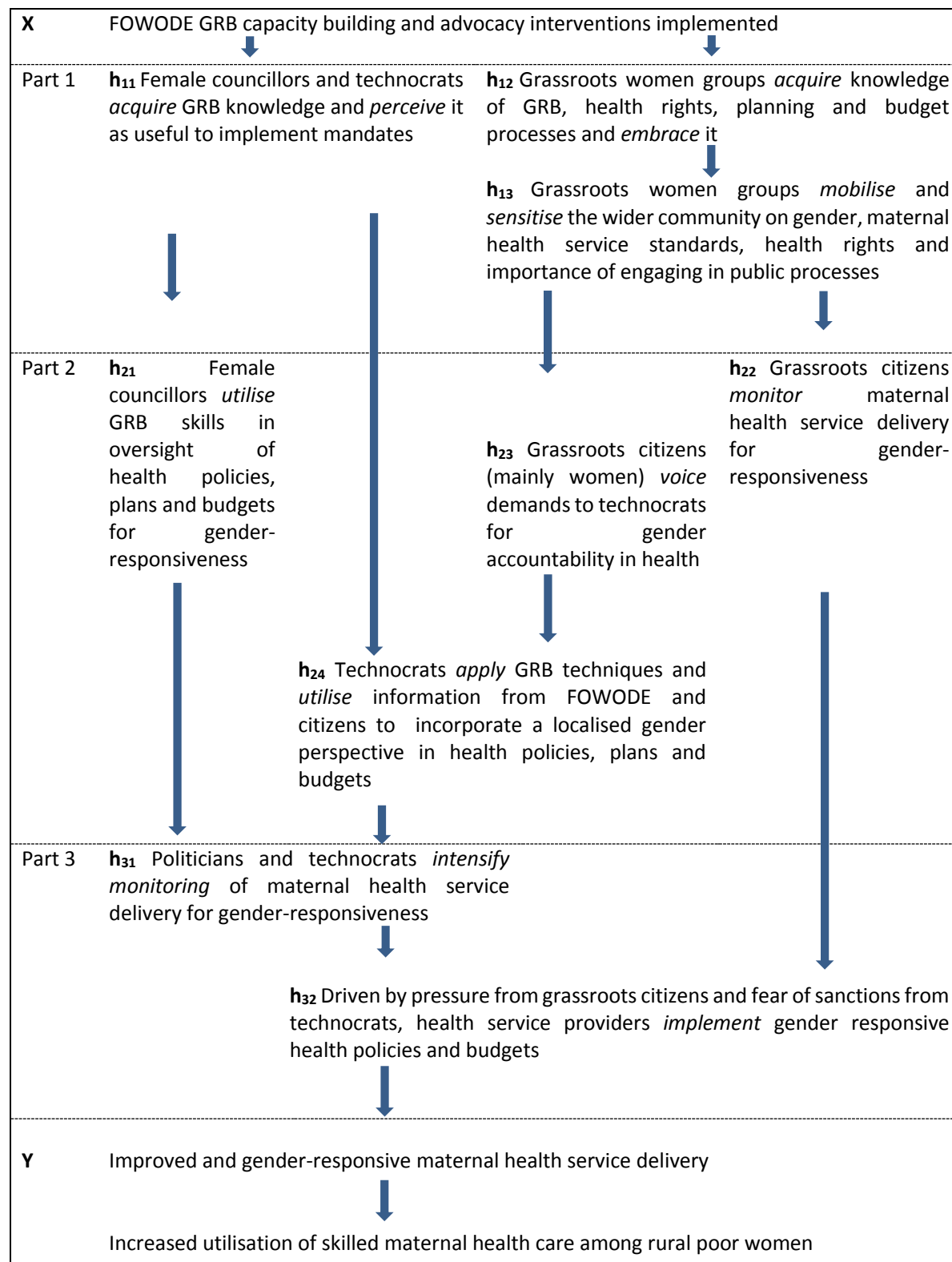
Y refers to the outcome.

\* refers to the logical “and”.

The logical expression above implies that the causal mechanism can only be confirmed to have been present in the case “(with some degree of confidence) if there is strong evidence that all parts of the mechanism were present and functioned as predicted” (Beach and Pedersen, 2013 cited in Bamanyaki and Holvoet, 2016: 75).

The theorised causal mechanism (and its sub-parts) is illustrated in Figure 6. It should be noted that the subscripts assigned to each of the ten sub-parts of the causal mechanism do not represent a successive order, but rather serve the purposes of identifying each sub part so as to guide the analysis. The actual sequential flow of the parts of the causal mechanism from, X to Y is represented by the arrows in Figure 6. Each of the parts (and sub-parts) of the causal mechanism is explained in more detail under Section 4, which operationalises the causal mechanism.

**Figure 6: Causal mechanism for FOWODE's GRB initiative in maternal health in Kabale District**



Source: Author's own adaptation of Figure 2 in Bamanyaki and Holvoet (2016: 82).

## 4. OPERATIONALISING THE CAUSAL MECHANISM

This section marks the second step of the theory-testing process tracing, where the theorised causal mechanism is operationalised. Similar to the foregoing section, Section 4.1 starts with a review of theory-testing process tracing principles regarding operationalisation of the causal mechanism, followed by the operationalisation of each part of the causal mechanism (from X through  $h_{nn}$  to Y) in Section 4.2. The mechanism as a whole is denoted by (H). Other plausible alternative explanations for the observed outcomes in the context of the case ( $\sim H$ ) could be: “(1) efforts of other civil society organisations engaged in the maternal health sub-sector of Kabale; and (2) national reforms to improve maternal health service delivery trickling down to the district” (Bamanyaki and Holvoet, 2016: 83). According to preliminary research, the other civil society organisations that were actively engaged in maternal health and/or holding government to account during the period 2010 to 2014 were World Vision Uganda, AMREF Health Africa, White Ribbon Alliance and Kick Corruption out of Kigezi. A summary of the activities of these organisations is presented in Table 15 in Annex IV.

### 4.1. Reviewing theory-testing process tracing principles on operationalising the mechanism

Operationalising the causal mechanism involves developing case-specific predictions about the types of evidence we should expect to find for each part, if the mechanism is actually valid (Beach and Pedersen, 2013; Bamanyaki and Holvoet, 2016). Bayesian logic further suggests that strong predictions should be made about what constitutes evidence for alternative hypotheses, while taking into consideration the conclusions that we can make when we do not find the predicted evidence in the case (Beach and Pedersen, 2013). Empirical tests are used to update our confidence in the theorised causal mechanism (H) when we find the predicted evidence (e), and when we do not find the predicted evidence ( $\sim e$ ) (Beach and Pedersen, 2013). According to Beach and Pedersen (2013: 101), empirical tests should be designed in a form “that captures traces of the transmission of causal forces through the theorised mechanism.” Furthermore, empirical tests should aim to maximise the inferential power of the evidence to enable us to update our confidence in the validity of a given hypothesis (Beach and Pedersen, 2013). In evaluating the strength of empirical tests, Beach and Pedersen (2013: 101) advance that predictions should be made about:

- whether finding (e) “increase[s] our confidence in the existence of the part of the mechanism in relation to plausible alternatives”; and
- whether not finding e ( $\sim e$ ) “update[s] our confidence that the part of the mechanism does not exist.”

To facilitate the description of the above two types of empirical predictions, Van Evera (1997) proposed the terminology of *uniqueness* and *certainty*. *Unique* predictions are “empirical predictions that do not overlap with those of other theories” (Beach and Pedersen, 2013: 101 cited

in Bamanyaki and Holvoet, 2016). Predictions of uniqueness of evidence correspond to the likelihood ratio,  $p(e|\sim h)$  divided by  $p(e|h)$ , which is the expected probability of finding evidence supporting the hypothesis when it is not true, compared to the expected probability of finding the evidence when the hypothesis is true (Beach and Pedersen, 2013). Our confidence in the presence of a given part of the mechanism depends on the size of this likelihood ratio. Thus, if a hypothesis is formulated to be highly unique (when  $p(e|h)$  is high and  $p(e|\sim h)$  is low) and we find the predicted evidence (e), then our confidence in the presence of that part of the mechanism greatly increases (Beach and Pedersen, 2013).

*Certain* predictions are “unequivocal, and the prediction (e) must be observed or the theory fails the empirical test” (Beach and Pedersen, 2013: 101; Bamanyaki and Holvoet, 2016). Logically, predictions of certainty imply that “when  $p(e|h) = 1$ , then  $p(h|\sim e) = 0$ , given that  $p(h) > 0$ ” (Howson and Urbach, 2006: 93). In other words, if the prediction is maximally certain and we do not find the evidence ( $\sim e$ ); our posterior confidence in the hypothesis (h) will be zero, meaning that we should maximally disconfirm the existence of (h) (Beach and Pedersen, 2013). Beach and Pedersen (2013: 102), however, caution that disconfirmation of the hypothesis should be a matter of degree, asserting that “if we find ( $\sim e$ ), [then] we merely downgrade our confidence in the existence of the theorised part of the mechanism in relation to the degree of certainty of the empirical prediction.”

Van Evera (1997) introduced four ideal-typical empirical tests which are used in process tracing, namely straw-in-the-wind test, hoop test, smoking gun test and the doubly-decisive test. Table 11 presents the four test types and their related attributes as summarised from Rohlfing (2014) in Bamanyaki and Holvoet, (2016: 17).

**Table 11: Types of empirical tests and related attributes**

Test type	Description
<b>Doubly-decisive</b>	Empirical predictions combine high uniqueness and high certainty Passing the test is both necessary and sufficient for inferring causation
<b>Smoking gun</b>	Empirical predictions have high uniqueness, but low certainty Passing the test is sufficient, but not necessary for inferring causation
<b>Hoop</b>	Empirical predictions have low uniqueness, but high certainty Passing the test is necessary but not sufficient for inferring causation
<b>Straw-in-the-wind</b>	Empirical predictions combine low uniqueness and low certainty Passing the test is neither sufficient, nor necessary for inferring causation

*Source: Adaptation of Rohlfing (2014: 610) in Bamanyaki and Holvoet (2016: 76)*

Smoking gun tests are tests of uniqueness that confirm the functioning of a hypothesised part of a mechanism based on the ‘signature’ evidence left behind, which is “deemed to be ‘unique to that mechanism and practically impossible to have been left by other mechanisms’” (Befani and Mayne, 2014: 24 cited in Bamanyaki and Holvoet, 2016: 76). Befani and Stedman-Bryce (2016) refer to this type of evidence as ‘love-to-see’ evidence, given its nature of being hard to find. Hoop tests are certainty tests, as “they enable the ruling out of some mechanisms if the evidence is not found” (Befani and Mayne, 2014 cited in Bamanyaki and Holvoet, 2016: 76). Hoop test evidence is regarded as ‘expect-to-see’ evidence, as its absence strongly refutes the hypothesised claim (Befani and Stedman-Bryce, 2016). Doubly-decisive tests simultaneously confirm the hypothesis and reject all alternative plausible explanations, while straw-in-the-wind tests neither confirm nor disconfirm hypotheses (Befani and Mayne, 2014; Bamanyaki and Holvoet, 2016). Befani and Stedman-Bryce (2016), however, propose that straw-in-the-wind evidence can also be used to evaluate the confidence in the validity of mechanisms if formal values of certainty and uniqueness are assigned to independent pieces of evidence, and the evidence is considered as a package.

Beach and Pedersen (2013) note that in real-world social research, there is an inverse relationship between uniqueness and certainty, as the more unique an empirical prediction is, the less likely we will be able to find its evidence and vice versa. The authors argue that, whereas seeking to maximise the levels of certainty and uniqueness of predictions is ideal, choices often have to be made between certainty and uniqueness of empirical predictions (Beach and Pedersen, 2013). In such instances, Beach and Pedersen (2013) recommend that process tracing designs based on Bayesian logic should prioritise certainty over uniqueness. Consequently, when operating with single-case studies, Beach and Pedersen (2013: 105) recommend that for each part of the mechanism,



“we need to design tests that have a relatively high degree of certainty (hoop tests), since the absence of the evidence ( $\sim e$ ) of a certain prediction allows us to infer with a reasonable degree of certainty that the part of the mechanism was not present.”

Furthermore, when multiple independent hoop tests of what we must find in the evidence (certainty) for each part of the mechanism are combined to test the overall hypothesis (H),

“[t]he result is an additive effect that increases our ability to update our confidence in the validity of [H] given that the probability of a non-valid hypothesis surviving multiple independent hoop tests fails after each successive hoop” (Beach and Pedersen, 2013: 105 cited in Bamanyaki and Holvoet, 2016: 76).

There are four distinguishable types of evidence used in process tracing, namely pattern, sequence, trace and account (Beach and Pedersen, 2013; Bamanyaki and Holvoet, 2016). “Pattern evidence relates to predictions of statistical patterns in the evidence”, while “sequence evidence deals with the temporal and spatial chronology of events predicted by a hypothesised mechanism” (Beach and Pedersen, 2013: 99). With trace evidence “its mere existence provides proof that a part of the hypothesised mechanism exists” and account evidence “deals with the content of empirical material” (Beach and Pedersen, 2013: 100).

To sum up, Bayesian logic, used in the context of theory-testing process tracing, requires the evaluator to ask the following fundamental questions:

- 1) On the basis of existing theories, empirical studies or expert knowledge, how confident are we in the hypothesised part prior to examining new evidence – the theoretical prior  $p(h)$ ?
- 2) What empirical fingerprints, in the form of pattern, trace, account or sequence evidence do we expect to find in the case if the hypothesised part holds true – (e)?
- 3) What is the likelihood of finding the predicted evidence given that the hypothesis is valid in the specific context of the case – description of certainty or sensitivity,  $p(e|h)$ ?
- 4) How probable is it that we would find the same predicted evidence in the case if the hypothesis of interest were false – description of uniqueness or the Type I error,  $p(e|\sim h)$ ?

The next sub-section applies these process tracing principles to operationalise the three-part causal mechanism accordingly.

## **4.2. Operationalising the three-part case-specific causal mechanism**

This sub-section makes empirical predictions of the evidence we should expect to see and/or would love to see in the case for each part of the theorised causal mechanism. As previously noted, some

level of confidence (above 0.50) is required that all parts (and sub-parts) of the mechanism were present in the case for the overall hypothesis of the FOWODE GRB initiative having contributed to improved and gender-responsive maternal health service delivery and/or the increased utilisation of skilled maternal health care among rural poor women of Kabale District (H) to hold true. The structure followed in operationalising the theorised causal mechanism utilises the four fundamental questions in Section 4.1 as a guide. Accordingly, for each part of the causal mechanism, the hypothesis (theorised part) is stated; followed by the theoretical prior of the hypothesis according to existing literature; the predictions of the sources and types of evidence to verify the hypothesis; a description of the certainty and uniqueness of finding the evidence; the empirical test types; and lastly, subjectively assigned probabilities for the sensitivity and Type I error for each type of evidence predicted. Two of the sub-parts ( $h_{11}$  and  $h_{21}$ ) were operationalised in Bamanyaki and Holvoet (2016) and will be presented in this section with minimal additions.

#### **4.2.1 The set of causes – X**

Part X of the mechanism relates to the activities of the FOWODE GRB initiative at district level (training technocrats and female councillors on GRB; technical support to technocrats on GRB; independent gender analyses of local government budgets and dissemination of the findings to technocrats) and at grassroots level (mobilisation and sensitisation of women-dominated grassroots community groups on gender, advocacy, health rights, planning and budget processes; simplification and dissemination of budget information and health service standards for popular consumption) (Bamanyaki and Holvoet, 2016).

Existing literature worldwide (Combaz, 2013; Robinson, 2006; UN Women, 2010) widely indicates that the primary interventions of GRB initiatives at different levels of government are to develop the capacities of policy makers, policy implementers and community based organisations on GRB, with a few initiatives also targeting ordinary citizens at the grassroots (Budlender, 2002). Specific to the health sector, evidence from UN Women reveals that regional training workshops with participants who included government officials from over 70 countries have been conducted “to support the application of GRB to advance women’s reproductive rights.” Civil society GRB initiatives have also widely engaged in conducting gender analyses of central and local government budgets and have used the information from such analyses as a basis to support advocacy campaigns for gender equality, at times involving grassroots communities (Krafchik, 2002). Consequently, our prior confidence in the validity of part X before examining new evidence ( $p(X)$ ) is high, assigned at 0.95, implying the  $p(\sim X)$  is 0.05.

1) If X is true, we would expect to obtain interview statements from district technocrats (especially from the health, planning, finance and community development departments); female district councillors; grassroots village budget club members; FOWODE staff and GRB trainers attesting to trainings and/or technical assistance having taken place in Kabale facilitated by FOWODE; as well as

individual affirmations of participation in these activities. We would also expect interview statements affirming that district technocrats periodically received gender analysis briefs of district health budgets from FOWODE, and that grassroots community groups received simplified health budgets and health service standards. Obtaining this information is critical (highly certain) for part X to be valid but not entirely unique, as we might expect that some interviewees will falsely report favourably out of personal motives. Furthermore, in consideration of the fact that interviewees are required to recall events that took place two or more years ago, we find it likely that some interviewees may confuse related activities that were undertaken by other players to the FOWODE GRB initiative. Consequently, this yields a hoop test. We assign  $p(e|X)$  at 0.80 and  $p(e|\sim X)$  at 0.35.

2) Secondly, we would expect to see trace evidence of training manuals for the three categories of participants, as well as account evidence that the specific topics outlined in the theorised causal mechanism correspond with content of the training manuals. Finding these pieces of evidence is highly certain but not unique to enhance our confidence in the presence of X. While the training manuals may exist and align with the theorised topics, it might be possible that the trainings may not have taken place; or that the content of the training manuals was not strictly followed during the trainings. This results in a hoop test. We assign  $p(e|X)$  at 0.85 and  $p(e|\sim X)$  at 0.20.

3) Thirdly, if part X were true, we would love to see trace evidence in the form of official and unofficial records of the various trainings and technical assistance. Regarding official documents, we would love to find evidence of training manuals, original training reports, signed invoices/receipts of payments made to the respective trainers and hosts of the workshops, and signed participant attendance registers highlighting the participants in attendance, the venues of the trainings, duration and sessions conducted. We would also expect to find trace evidence from FOWODE periodic reports – at field office and national level – indicating that the trainings and technical assistance took place accordingly. The unofficial records would include original participant notes from the trainings and technical assistance. Finding these pieces of evidence has moderate certainty and high uniqueness. Given the passage of time (dating as far back as 2003 for district technocrats) and the high dependence on the extent of record keeping among the different stakeholders, it is likely that some pieces of information may not be obtained. However, if the evidence is found it would strongly confirm that this part of the mechanism was present. This results in a smoking gun test. We assign  $p(e|X)$  at 0.20 and  $p(e|\sim X)$  at 0.05.

4) Fourthly, if part X were true, we would also love to find trace evidence of women-dominated community groups (village budget clubs) operating in the parishes, along with authentic registration certificates of the village budget clubs that detail the specific dates of registration, the area of operation and mandates of the village budget clubs within the respective parishes. We would also love to see records/briefs of simplified health budget information from FOWODE among village budget club documents. Finding these pieces of evidence has low certainty but high uniqueness to the presence of X. Given that FOWODE had concluded its direct support to the village budget clubs in the two sub counties (Bubare and Kamwezi) at the time this study was conducted, it may be likely

that the village budget clubs disintegrated, making it difficult to obtain the evidence (Busiinge, 2010). The associated test type is therefore a smoking gun test. We assign  $p(e|X)$  at 0.10 and  $p(e|\sim X)$  at 0.01.

#### 4.2.2. Part 1

Part 1 of the causal mechanism can be broadly described as the phase of knowledge and skills acquisition by technocrats, female councillors and grassroots women groups/village budget clubs. As depicted in Figure 6, the three sub-parts theorised under part 1 ( $h_{11}$ ,  $h_{12}$  and  $h_{13}$ ) are operationalised accordingly.

##### Sub-part $h_{11}$

As presented in Bamanyaki and Holvoet (2016: 83-84), sub-part  $h_{11}$  hypothesises that female councillors and technocrats at district level *acquire* knowledge of GRB techniques and *perceive* it as useful to help them implement their respective mandates.”

“According to existing evaluations conducted worldwide ([Sharp, 2003]; Combaz, 2013; UN Women, 2010), GRB initiatives have generally increased awareness of gender issues in budgets and built capacities of technocrats and elected representatives to implement GRB. On the basis of this evidence, our confidence in this hypothesised part being true before examining new evidence [...] is relatively high [at 0.90, implying that  $p(\sim h_{11})$  is set at 0.10 ]” (Bamanyaki and Holvoet, 2016: 84).

1) If sub-part  $h_{11}$  is true, we would expect to obtain account evidence in the form of:

“[...] interview statements from female councillors and technocrats demonstrating an understanding of GRB techniques, along with attestations to the relevance and applicability of GRB techniques in their work. Finding this piece of evidence in the case is critical (certain) [...] but not unique, as we might expect that some politicians and technocrats with wide knowledge and exposure will report positively in the interview and attest to what is not the reality. This constitutes a hoop test. [We assign  $p(e|h_{11})$  at 0.80 and  $p(e|\sim h_{11})$  at 0.40]” (Bamanyaki and Holvoet, 2016: 84).

2) Secondly, we would expect to find account evidence that aligns the exact content of the respective training manuals with the articulations of GRB principles by the technocrats and female councillors (Bamanyaki and Holvoet, 2016). “We posit that participants who are able to correctly recall and explain the GRB techniques are more likely to have perceived them as useful and probably implemented them in their work”(Bamanyaki and Holvoet, 2016: 84). Finding this piece of evidence is certain but not entirely unique, as it is possible that some technocrats and councillors who may have participated in other GRB trainings besides those organised by FOWODE could have been

exposed to similar content, resulting in a hoop test. We assign  $p(e | h_{11})$  at 0.60 and  $p(e | \sim h_{11})$  at 0.10

3) Thirdly, we would expect to find account evidence from FOWODE GRB training reports and participant evaluations forms that reveals positive ratings of the trainings and/or technical assistance received at district level, especially with regard to relevance, applicability and usefulness (Bamanyaki and Holvoet, 2016).

“Finding this piece of evidence is certain but not very unique. While we might expect that evaluations made immediately after the training are more likely to reflect the true opinion of the participants, some participants, as well as the trainer [who prepares the training report], may be biased towards giving positive feedback about the course that does not reflect reality. This constitutes a hoop test [We assign  $p(e | h_{11})$  at 0.60 and  $p(e | \sim h)$  at 0.20]” (Bamanyaki and Holvoet, 2016: 84).

### Sub-part $h_{12}$

Part  $h_{12}$  of the causal mechanism theorises that grassroots women groups *acquire* knowledge of GRB, health rights, planning and budget processes and *embrace* it (Bamanyaki and Holvoet, 2016).

Existing literature on the outcomes of grassroots level GRB interventions is scant. Whereas several authors (Sharp, 2003; Robinson, 2006; UN Women, 2010) highlight that GRB initiatives have been most successful in improving budget awareness among diverse stakeholders, available studies mainly highlight increased awareness among technocrats and politicians at state and local government levels, as well as among civil society non-government organisations and the media (Tan, 2009). Çağatay et al. (2000: 20) further point out that poor people (at the grassroots level) “may lack literacy and numeracy skills” needed to grasp the technical concepts taught. In view of the limited empirical evidence, our confidence in the validity of  $h_{12}$  prior to examining new evidence is conservatively set to be low at 0.50. This implies that  $p(\sim h_{12})$  is set at 0.50.

1) If  $h_{12}$  is true, we would expect to find account evidence of interview statements demonstrating the village budget club members’ sufficient knowledge and understanding of GRB, health rights and local government planning and budget processes. We would also expect to obtain interview statements attesting to the relevance and usefulness of the acquired knowledge on GRB, health rights, planning and budget processes. Finding this evidence is highly certain but not entirely unique for  $h_{12}$  to hold true. While we would expect that individuals who were actively engaged in the FOWODE grassroots GRB intervention from its inception to phase-out would be knowledgeable about GRB, health rights and local government planning and budget processes, it may also be likely that some village budget club members did not embrace the messages but merely performed what was expected of them in order to gain from the financial support and recognition given to the groups by FOWODE. This results in a hoop test. We assign  $p(e | h_{12})$  at 0.95 and  $p(e | \sim h_{12})$  at 0.20.

2) Secondly, we would expect to obtain account evidence of interview statements from trainers of village budget club attesting to the active participation of the village budget club members during the trainings and a demonstrated understanding of the modules that were taught. We postulate that if village budget club members were active participants, then it was highly likely that they embraced the messages taught. Finding this piece of evidence is highly certain but not very unique to confirm  $h_{12}$ , as we may expect the trainer to be biased towards positive reporting for personal motives. This results in a hoop test. We assign  $p(e|h_{12})$  at 0.90 and  $p(e|\sim h_{12})$  at 0.15.

3) Thirdly, from a review of the FOWODE training manual for village budget clubs, we would expect to see account evidence that the content of topics covered exactly corroborates participant statements made by the village budget club members with regard to the articulation of GRB principles, health rights, planning and budget processes. Finding this piece of evidence has high certainty and moderate uniqueness to  $h_{12}$ , given that correct articulation of concepts may not necessarily imply embracement of the message by all group members. This results in a hoop test. We assign  $p(e|h_{12})$  at 0.90 and  $p(e|\sim h_{12})$  at 0.02.

### **Sub-part $h_{13}$**

Sub-part  $h_{13}$  of the causal mechanism theorises that grassroots women groups/village budget clubs *mobilise* and *sensitise* the wider community on gender, maternal health service standards, health rights and the importance of engaging in public processes.

Existing literature, particularly from the fields of Governance and Participation affirms that mass mobilisation and sensitisation of communities has been widely employed as a strategy to engage local communities in public processes. Relating to GRB, Muchabaiwa (2010: 120) documents two non-government organisations in Zimbabwe that formed coalition groups in the community, whose members further sensitised the wider community “to participate in the discourse on budgetary matters” so as to hold “the state to account for its decisions and action.” On the basis of this evidence, our confidence in the validity of  $h_{13}$  prior to examining new evidence in the case is high at 0.85, implying that  $p(\sim h_{13})$  is set at 0.15.

1) For  $h_{13}$  to be true, we would expect to obtain account evidence of interview statements from village budget club members attesting to having conducted community sensitisation on GRB, maternal health service standards, maternal health rights and local government health budgets. Finding this piece of evidence is highly certain for  $h_{13}$  to have been present but not entirely unique, as it is likely that the village budget club members may over-report activities that may not have been implemented in reality. It might also be possible that the mobilisation and sensitisation of communities was done by other diverse players engaged in related activities within the parishes. This constitutes a hoop test. We assign  $p(e|h_{13})$  at 0.98 and  $p(e|\sim h_{13})$  is set at 0.15.

2) Secondly, from focus group discussions held with rural women residing in the parishes where village budget clubs operated, we would expect to obtain account evidence of interview statements attesting to the awareness of the village budget club groups and their sensitisation activities within the community. Finding this piece of evidence is certain for  $h_{13}$  to hold true but not very unique, as we may expect some interviewees to falsely attest to their knowledge of the groups for personal motives. It may also be possible that the community members confuse related interventions of other players for the FOWODE intervention. This results in a hoop test. We assign  $p(e|h_{13})$  at 0.70 and  $p(e|\sim h_{13})$  at 0.25.

3) Thirdly, we would love to see trace evidence of original records of the sensitisation events, including minutes of meetings, signed attendance registers, venues of the meetings and the categories of people in attendance and the content of the messages that were delivered. Finding these pieces of evidence is not very certain, as it would depend on the quality of record keeping of the village budget club groups and FOWODE office, given that direct support to the respective groups from FOWODE had already ended at the time of conducting this study. If the evidence is found, however, it would be a unique and increase our confidence in  $h_{13}$  that mobilisation and sensitisation of community members was done by the village budget club groups. This results in a smoking gun test. We assign  $p(e|h_{13})$  at 0.70 and  $p(e|\sim h_{13})$  at 0.02.

#### 4.2.3 Part 2

Part 2 of the causal mechanism can be broadly described as the phase in which the different entities at district and grassroots level apply the acquired knowledge and skills imparted by the FOWODE GRB initiative. Part 2 consists of 4 sub-parts which are operationalised accordingly.

##### Sub-part $h_{21}$

As presented in Bamanyaki and Holvoet (2016: 84), sub-part  $h_{21}$  theorises that “female councillors *utilise* the acquired GRB skills in their oversight of district health policies and budgets for gender-responsiveness.”

Available literature presents mixed opinions on the likelihood of  $h_{21}$  being present (Bamanyaki and Holvoet, 2016).

“[O]n the one hand, some authors suggest that the legislature generally lack effective powers to make changes to budgets and policies (Budlender, 2002; Sharp, 2003); while on the other hand, a few studies (Combaz, 2013; Elson and Sharp, 2010) report positive results. Our prior probability for [...] [ $h_{21}$ ] is, thus, conservatively set to be relatively low [at 0.55, implying that  $p(\sim h_{21})$  is 0.45]. This implies that our confidence in the existence of this part of the mechanism will be greatly updated if we can find strong evidence in the case.

[1]) One source of evidence to verify  $h_{2[1]}$  would be interviews with female councillors who participated in the FOWODE GRB trainings. If  $h_{2[1]}$  is true, we would expect interview statements from female councillors attesting to the application of GRB principles in the evaluation of health department plans and budgets prior to final approval by the district council. Finding this evidence is certain but not unique, as we might expect some female councillors to make false claims that do not reflect reality. This constitutes a hoop test. [We assign  $p(e|h_{21})$  at 0.90 and  $p(e|\sim h_{21})$  at 0.10].

[2]) A second source of evidence to verify  $h_{2[1]}$  would be records of proceedings of district council meetings convened to discuss the health department plans and budgets. If  $h_{2[1]}$  is true, we would love to find evidence of queries being raised by female councillors about how specific health policies and budgets address gender inequalities, and specifically maternal health challenges. Finding this evidence is not very certain, as Council minutes may not be easily accessible. However, if the evidence is found, it [...] [might not be entirely unique to the intervention, as the female councillors could also have been influenced by other events unrelated to the GRB intervention], resulting in a [straw-in-the-wind] test. [We assign  $p(e|h_{21})$  at 0.20 and  $p(e|\sim h_{21})$  at 0.10].

[3]) A third source of evidence to verify  $h_{21}$  would be a review of district health policies and budgets. We would [...] [love] to see traces of gender-related health needs being addressed following the GRB training. From a comparison of draft health budgets with approved health budgets on an annual basis since 2011 [...], we would expect to see evidence of adjustments being made to budget allocations to address gender-related health needs, more specifically maternal health. Finding this evidence is not very critical for  $h_{2[1]}$  to hold true, as female councillors could have raised health-related gender concerns but resolutions to change budgets were deferred to later financial years owing to limited funding. If the evidence is found, however, it would strongly confirm that gender inequality queries were raised and acted upon, [however, may not be entirely unique to the FOWODE GRB intervention, resulting in a straw-in-the-wind test. We assign  $p(e|h_{21})$  at 0.50 and  $p(e|\sim h_{21})$  at 0.10]" (Bamanyaki and Holvoet, 2016: 84-85).

### Sub-part $h_{22}$

Sub-part  $h_{22}$  theorises that grassroots citizens *monitor* maternal health service delivery at public health facilities for gender-responsiveness.

Existing GRB literature on citizen monitoring of maternal health service delivery for gender responsiveness is scant (Muchabaiwa, 2010; Budlender et al., 2005). However, vast studies relating to Transparency and Accountability in general affirm various cases worldwide of citizens monitoring public service delivery (including health) with the aim of enhancing the effectiveness and efficiency of service delivery and accountability for the use of public resources. Renowned civil society initiatives are community based monitoring and evaluations systems that have involved the participation of citizens in the monitoring of health service delivery using tools such as citizen report



cards (Björkman and Svensson, 2009; Reinikka and Svensson, 2005). On the basis of this evidence, our theoretical prior probability of  $h_{22}$  being valid in the case ( $p(h_{22})$ ) is moderate at 0.70, implying that  $p(\sim h_{22})$  is set at 0.30.

1) For  $h_{22}$  to be true, we would expect to obtain account evidence of interview statements from health workers at public health facilities in the two sub counties (Bubare and Kamwezi), as well as village budget club members, attesting to periodic monitoring visits having taken place at the health facilities with a focus on gender accountability in health service delivery. Finding this evidence is highly certain for  $h_{22}$  to hold true, but not very unique, as it is possible that some interviewees may falsely report positively for personal motives. It may also be possible that the monitoring of health facilities for gender-responsiveness was conducted by other citizens groups unconnected to FOWODE. This constitutes a hoop test. We assign  $p(e|h_{22})$  at 0.85 and  $p(e|\sim h_{22})$  at 0.10.

2) Secondly, we would expect to find trace evidence in the health facility visitor's books of village budget club members having officially visited the health facility on a periodic basis. Finding this evidence is highly certain but not unique, as it may be possible that signatures were made in the visitors book without actual monitoring of the health facility having taken place. It might also be likely that even though monitoring visits took place, issues of gender-responsiveness of service delivery were overlooked. This results in a hoop test. We assign  $p(e|h_{22})$  at 0.85 and  $p(e|\sim h_{22})$  at 0.15.

3) Thirdly, we would love to see trace evidence of signed village budget club monitoring reports that indicate that the monitoring visits were conducted to the respective health facilities, including specific dates on which they occurred and the persons who were present. We would also love to see account evidence that the content of original minutes of health facility monitoring visits and village budget club periodic reports reveals that gender-related maternal health issues were discussed, alongside other findings that were identified at the health facilities during the respective visits. Finding these pieces of evidence is not very certain, considering that it might be possible that the village budget clubs no longer have the original documents following the phasing out of direct support from FOWODE and the passage of time. However, if the evidence is found, it would strongly confirm the presence of  $h_{23}$ , resulting in a smoking gun test. We assign  $p(e|h_{22})$  at 0.15 and  $p(e|\sim h_{22})$  at 0.05.

### **Sub-part $h_{23}$**

Sub-part  $h_{23}$  theorises that grassroots citizens (mainly women) *voice* demands to technocrats for gender accountability in health – particularly gender-responsive maternal health service delivery.

Existing literature from the fields of Social Accountability, Governance and Participation presents mixed views regarding citizens voicing demands to technocrats and politicians. On the one hand, some authors such as Murthy (2008: 114) state that “[a]ccountability mechanisms often equate

citizens' participation to involvement of leaders of women's rights NGOs, who mostly come from the middle class" and whose demands may not necessarily match the priorities of citizens at the grassroots. Robinson (2006: 14) adds that citizen's voice "is typically mediated by organisations that represent the poor, either as membership organisations (such as unions and social movements) or civil society groups that advocate their interests in public forums." On the other hand, other authors document evidence of citizens at the grassroots level directly engaging with technocrats at interface meetings to voice demands regarding accountability for public service delivery (Muchabaiwa, 2012; Papp et al., 2013; Ramkumar, 2008). A few studies specifically document evidence of citizens voicing demands for gender accountability in health (Murthy, 2008; Björkman and Svensson, 2009; Papp et al., 2013). On the basis of the contradicting evidence, our confidence in the validity of this part of the mechanism prior to examining new evidence in the case ( $p(h_{23})$ ) is conservatively set to be moderate at 0.70, implying that  $p(\sim h_{23})$  at 0.30.

1) If  $h_{23}$  is true, we would expect to obtain account evidence of interview statements from technocrats, politicians (at district and sub county level), village budget club members, community members and the media attesting to interface meetings having taken place in the sub counties involving all the aforementioned categories of persons. We would also to expect to obtain personal accounts of what transpired at the meetings, which corroborate with the accounts of other participants. Finding this evidence is highly certain for  $h_{23}$  to have been present but not unique. Owing to the passage of time, we might expect that some interviewees will confuse interface meetings organised by other organisations or government (barazas<sup>19</sup>) for the FOWODE GRB interface meetings and therefore report falsely. This results in a hoop test. We assign  $p(e|h_{23})$  at 0.90 and  $p(e|\sim h_{23})$  at 0.15.

2) Secondly, if  $h_{23}$  is true, we would expect to see trace evidence of minutes of the interface meetings, signed attendance registers of participants at the meetings; as well as reports indicating the venues of the respective meetings, the specific dates the meetings were held, and the agenda that was discussed. From a review of the content of the minutes of the interface meetings, as well as from FOWODE programme and village budget club documents, we would expect to find account evidence that gender-related maternal health issues were discussed at the meetings. We would also expect to see account evidence that more women were present at the meetings than men. Finding these pieces of evidence is certain for  $h_{23}$  to hold true but not entirely unique, as we might expect that though women were in attendance at the meetings, they may have been passive participants and did not voice any demands. This results in a hoop test. We assign  $p(e|h_{23})$  at 0.70 and  $p(e|\sim h_{23})$  at 0.20.

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<sup>19</sup> Barazas are a government initiative initiated by the Office of the Prime Minister in 2009 to foster public accountability to citizens. Barazas are dialogues that bring together government representatives, political leaders, public service providers, the civil society and the users of public services "to share relevant public information and develop corrective strategies to outstanding challenges of issues that affect their livelihood" (Chimp Reports Website, 2014).

3) Thirdly, if  $h_{23}$  is true, we would love to see media (audio/visual) recordings of the interface meetings held in the sub county. From a replay of the recordings, we would expect to obtain account evidence that the interface meetings took place and involved the different categories of individuals. We would also be able to ascertain whether more women were in attendance, whether they actively participated at the meetings and whether gender-related maternal health needs were raised by citizens, who included women. Finding this evidence has low certainty, as it may not be easy to obtain recordings of activities that took place two or more years ago. However, if the evidence is found, it would strongly that increase our confidence that  $h_{23}$  was present, hence a smoking gun test. We assign  $p(e|h_{23})$  at 0.20 and  $p(e|\sim h_{23})$  at 0.01.

### Sub-part $h_{24}$

Sub-part  $h_{24}$  theorises that technocrats *apply* the acquired GRB skills, and *utilise* information obtained from the interface meetings with citizens and from FOWODE gender analyses to incorporate a localised gender perspective in health policies, plans and budgets.

Available literature widely suggests that civil society GRB initiatives have registered limited success in influencing budget policies and pro-poor budget allocations (Brautigam, 2004; Budlender, 2005; de Renzio and Krafchik, 2007; Tan, 2009; UN Women, 2010). Very few budget advocacy initiatives, notably in Mexico and Indonesia are known to have influenced budget allocations/re-allocations to maternal health (International Labour Organisation, 2006; Hofbauer and Garza, 2009). On the basis of this evidence, our confidence in the functioning of  $h_{24}$  prior to examining new evidence in the case ( $p(h_{24})$ ) is relatively low, set at 0.50, implying that  $p(\sim h_{24})$  is 0.50.

1) If  $h_{24}$  is true, we would expect to obtain account evidence of interview statements from district technocrats attesting to the application of GRB techniques in their work as well as their consideration of local gender needs in the health sector during planning and budget processes. We would also expect to obtain personal accounts demonstrating how GRB principles were applied in their respective functions. Finding this evidence is certain but with low uniqueness, as we might expect that some technocrats will falsely attest to what is not implemented in practice out of personal motives. Additionally, some technocrats may have received GRB training from other sources or been influenced by events unrelated to the FOWODE initiative. This results in a hoop test. We assign  $p(e|h_{24})$  at 0.90 and  $p(e|\sim h_{24})$  at 0.10.

2) Secondly, we would love to see trace evidence of gender-aware health plans, policies and budget statements being prepared on an annual basis, especially for the period following the GRB training by FOWODE. Finding these pieces of evidence has moderate certainty. Whereas it is a national directive for all sector plans, policies and budgets to be gender-sensitive, local governments in Uganda currently utilise standardised computerised reporting formats which may not have it as a requirement permit such reports to be produced. If the evidence can be found, however, it may also not be uniquely attributable to the FOWODE intervention. This results in a straw-in-the-wind test,

which neither confirms nor disconfirms the hypothesis. We assign  $p(e|h_{24})$  at 0.75 and  $p(e|\sim h_{24})$  at 0.20.

3) Thirdly, from a critical review of the content of district annual health plans, budgets and policies, we would expect to see account evidence reflecting a consideration of prevailing gender-related maternal health needs, which correspond with issues raised at the interface meetings and from FOWODE gender analysis briefs. Finding this evidence is highly certain but not entirely unique, as it may also be coincidental that the special consideration of maternal health needs resulted from the efforts of other NGOs engaged in the maternal health sector of the district, or from a national directive from the Ministry of Health. This gives rise to a hoop test. We assign  $p(e|h_{24})$  at 0.85 and  $p(e|\sim h_{24})$  at 0.15.

4) Fourthly, we would expect to find sequence evidence that the gender-related maternal health issues identified by village budget club members during monitoring visits at public health facilities were voiced at the interface meetings with technocrats and politicians, and that the same issues, alongside information from gender budget analyses conducted by FOWODE were duly considered in annual health policies, plans and budgets. We would also expect to find sequence evidence that the focus on addressing gender-related maternal health issues followed the GRB capacity building and technical assistance from FOWODE. Finding these pieces of evidence is highly certain but not unique as the consideration of specific gender-related maternal health service delivery issues could also have been a long-term district plan or a result of the efforts of other NGOs engaged in the maternal health sector of Kabale District. This results in a hoop test. We assign  $p(e|h_{24})$  at 0.80 and  $p(e|\sim h_{24})$  at 0.15.

#### **4.2.4. Part 3**

Part 3 of the causal mechanism can be generally described as the phase of transformation of attitudes and practices in the delivery of maternal health services at public health facilities. Part 3 has three sub-parts, which are described and operationalised accordingly.

##### **Sub-part $h_{31}$**

Sub-part  $h_{31}$  theorises that politicians and technocrats intensify monitoring of maternal health service delivery for gender-responsiveness.

According to the World Bank (2003), supervision/monitoring of frontline provider services constitutes part of the compact relationship that is intended to provide incentives to improve health provider performance. Specific literature that focuses on monitoring maternal health service delivery for gender-responsiveness is scant. Available studies from the field of Health Policy and Planning widely substantiate that systematic supervision of lower-level health provider performance generally improves health service delivery (World Health Organisation, 2006; Bosch-

Capblanch and Garner, 2008; Rowe et al., 2010). Rowe et al. (2010: 129), however, stress that “supervision is important but difficult to maintain” and cite a number of studies worldwide that have investigated inadequate supervision of health provider performance. Golooba-Mutebi (2005) also found that remote health facilities in Uganda were infrequently supervised owing to poor accessibility. On the basis of this evidence, our prior confidence in  $h_{31}$  being true before examining new evidence ( $p(h_{31})$ ) is low, set at 0.55, implying that  $p(\sim h_{31})$  is 0.45.

1) If  $h_{31}$  is true, we would expect to obtain account evidence of interview statements from health in-charges at the health facilities, health sub-district superiors and technocrats from the district health department attesting to supervisory visits having been conducted on a regular or more than regular basis at the health facilities in the two sub counties (Kamwezi and Bubare). Finding this evidence is highly certain but not unique, as it might be possible that the interviewees report positively out of personal motives, or the frequent supervision was influenced by other events unrelated to the FOWODE initiative. This results in a hoop test. We assign  $p(e|h_{31})$  at 0.70 and  $p(e|\sim h_{31})$  at 0.20.

2) Secondly, if  $h_{31}$  is true, we would expect to find trace evidence of health facility Visitors Books indicating regular and/or frequent visits by the district health department staff or health sub-district supervisors. We would also expect to find sequence evidence in the form of more visits having occurred following the FOWODE intervention compared to before. Finding these pieces of evidence has high certainty but moderate uniqueness, as it could have been a district initiative to visit health facilities regularly, or a result of other events that were unrelated to the FOWODE GRB intervention. This results in a hoop test. We assign  $p(e|h_{31})$  at 0.70 and  $p(e|\sim h_{31})$  at 0.15.

3) Thirdly, from a review of the content of health facility supervisory visit reports, we would love to see account evidence revealing that gender-sensitivity of maternal health service provision was monitored. Finding this piece of evidence has low certainty, as all health facilities have a standardised supervisory visit report format which may not explicitly reveal all the issues that were verbally discussed during the visits. However, if the evidence is found, it would increase confidence in the presence of  $h_{31}$ , although this may not be uniquely attributable to the FOWODE GRB intervention. This results in a straw-in-the-wind test. We assign  $p(e|h_{31})$  at 0.35 and  $p(e|\sim h_{31})$  at 0.1.

### Sub-part $h_{32}$

Sub-part  $h_{32}$  theorises that the health service providers, driven by *pressure* from grassroots citizens and the *fear of sanctions* from their superiors at health sub-district and district level implement gender responsive health policies and budgets.

Existing literature offers mixed opinions regarding the influence of professional and community-based supervision on health provider attitudes and service delivery. On one end of the spectrum,

numerous studies from the field of Health Policy and Planning (Loevinsohn et al., 1995; Trap et al., 2001; Rowe et al., 2005) affirm that effective supervision of lower-level health provider services by professional superiors significantly improves adherence to institutional policies and guidelines. Björkman and Svensson (2009) also found that the forethought of social rewards and sanctions by community members influenced health provider attitudes, and that health provider services significantly improved in locations where community members monitored health facilities. On the other end of the spectrum, studies such as Golooba-Mutebi (2005) and Hill et al. (2014) assert that ineffective and/or irregular professional supervision that was unsupportive and lacked “problem solving or feedback mechanisms for providers” (Hill et al., 2014: 2) resulted in health provider dissatisfaction and demotivation. Golooba-Mutebi (2005: 176), adds that “where health workers were not subject to supervision by professional peers” and were instead supervised by local actors, “they engaged in unrestrained malfeasance that undermined service quality.” Basing on the findings from the two sets of studies, our prior confidence in the validity of  $h_{32}$  before examining new evidence in the case is moderate, set at 0.60, implying that  $p(\sim h_{32})$  is 0.40.

1) If  $h_{32}$  is true, we would expect to obtain interview statements from health workers and in-charges at health facilities, as well as health facility superiors from the health sub-district and district health department affirming their awareness of the existence of sanctions for non-compliance with district health policies and procedures; including an account description of the respective sanctions undertaken for errant health worker behaviour. We would also expect to obtain interview statements from health workers attesting to having felt pressured by citizens during the execution of their work along with descriptions of experiences to demonstrate this. Lastly, we would expect to obtain interview statements from health workers and their superiors at health sub-district and district levels attesting to the implementation of health policies, plans and budgets in accordance with stipulated provisions/regulations. Finding these pieces of evidence is highly certain but not unique. We might expect that some interviewees, driven by personal motives, will falsely attest to what is not actual practice. It might also be possible that some health workers implement gender-responsive health policies and budgets willingly, guided by the medical professional code of conduct and not owing to any form of duress. The pressure mounted by citizens may also be as a result of other interventions operating in the programme area, which are unrelated to FOWODE. This results in a hoop test. We assign  $p(e|h_{32})$  at 0.80 and  $p(e|\sim h_{32})$  at 0.20.

2) Secondly, we would expect to see account evidence of district health policies, health facility financial and management records and health facility monitoring reports by village budget club members revealing that no discrepancies exist between the stipulated health policies and their implementation at the health facilities; as well as between the disbursement of finances, health equipment and medical supplies and their utilisation at the health facilities. In the event of any irregularities found present, we would expect to find trace evidence that appropriate sanctions were imposed on the errant health provider. Finding this evidence (especially lack of discrepancy) has high certainty but low uniqueness, as we might expect that the authors of the reports may cover

up and not record some health facility malfeasances for personal motives. This results in a hoop test. We assign  $p(e|h_{32})$  at 0.70 and  $p(e|\sim h_{32})$  at 0.25.

3) Thirdly, we would expect to obtain account evidence of interview statements from village budget club members, FOWODE staff and Health Unit Management Committee members attesting to satisfaction with the implementation of health budgets and policies at the respective health facilities, along with testimonies of the actions that were taken for any errant health provider behaviour. Finding this evidence is highly certain but not unique, as it might also be possible that health facility staff complied with health policies and budgets in accordance with personal and/or professional ethics and not out of the pressure mounted upon them. This therefore constitutes a hoop test. We assign  $p(e|h_{32})$  at 0.85 and  $p(e|\sim h_{32})$  at 0.10.

#### **4.2.5 The outcomes – Y**

As already indicated, part Y relates to the supply-side and demand-side maternal health outcomes respectively. Having operationalised all the preceding parts of the theorised causal mechanism, we now operationalise the two outcomes of improved and gender-responsive maternal health service delivery ( $Y_1$ ) and increased utilisation of maternal health services among rural poor women ( $Y_2$ ) respectively.

##### **Outcome $Y_1$**

Outcome  $Y_1$  relates to improved and gender responsive maternal health service delivery. As pointed out in Chapter 3, the dimensions of improved and gender-responsive maternal health service delivery relate to accessibility, availability, affordability and acceptability. In a comment on reforming country health systems for women's health, Samb (2010: 354) summarises "three areas of health systems reform that have great potential for increasing access and uptake of health services by women." The three areas include the removal of financial constraints (related to distance, accommodation costs and user charges); the provision of flexible services that respond to women's needs (notably services that ensure trust, respect, privacy and confidentiality by health providers); and full and meaningful participation of women "in decision-making processes related to health systems and health-care provision." In Chapter 3, we noted that whereas advances have been made by governments to reform health systems so as to reduce maternal mortality, numerous studies from developing countries, including Uganda, (Grossman-Kendal, 2001; Golooba-Mutebi, 2011; Matsuoka et al., 2010; World Health Organisation, 2010) still highlight the challenge of maternal health service delivery that is unresponsive to women's needs. On the basis of this evidence, our prior confidence in the validity of  $Y_1$  before examining new evidence from the case ( $p(Y_1)$ ) is low, set at 0.52, implying that  $p(\sim Y_1)$  is 0.48.

1) If  $Y_1$  is true, we would expect a physical observation of health facilities in the FOWODE programme area to reveal trace evidence of necessary requirements to ensure clean and safe delivery by

mothers (notably infrastructure, equipment and supplies) available and in operational condition. We would also expect to see trace evidence of doctors and/or skilled birth attendants available at the health facilities and providing round-the-clock and affordable maternal health services. Additionally, we would expect to see that the health facilities can be easily accessed by residents from the surrounding villages, and interpersonal relations between health providers and patients at health facilities seem amicable. Finding this evidence is certain but not unique, as the presence of gender-sensitive services could also be a result of the efforts of other organisations, as well as government. This forms a hoop test. We assign  $p(e|Y_1)$  at 0.90 and  $p(e|\sim Y_1)$  at 0.30.

2) Secondly, if  $Y_1$  is true, we would expect to obtain statements from focus group discussions held with women of reproductive age, village budget club members, rural women; as well as interviews with local leaders, health unit management committee members and health providers at the health facilities affirming that the maternal health services provided at the health facilities respond to gender-specific maternal health needs. Specifically, we would expect to obtain testimonies that the staff is kind and respectful towards expectant mothers, maternal health services are easily accessible by all; no user charges are paid to access services; mama (delivery) kits are freely provided to all expectant mothers; the necessary equipment for safe delivery is available; the referral system at health facilities is functional and efficient; delivery services are available round-the-clock; expectant mothers do not have to wait for too long to be attended to and that the midwives and other maternal health personnel are available at the health facilities. Finding this evidence is certain but not unique, as we might expect that some of the interviewees will attest positively, either out of fear of being victimised or for other personal motives. Finding the evidence might also not be unique to the FOWODE GRB intervention. This forms a hoop test. We assign  $p(e|Y_1)$  at 0.90 and  $p(e|\sim Y_1)$  at 0.25.

3) Thirdly, we would expect to find sequence evidence that substantive improvements in health service provision at public health facilities in the programme area followed advocacy by the FOWODE GRB intervention in the respective sub county. Finding this evidence is highly certain but not unique, as it might also be coincidental that other non-governmental organisations intervened or a national-level reform of the health sector occurred at about the same time to influence the observed changes. This forms another hoop test. We assign  $p(e|Y_1)$  at 0.85 and  $p(e|\sim Y_1)$  at 0.10.

## **Outcome $Y_2$**

Outcome  $Y_2$  theorises that more rural poor women of reproductive age residing in the communities of FOWODE's GRB intervention access and utilise skilled maternal health care, namely prenatal, delivery and post-natal services.



Existing literature on the utilisation of maternal health services by rural women following improvements made to health service delivery is mixed. While some studies (Björkman and Svensson, 2009; Duong et al., 2004; McQuestion and Velasquez, 2006; Sabitu et al., 1997) found that improvements in health service provision led to increased utilisation of maternal health care, other studies (Gage, 2007; Idris et al., 2013; Saha and Kabir, 2006) found that the quality of care at health facilities had less significance in influencing a woman's decision to utilise maternal health care as compared to demographic, socio-economic and cultural factors. Dettrick et al. (2013) conducted a systematic review of 278 studies that assess the impact of strategies to improve the quality of maternal and child health care on maternal and child health outcomes. The authors concluded that there is very limited evidence that links quality improvement strategies of health care at health facilities to improved maternal health outcomes (Dettrick et al., 2013). Premised on these findings, our theoretical prior confidence in  $Y_2$  before examining new evidence in the case is quite low, set at 0.50. This implies that  $p(\sim Y_2)$  is also set at 0.50.

1) If  $Y_2$  is true, we would love to see pattern evidence from health facility monthly, quarterly and annual management information system reports revealing a growing trend in the utilisation of skilled maternal health care at health facilities within the operation area of the FOWODE grassroots level GRB intervention. Finding this evidence is not very certain, as we might expect that rural women, despite their knowledge of the improvements at the nearby health facility still prefer to access maternal health care from other health facilities other than the ones closest to them (Kiwanuka et al., 2008). It might also be the case that improvements in maternal health service provision play an insignificant role in influencing the decision to access skilled maternal health care among rural poor women. If the evidence is found, however, it may not be entirely attributable to the FOWODE intervention, but to other interventions, as well as socioeconomic and demographic factors. This results in a straw-in-the wind test. We assign  $p(e|Y_2)$  at 0.40 and  $p(e|\sim Y_2)$  at 0.25.

2) Secondly, we would expect to obtain account evidence of interview statements from expectant and new mothers residing in the FOWODE programme area (Bubare and Kamwezi Sub Counties) attesting to their use of skilled maternal care (antenatal, delivery and postnatal) during the most recent pregnancy, with some participants attesting to having received the services from the public health facilities within the sub county. Finding this evidence is certain but not unique, as there is a likelihood that some of the mothers may have still used skilled maternal health regardless of the FOWODE intervention. Additionally, we might expect that some women will falsely attest positively out of personal motives. This results in a hoop test. We assign  $p(e|Y_2)$  at 0.60 and  $p(e|\sim Y_2)$  at 0.20.

As noted before, the evidence of the presence and functioning of  $Y_2$  is investigated further at household level using quantitative methods, presented in Chapter 6.

## **5. EVALUATING THE CAUSAL MECHANISM**

The third and final step of the theory-testing process tracing procedure is the evaluation of each hypothesised part of the causal mechanism and the mechanism as a whole. The main objective of evaluating the causal mechanism is to be able to update our confidence in the validity of the theorised mechanism relative to the theoretical prior from existing evidence. This section presents and evaluates the evidence found for each part of the theorised mechanism and the mechanism as a whole in Kabale district. Consistent with the preceding two sections, this section briefly reviews theory-testing process tracing principles for the evaluation of empirical evidence in Section 5.1, followed by the evaluation of the theorised causal mechanism in Section 5.2.

### **5.1. Reviewing theory-testing process tracing principles**

The third and final step of the theory-testing process tracing procedure involves collecting evidence to evaluate the presence of individual parts of the mechanism, and the mechanism as a whole having functioned as predicted to contribute to producing the observed outcomes. Beach and Pedersen (2013: 123) recommend that the collection of evidence should be strategic so as to “enable us determine whether the predicted (e) or (~e) is present.” Furthermore, the content, accuracy and probability of empirical observations should be critically assessed before the observations can be used as evidence to update our confidence in the hypothesised part of a given causal mechanism.

With regard to content, contextual knowledge of the specific case helps us to “determine what our observations tell us in relation to what evidence was predicted to occur” (Beach and Pedersen, 2013: 122). This involves a careful consideration of the source of the observation and the context in which the observation is produced – for instance, “what is known about the actors, their intentions, their interactions and the situation in which they found themselves” (Beach and Pedersen, 2013: 126).

Regarding accuracy of the evidence, Beach and Pedersen (2013) suggest that we need to be able to trust that the collected observations are in fact evidence of what we intend to measure and have been evaluated for potential sources of error accordingly. Unreliable measures decrease the ability of the evidence to update our confidence about the presence and functioning of the theorised mechanism and its constitutive parts (Beach and Pedersen, 2013). The collection of multiple independent observations, however, provides a solution to unreliable measures, “as it is highly unlikely that the measures will result in the same evidence (e) unless (e) is actually a true measure” (Howson and Urbach, 2006: 125).

Lastly, assessing the probability of the evidence relates to the odds of finding the evidence in the context of the specific case (Beach and Pedersen, 2013). As asserted by Beach and Pedersen (2013: 129-130), assessing the probability of the evidence involves asking the question “how many pieces

of evidence are necessary to update our confidence in the validity of a hypothesis [?]” According to Bayesian theorem, if the probability of finding the evidence  $p(e)$  is very low (smoking gun test), finding one piece of evidence is enough to significantly update our confidence in the hypothesis being true (Beach and Pedersen, 2013).

Our posterior confidence in a hypothesis being true conditional on the found evidence is calculated by multiplying the weight of evidence (the probability of finding particular evidence conditional on the theory being true relative to finding the evidence when alternative theories are true) times the prior probability (Schmitt and Beach, 2015; Beach and Pedersen, 2013). The Bayesian formula is given as follows:

$$p(h|e) = \frac{p(h) * p(e|h)}{p(h) * p(e|h) + p(\sim h) * p(e|\sim h)}$$

When evaluating evidence in Bayesian terms, Befani and Stedman-Bryce (2016: 12) propose that quantification of the probative value of specific pieces of evidence enables us to overcome “the uncertainty around classifying specific pieces of evidence as smoking gun, straw-in-the wind or hoop tests.” Befani and Stedman-Bryce (2016), further propose qualitative rubrics for describing the quantitative levels of confidence of specific pieces of evidence as shown in Table 12.

**Table 12: Qualitative rubrics describing different quantitative levels of confidence**

Practical certainty	0.99+
Reasonable certainty	0.95 to 0.99
High confidence	0.85 to 0.95
Cautious confidence	0.70 to 0.85
More confidence than not	0.50 to 0.70
No information	0.50

Source: Adapted Befani and Stedman-Bryce (2016: 14).

Following these principles, sub-section 5.2 discusses the found evidence and evaluates its ability to update our confidence in the theorised causal mechanism having functioned in Kabale District to result in the observed outcomes. Conclusions about the presence of each part/sub-part of the theorised causal mechanism are arrived at by calculating the probabilities of observing the packages of evidence (products of the probabilities of observing the single pieces of evidence). A summary of the application of formal Bayesian updating to evaluate the theorised parts of the causal mechanism is presented in Table 16 in Annex IV.

## **5.2. Evaluating the theorised causal mechanism in Kabale District**

The evaluation of the evidence for each part of the theorised causal mechanism in Kabale is presented as follows. First, a brief description of the theorised part of the causal mechanism is presented, followed by the findings relating to each predicted piece of evidence (including the posterior probability value), and lastly, a judgement of our updated confidence in each hypothesised part and the mechanism as a whole having functioned as theorised to produce the outcomes.

### **5.2.1. Part X: FOWODE GRB capacity building and advocacy interventions implemented at district and grassroots levels**

Part X of the mechanism hypothesised that FOWODE *implemented* its GRB capacity building and advocacy interventions at district and grassroots levels respectively.

1) As stated in Bamanyaki and Holvoet (2016: 85), “[i]nterview statements made by technocrats from the health department, planning and budget offices, community development office, as well as female councillors confirm that FOWODE conducted GRB trainings for selected district-level stakeholders between 2000 and 2013.” According to FOWODE staff and district technocrats, GRB trainings for district technocrats were conducted in 2003/2004. District technocrats were also guided on how to develop gender-aware budget plans and a district GRB focal person was identified and tasked with ensuring that departmental heads who had participated in the training continually submitted gender-aware plans and budgets to the district planning department on an annual basis. Four out of the six technocrats interviewed, who were present in the district during 2003/2004, affirmed that FOWODE provided technical assistance, which resulted in the publication of a district gender analysis of sectors and a district gender policy. District technocrats from the departments of health, planning and community development also affirmed to having received briefs from FOWODE analysing the district health budget as well as other sectors on an annual basis, especially during the years prior to 2010. Interview statements made by FOWODE Kabale Office staff, however, attested to gender analyses of district draft budgets (including health) still being produced on an annual basis and disseminated to the District Technical Planning Committee in the form of alternative budget proposals for consideration prior to budget approval.

Regarding the grassroots level intervention, interview statements made by FOWODE staff, village budget club members, district and local leaders from the two sub counties of Bubare and Kamwezi unanimously affirmed that village budget club groups comprising of 20 to 30 members were mobilised and established, with the support of local leaders in the villages. Village budget club members also attested to having received training on GRB and budget monitoring, as well as guidance on when, what and how to monitor different levels of health facilities using health facility tools developed by FOWODE. According to statements made by village budget club members, local leaders in the two sub counties and FOWODE staff, FOWODE utilised the mobilisation meetings at

parish level to sensitise communities on health rights and entitlements, citizen roles and responsibilities, and the importance of participating in public decision-making processes so as to influence plans and budgets that address their needs. Village budget club members also attested to having received simplified health budget information from FOWODE on an annual basis, which contained highlights of specific capital investment activities that were to be implemented at the health facilities in the respective sub counties during a particular financial year, along with the budget allocations towards those activities.

The found evidence at district and grassroots level makes us reasonably certain of the validity of part X in our contribution claim,  $p(X|e) = 0.98$ .

2) Trace evidence was found of training manuals for district technocrats, female councillors and village budget club groups at the FOWODE office. Some training reports were also seen (for trainings conducted between 2012 and 2014), as well as a few personal notes of 1 female councillor and 2 village budget club members that were written during the trainings. The reports for trainings conducted prior to 2012 could not be retrieved from the FOWODE office<sup>20</sup>. Original participant evaluation forms were also not seen, as the trainings had been conducted by external consultants who did not provide participant evaluation forms to FOWODE. Other documentary traces of evidence included a district gender analysis of sectors prepared by technocrats in 2003, and a draft district gender policy prepared by technocrats in 2009. The Forewords of both documents explicitly acknowledge FOWODE as having provided assistance, which is proof of FOWODE technical assistance to district technocrats of Kabale. While some of the evidence could not be retrieved (training reports and original participant evaluations for technocrat trainings), most of the crucial evidence to verify X was found. We further reason that the district technocrats had to have received GRB training for them to have been able to produce the two outputs that were seen. On the basis of the found evidence, we are practically certain of the validity of part X in our contribution claim,  $p(X|e) = 0.99$ .

3) A review of the content of different training manuals revealed that the modules for district technocrats encompassed: (i) gender and related concepts; (ii) the budget process cycle; (iii) policy, planning and budgeting; (iv) analysis of gender issues and prioritisation of interventions; and (v) mainstreaming gender issues (FOWODE, 2012). The training manual for female councillors consisted of three separate modules, namely: (i) how to analyse proposed legislation, budgets and existing policies from a gender perspective; (ii) how to frame budget proposals, prepare motions and lobby for women's issues in the council; and (iii) public speaking, effective communication, confidence building and coalition building through the use of a women's caucus (FOWODE, n.d.). At the grassroots level, the topics outlined in the training manual were: (i) GRB and budget monitoring, (ii)

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<sup>20</sup> The FOWODE Field Office in Kabale was opened in 2010 and only had documents from 2010 to date. At the national office, training reports for the technocrats' training had already been archived and were impossible to retrieve, given that the staff responsible at the time had already left the institution.

the legal framework, local government planning and budgeting processes; and (iii) how to advocate for improved service delivery from political and administrative leaders. FOWODE also developed monitoring tools for the different levels of health facilities which were based on the UNMHCP. The training manuals also indicate that participatory sessions were conducted to guide village budget club members on how to administer the monitoring tools. The content of the different training manuals aligns with the topics theorised in the causal mechanism. This evidence makes us practically certain of the validity of part X in our contribution claim,  $p(X|e) = 0.99$ .

4) At the grassroots level, physical observation established trace evidence of the existence of village budget clubs in the two sub counties. Face-to-face focus group discussions were held with leaders and a few members of Kagarama Village Budget Club in Bubare Sub County and the Kyabuhangwa Village Budget Club in Kamwezi Sub County respectively. Despite the completion of funding support from FOWODE, both village budget clubs still exist, although membership has reduced to at most 10 people per group. Both village budget clubs provided evidence of original registration certificates which confirmed their recognition at parish and sub county level, as well as the authorisation to operate in the sub country. The registration certificates state that village budget clubs are mandated to: mobilise community members to participate in planning and budgeting processes; create space for community members to engage with service providers; and advocate for community concerns. This evidence also makes us practically certain of the validity of part X in our contribution claim,  $p(X|e) = 0.99$ .

Considering the four observed pieces of evidence as a package (the product of the four probabilities), we have high confidence in the validity of part X in our contribution claim,  $p(X|e) = 0.95$ . No updating, however, has been made of our confidence in part X given that the theoretical prior,  $p(e|X)$ , was also 0.95. The confirmation of the presence and functioning of X in Kabale permits us to proceed with the evaluation of part 1 of the theorised causal mechanism.

### **5.2.2. Part 1: Knowledge and skills acquisition by technocrats, female councillors and grassroots women groups**

#### **Sub-part $h_{11}$ : Female councillors and technocrats acquire GRB knowledge and perceive it as useful to implement mandates**

[The operationalisation of  $h_{11}$  sought to verify that female councillors and technocrats *acquired* GRB knowledge and *perceived* it as useful to implement their respective roles.

1) As stated in Bamanyaki and Holvoet (2016: 85), interview statements made by technocrats (including the health, planning and community development departments) and female councillors

“who had participated in the trainings affirmed that the trainings were well delivered, relevant and applicable to their respective duties. Although the trainings had been conducted more than three years

ago, the technocrats and female councillors interviewed were able to explain key aspects of GRB principles relating to gender analysis of sectors and mainstreaming gender into policies, plans and budgets. Three out of the six technocrats interviewed attested to have received additional GRB training that was facilitated by the Ministry of Local Government and the Ministry of Gender Labour and Social Development. [The female councillors interviewed expressed having learnt issues to deal with effective leadership and public speaking, the analysis of gender issues in sectors including health, and the allocation of district resources in ways that take into consideration the different gender needs.]”

The evidence gives us high confidence in the validity of  $h_{11}$  in our contribution claim,  $p(h_{11}|e) = 0.95$ .

2) As asserted in Bamanyaki and Holvoet (2016: 85), the findings from the content of the training manuals (see (3) of part X above)

“triangulated the interview statements made regarding the understanding of GRB principles and techniques. The technocrats and councillors interviewed were able to recall and satisfactorily explain at least three out of the five course modules that relate to gender concepts, the budget process cycle and mainstreaming gender in the prioritisation of interventions and allocation of resources.”

The evidence makes us reasonably certain of the validity of  $h_{11}$  in our contribution claim,  $p(h_{11}|e) = 0.98$ .

3) A review of the content of training reports for female councillors, as well as FOWODE annual reports for 2003 and 2004, confirmed that technocrats and female councillors received training on GRB techniques and “[t]he ratings of the trainings according to the training reports were positive, showing consistency with the interview statements made” (Bamanyaki and Holvoet, 2016: 86). The found evidence makes us reasonably certain of the validity of  $h_{11}$  in our contribution claim,  $p(h_{11}|e) = 0.96$ .

Considering the three observed pieces of evidence as a package, we have high confidence in the validity of sub-part  $h_{11}$  in our contribution claim,  $p(h_{11}|E) = 0.90$ . No updating, however, has been made of our confidence in part X given that the theoretical prior,  $p(e|X)$ , was also 0.90.

### **Sub-part $h_{12}$ : Grassroots women groups acquire knowledge of GRB, health rights, planning and budget processes**

The operationalisation of  $h_{12}$  sought to verify that grassroots women groups *acquired* knowledge of GRB, health rights, planning and budget processes and *embraced* it.

1) Participants of the village budget club focus group discussions held in the two sub counties were collectively able to articulate health-related gender issues affecting their communities (at household, community and health facility level), patient rights at public health facilities, GRB and its importance, local government planning and budget processes, as well as the importance and role of citizen participation in planning and budget processes. From the focus group discussions, however, it was noted that not all the members of the two village budget clubs completely understood the concepts that were taught to them, owing to variations in literacy levels. These participants attested to having relied on their peers within the group to explain to them the concepts after the training, which enabled them to complete their duties well. The village budget club members also attested to having composed songs based on the messages that were taught, which helped them to memorise and further appreciate the concepts. Given that the village budget clubs conducted their activities as a group, the satisfactory articulation of GRB, health rights, planning and budget processes at group level makes us cautiously confident of the validity of  $h_{12}$  in our contribution claim,  $p(h_{12}|e) = 0.83$ .

2) The trainers of village budget clubs were community members who had been identified by FOWODE in collaboration with the local leaders of the parishes of FOWODE's grassroots level intervention. FOWODE trained these resource persons, referred to as community budget advisors, and tasked them with training and providing ongoing technical support to the village budget clubs in the respective parishes as required. At the time of conducting this research, one out of the four community budget advisors was still available among the communities, while the others had since relocated out of the district. The community budget advisor interviewed attested to having trained Kagarama Village Budget Club on GRB, citizen rights and group dynamics. According to the community budget advisor, the group members were eager to receive new knowledge and demonstrated a fair understanding of the concepts taught. The evidence gives us high confidence in the validity of  $h_{12}$  in our contribution claim,  $p(h_{12}|e) = 0.86$ .

3) As was noted in part X, the training manual for village budget club groups included topics related to the legal framework, local government planning and budget processes, health facility minimum standards and GRB. A detailed review of the content covered under the respective topics corroborated with the participant statements that were made explaining the understanding of GRB, health rights, local government planning and government processes. The members also pointed out that their service in the communities was voluntary, and that members who did not embrace the messages dropped out and were replaced. The evidence makes us reasonably certain in the validity of  $h_{12}$  in our contribution claim,  $p(h_{12}|e) = 0.98$ .

A consideration of the package of the three observed pieces of evidence makes us more confident than not in the validity of sub-part  $h_{12}$ , in our contribution claim,  $p(h_{12}|e) = 0.69$ . In relation to the theoretical prior of no information,  $p(e|h_{12}) = 0.50$ , high updating has been made to our confidence in sub-part  $h_{12}$ .



**Sub-part  $h_{13}$ : Grassroots women groups mobilise and sensitise the wider community on gender, maternal health service standards, health rights and the importance of engaging in public processes**

The operationalisation of  $h_{13}$  sought to verify that the women-dominated village budget clubs *mobilised* and *sensitised* community members in their respective parishes on gender, maternal health service standards, health rights and the importance of engaging in public processes.

1) Participant statements from focus group discussions held with members of the two village budget clubs in Bubare and Kamwezi attested to having conducted community sensitisations in the respective parishes of operation. Community sensitisation was mainly done through talks or drama (songs and short plays) at social gatherings such as places of worship, women's group meetings and other village events. Specific to health, the sensitisation messages focused on informing community members about health facilities and services available, the dangers of delivering children from home, government programmes taking place in the sub county and how it was the responsibility of all citizens to own government programmes, monitor service delivery and hold government to account. Community members were also sensitised on the concept of gender equality and how they should ensure equal opportunities for males and females in the household with regard to access to resources. Community members, particularly women, were also urged to participate in public processes so as to influence decisions to address issues that affect them. The focus group participants of Kyabuhangwa Village Budget Club in Kamwezi, in particular, attested to having sensitised community members of Kamwezi about maternal health through a play titled 'The Story of Yona'. The play depicts the inefficiencies of government in delivering timely and quality maternal health services and inspires communities to challenge government and demand for change. The evidence gives us reasonable certainty in the validity of  $h_{13}$  in our contribution claim,  $p(h_{13} | e) = 0.97$ .

2) Focus group discussions with rural women of reproductive age residing in the two parishes of Kyabuhangwa (Kamwezi) and Kagarama (Bubare) revealed mixed opinions regarding knowledge of village budget clubs. While some of the focus group participants reported to be aware of the village budget clubs in their community, other participants reported not to have knowledge of their existence. The participants who reported to be knowledgeable of the village budget clubs expressed having received messages related to delivering at health facilities, the availability of midwives at health facilities, the status of government programmes and their rights as women. Irrespective of the mixed opinions amongst the women, we acknowledge that the selection of focus group participants (14 women per parish) may not be representative of the community. The mere confirmation amongst some of the women of their knowledge of the village budget clubs and their activities within the community gives us high confidence in the validity of  $h_{13}$  in our contribution claim,  $p(h_{13} | e) = 0.94$ .

3) Hand-written minutes of some of the village budget club sensitisation meetings were found among village budget club official documents. The observed minutes specified the dates of the meetings, the persons involved at the meeting and the messages that were delivered. No minutes were seen for talks that were given at places of worship and women's group meetings, however, quarterly reports of the respective village budget clubs mention the places of worship that were visited and the names of village budget club members who gave the talks. The found evidence makes us practically certain of the validity of  $h_{13}$  in our contribution claim,  $p(h_{13}|e) = 0.99$ .

Considering the three observed pieces of evidence as a package, we have high confidence in the validity of sub-part  $h_{13}$  in our contribution claim,  $p(h_{13}|e) = 0.91$ . Limited updating, however has been made to our confidence in sub-part  $h_{13}$ , given that the theoretical prior was also high at  $p(e|h_{13}) = 0.85$ . Having ascertained confidence in the functioning of part 1, the next sub-section evaluates the second part of the theorised causal mechanism.

### **5.2.3. Part 2: Application of the acquired knowledge and skills by technocrats, female councillors and citizens at the grassroots**

#### **Sub-part $h_{21}$ : Female councillors utilise GRB skills in the oversight of health policies, plans and budgets for gender-responsiveness**

The operationalisation of  $h_{21}$  sought to verify that female councillors *utilised* the GRB skills acquired in their oversight of district health policies, plans and budgets for gender-responsiveness. The evaluation of the predicted evidence for  $h_{21}$  was presented in Bamanyaki and Holvoet (2016: 86-87) and is reproduced with a few additions below.

"[1]) Interview statements made by female councillors attested to the application of GRB techniques in the evaluation of health policies, plans and budgets prepared by technocrats. The female councillors interviewed revealed that following the FOWODE training, 15 out of the 18 female district councillors formed a women's caucus to periodically monitor health facilities and identify issues that affect women, which they would then collectively prioritise and lobby for at district council meetings. [The female councillors interviewed also attested to attending district council health committee meetings to ensure that specific measures to address the identified issues are included in district plans and appropriate budget allocations are made accordingly. The found evidence gives us high confidence in the validity of  $h_{21}$  in our contribution claim,  $p(h_{21}|e) = 0.92$ .]

[2]) The minutes of district council health committee meetings could not be readily obtained so the smoking gun test failed. A review of the minutes of women's caucus meetings [that preceded district council meetings], however, revealed details of the health facilities monitored and the issues identified and prioritised, which included staffing health centres that offer maternal health care with midwives; constructing placenta pits at health facilities; providing free mama kits to expectant mothers; constructing staff accommodation at remote-rural health facilities; equipping the regional referral

hospital with blood supplies], and improving access to maternal health facilities by rehabilitating dilapidated roads and bridges. A further triangulation of this observation with interview statements made by male members of the district council health committee affirmed that [some] women caucus members were vocal about the consideration of women's health needs in health plans and budgets. [...] [T]he found evidence points towards the female councillors having utilised the acquired GRB skills in their oversight role [and makes us cautiously confident in the validity of  $h_{21}$  in our contribution claim,  $p(h_{21}|e) = 0.71$ .]

[3]) A review of the annual district budgets revealed that from the year 2011/12 to 2014/15, the district prioritised the construction of placenta pits and staffing of midwives at selected health centres II using locally generated revenue, in a bid to address maternal health issues in the district. [The approved budgets of 2012/13, 2013/14 and 2014/15 particularly show that locally generated district revenue was allocated on an annual basis towards the construction of 4 to 6 placenta pits at health centres II and III respectively.] According to Uganda's health service delivery structure, health centres II [were] not mandated to provide maternity services. Kabale District Council, however, passed a resolution to equip health centres II in hard-to-reach villages with maternal health equipment, following a proposal presented by the district council health committee. [A further comparison of draft budget estimates to approved budget allocations of Kabale district from 2010/11 to 2014/15 reveals that annually, the district council allocated above 10 per cent of its resources towards the health sector (see Figure 7 in Annex IV). Specifically in financial year 2013/14, the comparison shows that whereas the draft budget estimate allocated towards the health sector was 13.6 per cent, the approved budget by the district council for the same financial year was 15.5 per cent. The evidence gives us high confidence in the validity of  $h_{21}$  in our contribution claim,  $p(h_{21}|e) = 0.86$ .]"

Considering the three observed pieces of evidence as a package, we are more confident than not in the validity of sub-part  $h_{21}$  in our contribution claim,  $p(h_{21}|e) = 0.56$ . Very limited updating has been made to our confidence in sub-part  $h_{21}$  relative to the theoretical prior,  $p(e|h_{21}) = 0.55$ .

### **Sub-part $h_{22}$ : Grassroots citizens monitor maternal health service delivery for gender-responsiveness**

The operationalisation of  $h_{22}$  sought to verify that grassroots citizens, represented by village budget club members, periodically *monitored* the gender-responsiveness of maternal health service delivery at public health facilities.

1) Participant statements from village budget club focus group discussions held in the Kamwezi and Bubare affirmed that monitoring visits to health facilities had been conducted to ascertain gender-

responsiveness and the effectiveness of the delivery of health services. Whereas the village budget club in Bubare had not conducted health facility monitoring visits since FOWODE's completion of funding support in 2012, the village budget club in Kamwezi attested to having continued monitoring health facilities in the sub county beyond FOWODE's phasing out of direct support in 2014. Participants of the two focus groups described a similar process that was followed during monitoring visits, which involved physical observation of health facility premises, equipment and service provision, followed by an interview with the health centre in-charge/person responsible to discuss and agree on the issues noted at the health facility.

At health facility level, interview statements of health facility in-charges in the two sub counties affirmed their knowledge of and interaction with village budget club members at the health facility at least once in each quarter of the year, and more so during the period when FOWODE was actively supporting the village budget club groups. The description provided by health in charges, of the process followed by village budget club members during monitoring visits at the health facility exactly corroborated the description provided by the village budget club focus group participants. The evidence gives us high confidence in the validity of  $h_{21}$  in our contribution claim,  $p(h_{22}|e) = 0.95$ .

2) A review of health facility visitors' books at Kyogo Health Centre III in Kamwezi and Kagarama Health Centre II in Bubare revealed signatures of three to four village budget club members having visited the health facility at quarterly intervals in a year from 2010 to 2012 in Kagarama, Bubare and from 2012 to half of 2014 in Kyogo, Kamwezi. The remarks alongside the signatures indicated 'VBC monitoring visit'. The findings triangulated with the dates mentioned in the village budget club reports, as well as with interview statements made by in-charges and other health workers who were present at the health facility when the visits were conducted. This evidence gives us high confidence in the validity of  $h_{21}$  in our contribution claim,  $p(h_{22}|e) = 0.93$ .

3) From a critical review of village budget club records, it was noted that minutes were not written during monitoring visits; rather, village budget club members used monitoring checklists for the respective level of the health facility as a guide to assess whether minimum standards of service delivery were being met. The monitoring checklists included four sections, namely 1) the background of the health facility; 2) the status of the health facility with regard to the set minimum standards relating to staffing, health facility structures (including staff accommodation), availability of transport and essential drugs; 3) the status of health facility management and financial control; and 4) a description of how client rights relating to the dimensions of awareness, access, availability, quality, utilisation and satisfaction were being met by health facility staff. At the end of every monitoring checklist was a hand-written signature of the health facility in-charge (alongside those of village budget club members present) affirming agreement with the contents of the checklist and the issues discussed during the monitoring visit. The found evidence gives us high confidence in the validity of  $h_{22}$  in our contribution claim,  $p(h_{22}|e) = 0.88$ .

Considering the three observed pieces of evidence as a package, we are cautiously confident of the validity of sub-part  $h_{22}$  in our contribution claim,  $p(h_{22}|e) = 0.77$ . Moderate updating has been made to our confidence in sub-part  $h_{22}$  relative to the theoretical prior,  $p(e|h_{22}) = 0.70$ .

**Sub-part  $h_{23}$ : Grassroots citizens (mainly women) voice demands to technocrats for gender accountability in health**

The operationalisation of  $h_{23}$  sought to verify that grassroots citizens – predominantly women – *voiced* demands to technocrats for gender accountability in health service delivery at public health facilities.

1) Interview statements made by FOWODE staff, media journalists, district technocrats, district councillors and local leaders at sub county and parish levels unanimously affirmed that interface meetings had taken place in the sub counties of Bubare and Kamwezi, organised by FOWODE. Participant statements from village budget club focus group discussions, interview statements made by local leaders at sub county level, as well as FOWODE staff at the Kabale field office additionally attested to community dialogue meetings having been held prior to each interface meeting. Community dialogue meetings were held at parish level and involved community members residing in the parishes and a few local leaders. The community dialogues were organised by village budget club members to communicate the findings obtained from monitoring public health facilities, which would be discussed and the community members would collectively prioritise and frame three to five issues that would be presented to technocrats and politicians at the interface meetings for redress.

All respondents interviewed affirmed that the attendance of women often exceeded that of men (about 70 per cent women and 30 per cent men) at both community dialogues and interface meetings. The active participation of women, however, was more pronounced at community dialogue meetings, as compared to interface meetings. All categories of respondents were asked to describe what transpired at interface meetings, and the descriptions corroborated with the views of other respondents. In addition to voicing demands at interface meetings, interview statements made by councillors, FOWODE staff, local leaders, health workers and village budget club members attested to radio talk shows having been held at a local radio station immediately after the interface meetings (from 9pm to 10 pm). The radio talk shows involved village budget club members, FOWODE staff and technocrats expounding on the issues that were discussed and agreed upon at the interface meeting for the benefit of other community members and listeners who were not physically present at the interface meetings. The respondents affirmed that during the radio talk shows, listeners of the programme would phone in and voice their opinions on air. The found evidence gives us high confidence in the validity of  $h_{23}$  in our contribution claim,  $p(h_{23}|e) = 0.93$ .

2) Trace evidence was found in FOWODE official documents and village budget club documents ascertaining that interface meetings and community dialogues took place four times each year in

each sub county. From village budget club records in Kamwezi Sub County, evidence was also found of original flyers that were reported to have been distributed to community members at dialogue meetings, outlining issues that were found at the health facilities during village budget club monitoring visits. Additional observations were signed attendance registers of persons present at the respective meetings, who ranged from 60 to 140 people, most of who were women. Hand-written minutes of the proceedings of interface meetings were also seen, which detailed the dates of the respective meetings, the venues of the meetings (at church grounds, which were normally a central location in the parish), the technocrats and politicians who were in attendance and detailed proceedings of the issues that were discussed at the meetings. At each interface meeting, three to five technocrats were usually present (including, among others, representatives from the district health department and the office of the Chief Administrative Officer). Other persons in attendance – relevant to the health sector – were local leaders from the Sub County, parish and village levels, as well as in-charges/health workers of the health facilities that were monitored in the respective sub counties. From the FOWODE Kabale office, invoices and or/receipts for payments made to cover the costs of transporting technocrats, media coverage and refreshments during the meetings were seen. Also seen, was a photocopy of a citizens' petition signed by 320 residents in Kamwezi Sub County (mostly women) to Kabale District Local Government seeking an audit of the quality of work that was done to reconstruct the Kyogo bridge (connecting the villages to Kyogo Health Centre III).

A review of the content of the proceedings of interface meetings that were held in Kamwezi Sub County, as well as FOWODE programme reports, reveals that the issues that were discussed included the poor conduct of health workers towards patients at health facilities; the distribution of incomplete (tampered with) mama kits to expectant mothers; the lack of safe water and an ambulance for referrals at the health facilities; a dilapidated bridge which cut off access to Kyogo health centre III; the lack of privacy in maternity wards; inadequate staff housing at the health facilities; as well as calls made by health workers and technocrats for expectant mothers to attend prenatal care and not to deliver from home.

The found evidence gives us high confidence in the validity of  $h_{23}$  in our contribution claim,  $p(h_{23}|e) = 0.89$ .

3) Audio and visual recordings of some of the interface meetings and community dialogue meetings conducted in Bubare and Kamwezi were retrieved from FOWODE, which revealed the attendance of more women than men at the meetings and the issues that were discussed. The video recordings corroborate the interview statements and focus group participant statements made with regard to the participants that were in attendance and the issues that were discussed. The video recordings, however, showed that most of the women were passive listeners, and that the women who spoke at the meetings were village budget club members, who were told apart by the uniforms they wore (blue T-shirts). Considering that the predicted evidence sought to verify that rural women voiced demands at meetings (irrespective of their group affiliation), it could be argued that the needs were

voiced through elected women leaders. This evidence makes us reasonably certain of the validity of  $h_{23}$  in our contribution claim,  $p(h_{23}|e) = 0.98$ .

Considering the three observed pieces of evidence as a package, we have high confidence in the validity of sub-part  $h_{23}$  in our contribution claim,  $p(h_{22}|e) = 0.81$ . Moderate updating has been made to our confidence in sub-part  $h_{23}$  relative to the theoretical prior,  $p(e|h_{23}) = 0.70$ .

**Sub-part  $h_{24}$ : Technocrats apply GRB techniques and utilise information from FOWODE and citizens to incorporate a localised gender perspective in health policies, plans and budgets**

The operationalisation of  $h_{24}$  sought to verify that technocrats *applied* the acquired GRB techniques and *utilised* information obtained from FOWODE and from citizens at the interface meetings to *incorporate* a gender perspective in health policies, plans and budgets that align with local gender needs.

1) Interview statements made by technocrats attested to the application of GRB techniques in their work, including conducting gender analyses and the preparation of gender aware budget statements prior to the year 2010. According to the district technocrats interviewed from the health, planning and community development departments, gender aware budget statements were prepared on an annual basis at sectoral level prior to the introduction of output oriented budgeting by the Ministry of Finance, Planning and Economic Development in the financial year 2008/09. All district local governments in Uganda are now mandated to use a standardised Output Budgeting Tool (OBT) to prepare annual sectoral work plans, budgets, and performance reports. The technocrats interviewed professed that the tool does not provide for gender disaggregated information, which makes it difficult to track the gender responsiveness of plans and budgets. Each of the technocrats was asked to describe the prevailing gender-related health needs, and the descriptions largely aligned with the views expressed by village budget club members, rural women and FOWODE staff. Additionally, four out of the six technocrats interviewed affirmed that they had ever attended an interface meeting with community members and that the findings from the interface meetings were always discussed at district technical planning committee meetings. The technocrats attested to verifications being made of the issues that were raised at interface meetings and remedial measures would be incorporated into the district policies, plans and budgets. The evidence gives us high confidence in the validity of  $h_{24}$  in our contribution claim,  $p(h_{24}|e) = 0.90$ .

2) The research was not able to find any gender aware budget statements prepared by the health department, as they were abolished. Evidence was sought from the reports generated by the output budgeting tool, as well as the five year district development plans for the financial year 2011/12 to 2015/16 and financial year 2015/16 to 2019/20 respectively. As was alluded to by the district technocrats, the work plans, budgets and analysis of performance generated by the output budgeting tools do not disaggregate information according to sex. The tool provides pre-determined

indicators to track performance, which are not explicitly gender-sensitive. The two five year district development plans (2010/11 to 2014/15 and 2015/16 to 2019/20), however, include a section that analyses the situation of Kabale District with respect to gender as a cross-cutting issue across the different sectors. Specific to the health sector, gender-related health issues are identified as “higher mortality and morbidity of girls and women versus boys and men, absent or insufficient antenatal care [and] domestic violence” (Kabale District Council, 2015: 78-79). Relating to these identified issues, the section analyses underlying causes, the effects of the issues, the most affected segments of the population in the district, and specific sectoral strategies that will be implemented in order to address these issues. The found evidence makes us cautiously confident in the validity of  $h_{24}$  in our contribution claim,  $p(h_{24}|e) = 0.79$ .

3) Account evidence was sought from a comparison of the content of the three-year district rolling plan 2009/10 to 2011/12 and the budget framework paper for the same period, with health facility records of Kagarama Health Centre II in Bubare Sub County. The three-year district rolling plan 2009/10 to 2011/12 for the health sector prioritised the provision of electric power to health units, procurement of medical equipment, renovation of old structures, repair of health equipment and improvement of staffing levels. While other health facilities are explicitly mentioned in the plan, Kagarama Health Centre II was not listed as one of the targeted health facilities for the period. However, health facility records, backed by interview statements made by health facility staff, indicate that the health facility obtained an examination bed, a delivery bed and a fridge for vaccines in 2011. This followed a FOWODE interface meeting held in the third quarter of the year 2010. All three equipment were physically observed at the health facility, which is still at the level of health centre II but now offering maternal health services.

The district five-year development plan 2011/12 to 2015/16 prioritised improving health service delivery by construction of maternity wards and rehabilitation of dilapidated ones, renovation of health centres II, construction of twin staff houses at health centres II, construction of ventilated improved pit latrines at health centres, construction of placenta pits and the provision of primary health care services. The capital development activities that were planned for Kyogo Health Centre III in Kamwezi Sub County during the five-year period were the construction of a placenta pit and a three-stance ventilated improved pit latrine. Both activities were accomplished by 2013/14. In addition to the two planned activities, improvements were made to Kyogo Health Centre III during the financial year 2013/14, which included the renovation of the maternity wing and the rehabilitation of the dilapidated Kyogo Bridge leading to the health facility. Following a petition by citizens over shoddy work done, additional budget re-allocations were made towards the re-working of the Kyogo Bridge during the financial year 2014/15. The evidence makes us cautiously confident of the validity of  $h_{24}$  in our contribution claim,  $p(h_{24}|e) = 0.85$ .

4) A close examination of the sequence of events indicates that the GRB training and technical assistance of technocrats took place in 2003/04. Official records, backed by affirmations from all



the different categories of interviewees, indicate that the equipment received at Kagarama Health Centre II in 2012, and the improvements made to Kyogo Health Centre III in 2013/14 and 2014/15 respectively followed interface meetings, radio talk shows and petitions made by citizens. Additional evidence obtained from a review of the contents of the interface meeting held in the Kamwezi Sub County in December 2012 confirms that the dilapidated bridge leading to Kyogo Health Centre III was discussed and that the district technocrats who were present at the meeting committed to lobbying for its reconstruction in the following financial year. Furthermore, whereas the draft budget for financial year 2013/14 did not include rehabilitation of the Kyogo Bridge, the approved budget by the district council for 2013/14 includes a budget allocation of UGX 20 million towards the rehabilitation of Kyogo Bridge. The evidence makes us cautiously confident of the validity of  $h_{24}$  in our contribution claim,  $p(h_{24}|e) = 0.84$ .

Considering the three pieces of evidence as a package makes us more confident than not of the validity of sub-part  $h_{24}$  in our contribution claim,  $p(h_{24}|e) = 0.51$ . Limited updating has been made to our confidence in sub-part  $h_{24}$  relative to the theoretical prior,  $p(e|h_{24}) = 0.50$ .

#### **5.2.4. Part 3: Transformation of attitudes, practices and behaviour in the delivery of maternal health services at public health facilities**

##### **Sub-part $h_{31}$ : Politicians and technocrats intensify monitoring of maternal health service delivery for gender-responsiveness**

The operationalisation of  $h_{31}$  sought to verify that politicians and technocrats intensified monitoring of maternal health service delivery for gender responsiveness.

1) Interview statements made by female councillors from the district Women's Caucus affirmed that in every quarter of the financial year, one health facility or government hospital would be chosen randomly and monitored using a checklist that was designed by FOWODE, but based on the minimum standards for the corresponding level of facility according to the UNMHCP. The monitoring checklist evaluated aspects related to staffing; availability and adequacy of maternal health equipment, transport and essential drugs at the health facilities; health facility management; and the responsiveness of health service delivery to patient needs.

Interview statements made by health in-charges at the two health facilities (Kagarama Health Centre II and Kyogo Health Centre III), the health sub-district (Kamwezi Health Centre IV), as well as district technocrats from the health department affirmed that the different levels of health facilities were monitored by a higher level facility (normally the health sub-district), and intermittently by the district health department. However, following interface meetings that discussed issues related to the two health facilities (Kagarama Health Centre II and Kyogo Health Centre III), the in-charges of the health facilities, as well as district technocrats from the health department and health sub-district all affirmed that more visits were made to the health facilities by district technocrats and

health sub-district representatives to verify the issues that had been raised by community members accordingly.

The found evidence makes us cautiously confident of the validity of  $h_{31}$  in our contribution claim,  $p(h_{31}|e) = 0.81$ .

2) A review of the Visitors Books for the two health facilities revealed that on a mostly quarterly basis, signatures were made by representatives from the health sub-district indicating that they had conducted quarterly monitoring assessments of the facility. However, during the fourth quarter of 2012 and first quarter of 2013 at Kagarama Health Centre II and Kyogo Health Centre III respectively, several other visits were made by technocrats from the district health department and local leaders as noted by the signatures. The evidence makes us cautiously confident of the validity of  $h_{31}$  in our contribution claim,  $p(h_{31}|e) = 0.85$ .

3) A detailed review of the content of health facility quarterly assessment reports revealed that the objectives of the supervision visits were to assess the performance of the respective health facility against set targets for the particular quarter, as well as monitor the delivery of health services to ensure that they comply with national and district health policy guidelines and standards. The content of the assessment reports revealed that, on a routine basis, a pre-set checklist of issues was evaluated, which included outpatient service utilisation and disease burden; reproductive health utilisation; child health and immunisation; resource management (essential drugs, medical supplies, timeliness of staff salaries and wages); promptness of health management information system monthly reporting; whether the health unit held monthly staff meetings; and whether the Health Unit Management Committee had met during the quarter. Specific to reproductive health, the areas of focus were: the proportion of pregnant women attending the fourth antenatal care visit; the proportion of expectant mothers receiving two doses of malaria treatment; the percentage of deliveries taking place at the health facility; the trend in couple years of protection (family planning) and maternal and perinatal deaths during the quarter. Although gender-responsiveness is not explicitly stated in the assessment report<sup>21</sup>, a section for additional remarks is included, where some of the issues relating to service delivery and staff performance were written. The found evidence makes us cautiously confident of the validity of in  $h_{31}$  our contribution claim, from  $p(h_{31}|e) = 0.81$ . Given that it was a straw-in-the wind test, we choose to exclude it from the package of pieces of evidence.

Considering the three pieces of evidence as a package make us more confident than not in the validity of sub-part  $h_{31}$  in our contribution claim,  $p(h_{31}|e) = 0.56$ . On the basis of these pieces of evidence limited updating has been made to our confidence in sub-part  $h_{31}$  relative to the theoretical prior,  $p(e|h_{31}) = 0.55$ .

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<sup>21</sup> The health facility supervisory reports are standardised at national level.

**Sub-part  $h_{32}$ : Driven by pressure from grassroots citizens and the fear of sanctions from technocrats, health service providers implement gender-responsive maternal health policies and budgets**

The operationalisation of  $h_{32}$  intended to verify that frontline health service providers, faced with *pressure* from community members and the *fear* of facing sanctions from superiors in the district health system, implemented gender-responsive maternal health policies and budgets.

1) Interview statements made by health workers at the health facilities and the health sub-district, as well as technocrats from the district health department similarly attested to the knowledge of the existence of sanctions which are enforced for errant health worker behaviour. Common types of errant behaviour that were mentioned included pilferage of drugs and medical supplies, absenteeism from work, late opening and early closure of the health facility, and the mistreatment of patients. All interviewees affirmed that the penalties for malfeasances varied according to the crime, whereby health staff caught stealing drugs would be prosecuted in the courts of law. For the other offences mentioned, disciplinary action often started with a warning letter and reprimand from the health facility in-charge, which if not adhered to would lead to a warning letter from the health sub-district, and ultimately the district health department, with the possibility of dismissal. While no malfeasances were reported at Kagarama Health Centre II, account evidence was obtained of two laboratory staffs who were dismissed in 2013/14 due to chronic absenteeism at Kyogo Health Centre III.

Interview statements made by health facility in-charges and technocrats from the district health department affirmed that all activities implemented at health facility level aligned with the work plans and budgets approved by the lower local government and higher local government councils for the corresponding financial year. The health facility in-charges affirmed that the only funds received and managed at health facility level were to cover the costs of providing primary health care, and were disbursed on a quarterly basis. The process of obtaining the health facility funds started with a requisition made by the health facility in-charge to the accountant at the relevant health sub-district detailing primary health care activities to be implemented during the coming quarter. The accountant at the health sub-district would then obtain approval from the sub county chief and issue a cheque to disburse the funds accordingly. The health in-charges attested to making accountabilities for the funds received at the end of every quarter, which were submitted to the health sub-district and ultimately the district health office.

The health in-charges and staffs from the health sub-district and district health department attested to always taking necessary steps to address the issues that were raised by community members during village budget club monitoring visits to health facilities, interface meetings and over the radio on FOWODE-sponsored radio talk show programmes. The evidence gives us relatively high confidence in the validity of  $h_{32}$  in our contribution claim,  $p(h_{32}|e) = 0.86$ .

2) A detailed review of official documents obtained from the district health office revealed that the health policies at district level derive from the second National Health Policy 2010, as well as specific objectives for the health sector over the five-year period of the corresponding National Development Plan. As already noted in the introductory chapter of this thesis, the national health policy incorporates a gender perspective which prioritises the development of health sector plans that are informed by a gender analysis and the provision of gender-responsive health services. Whereas original financial records from the district health office could not be accessed, carbon copies of hand-written health unit quarterly and annual reports were seen at the two health facilities. The health unit reports included a section that provides a summary of the funds that were budgeted for the health facility, the funds that were released to the health unit and the amount that was expended. All health centres in the district receive an amount of primary health care funds according to the level of the facility. Health centres II receive UGX 1.2 million per annum, while Health centres III receive UGX 3.6 million per annum. The types of activities on which the funds were spent included community outreaches for immunisation, health education, school health and home visits; utilities expenses at the health facility; transport and communication; infrastructure maintenance; and facilitation allowances for village health teams and health unit management committee members to conduct their roles.

Trace evidence was also found of the quarterly releases to the health facilities, which were displayed on the health facility public notice boards. The health facility monitoring tools completed by Kyabuhangwa Village Budget Club in Kamwezi Sub County revealed that village budget club members, on a quarterly basis, had seen and were satisfied that the health facilities had operational budget information that was approved by the Health Unit Management Committee chairperson; that cashbooks were maintained up-to-date with records of income and expenditure and that the financial statements of the health facilities were audited annually. The found evidence makes us cautiously confident of the validity of  $h_{31}$  in our contribution claim,  $p(h_{32}|e) = 0.81$ .

3) Participant statements from focus group discussions held with village budget club members affirmed that health facility staff always endeavoured to make improvements to service delivery with regard to the issues that were brought to their attention and that there was no known case of misappropriation of health facility funds that had been encountered by village budget club members at both health facilities. Participants of the village budget club focus group discussion in Kamwezi Sub County, as well as local leaders and female councillors reiterated one issue that was brought to the attention of district technocrats and politicians at an interface meeting during the third quarter of 2013, where women were being given incomplete mama kits (delivery kits) by health workers at the health facilities in the sub county. Village budget club focus group participants and local leaders attested to changes having been made following exposure of the issue at the interface meeting, and that women were now receiving complete mama kits. Village budget club members also attested to improvements in health worker interpersonal relations with patients at the facility. The evidence gives us high confidence in the validity of  $h_{32}$  in our contribution claim,  $p(h_{32}|e) = 0.93$ .

Considering the three observed pieces of evidence as a package, we are more confident than not in the validity of sub-part  $h_{23}$  in our contribution claim,  $p(h_{32} | e) = 0.64$ . Limited updating, however, has been made to our confidence in sub-part  $h_{32}$  relative to the theoretical prior,  $p(e | h_{32}) = 0.60$ .

#### 4.2.5 The outcomes – Y

Part Y represents the theorised outcomes of improved and gender-responsive maternal health service delivery ( $Y_1$ ) and increased utilisation of skilled maternal health care among rural poor women of reproductive age ( $Y_2$ ) respectively.

##### **Outcome Y1: Improved and gender-responsive maternal health service delivery**

The operationalisation of  $Y_1$  sought to verify that public health facilities in Kabale and particularly in the two sub counties of FOWODE's grassroots level GRB operation *offer* improved and gender-responsive maternal health services. As already highlighted under section 5.3.2, the causally relevant dimensions of improved and gender-responsive maternal health service delivery relate to accessible, affordable, available and acceptable maternal health services for rural poor women.

1) Physical observation of health facilities in the two sub counties, particularly Kagarama Health Centre II in Bubare and Kyogo Health Centre III in Kamwezi, ascertained the existence of maternal health infrastructure (excluding a theatre), equipment and qualified medical staff necessary to ensure clean and safe delivery of mothers.

With regard to accessibility, physical observation ascertained that efforts were made to bring services closer to women by offering maternal health services at Kagarama Health Centre II in Bubare and the rehabilitation of Kyogo Bridge in Kamwezi, which ensured that expectant mothers residing in surrounding communities could access Kyogo Health Centre III. Relating to availability, one week's observation of operations at the two health facilities revealed that both facilities were opened early and health workers were available at the facility to attend to patients during the day, and at least one trained health worker was always available on call (at an adjacent health facility staff house) to attend to emergencies and deliveries beyond official working hours. Both facilities had a special day reserved during the week to conduct prenatal examination of expectant mothers and another day for child immunisation, which health facility staff utilised as an opportunity to conduct postnatal examination of the mother as well. Relating to affordability, it was observed that the mothers who came to the health facility were attended to at no charge and supplies of free mama kits and mother's passports (maternal health cards) were also observed at health facility stores. The maternity wards at both facilities were found equipped with patient beds and solar light to aid night deliveries. While the wards were open rooms, curtains were available for patient privacy. Physical observation ascertained that the maternity ward of Kyogo Health Centre III had

been recently renovated and also fitted with a ramp for people with disabilities. The found evidence makes us cautiously confident in the validity of  $Y_1$  in our contribution claim,  $p(Y_1|e) = 0.76$ .

2) Interview statements made by health workers of Kagarama Health Centre II, as well as local leaders in Bubare Sub County affirmed that maternal health services were made accessible for women in Kagarama Parish following the receipt of maternal health equipment and the posting of a mid-wife to the health facility in 2011. Participant statements from focus group discussions held with village budget club members and rural women of reproductive age in Kagarama Parish, Bubare similarly attested to the eased burden of accessing maternal health among rural women, who previously had to walk for long distances (over 10 kilometres) to access care at Bubare Health Centre IV or at Kabale Referral Hospital. In Kamwezi Sub County, health workers, village budget club members and health unit management committee members attested to a second midwife having been posted to Kyogo Health Centre III during 2014 to boost maternal health service provision.

Village budget club members and rural women in both sub counties revealed that maternal health services were provided at no charge at the health facilities and that mama kits were provided for free to expectant mothers at the fourth antenatal visit/ towards the time of delivery. Participant statements from the two categories of focus groups (village budget club members and rural women) attested to improved health worker conduct towards expectant mothers, noting further room for improvement. Although some demands raised by citizens were not met, notably the construction of health units in parishes that lacked health facilities (Kyabuhangwa Parish in Kamwezi and Kitojo Parish in Bubare) and construction of additional staff houses to accommodate all health workers at the health facilities; village budget club members, rural women and local leaders generally expressed appreciation towards the district local government for taking strides to make maternal health service delivery responsive. The found evidence makes us cautiously confident in the validity of  $Y_1$  in our contribution claim,  $p(Y_1|e) = 0.80$ .

3) An examination of the sequence of events leading to the observed changes in maternal health service delivery in the two sub counties reveals that substantive improvements at the two health facilities (many of which were unplanned in district documents) took place during the period following citizen monitoring of health facilities and interface meetings held with technocrats, as well as radio talk show programmes that drew attention to gender-related issues affecting access to maternal health care at public health facilities. The found evidence gives us high confidence in the validity of  $Y_1$  in our contribution claim,  $p(Y_1|e) = 0.90$ .

With three hoop tests passed, we can reasonably confirm that  $Y_1$  was present, implying that significant changes were made to improve maternal health service delivery and make it more gender-responsive within the limits of the resources that were available in the district. Our confidence in the functioning of  $Y_1$  is also greatly updated in light of the new evidence, given that our theoretical prior confidence in this part of the mechanism being present was low.

Considering the three observed pieces of evidence as a package, we are more confident than not in the validity of outcome  $Y_1$  in our contribution claim,  $p(Y_1|e) = 0.55$ . Some updating has been made to our confidence in the contribution claim relative to the theoretical prior,  $p(e|Y_1) = 0.52$ .

### **Outcome $Y_2$ : Increased utilisation of skilled maternal health care among rural poor women**

The operationalisation of  $Y_2$  sought to verify that more rural poor women of reproductive age residing in communities where the FOWODE grassroots GRB intervention operated utilise skilled maternal health care, with the dimensions of services being prenatal care, delivery at health institutions, delivery assisted by a skilled birth attendant and postnatal care. While the predicted sources of information to verify  $Y_2$  at health facility level and community level were health facility management information system records and focus group discussions with rural women (expectant and new mothers) and village budget club members; this hypothesis is further explored in detail at household level using quantitative methods (Chapter 6).

1) Monthly health facility records were retrieved for Kagarama Health Centre II in Bubare Sub County and Kyogo Health Centre III in Kamwezi Sub County for the period 2011 to 2015 respectively. Trend analyses, however, could not be completed owing to gaps in information (some of the records were missing). The records revealed that following the receipt of maternal health equipment at Kagarama Health Centre II, the health facility received an average of 32 women per month attending the first prenatal care visit and 29 deliveries were conducted at the health facility over the 10 months from January 2012 to October 2012. Only 5 postnatal visits were recorded during the same period. Health unit annual reports obtained from the Health Sub-District in Kamwezi Sub County (Kamwezi Health Centre IV) revealed a declining trend in new prenatal attendances from 809 in 2011/12 to 770 in 2012/13 and 606 in 2013/14. Deliveries at the health facilities in the sub county initially dropped from 517 in 2011/12 to 382 in 2012/13 and rose to 432 in 2013/14. Postnatal visits first increased from 269 in 2011/12 to 374 in 2012/13 and dropped to 273 in 2013/14. While the findings reveal increasing trends in deliveries at both health facilities following the GRB intervention, the drops in prenatal and postnatal care attendances contradict  $Y_2$ . The growth in deliveries at health facilities, especially following the improvements that were made to service delivery in 2012/13 and 2013/14 makes us more confident than not in the validity of  $Y_2$  in our contribution claim,  $p(Y_2|e) = 0.62$ .

2) Participant statements from focus group discussions with village budget club members and rural women attested to a growing utilisation of maternal health services at health facilities among rural women. According to the rural women interviewed, especially from Bubare Sub County, the majority of women residing in the villages of the sub county were members of groups (referred to as *Ngozi*), which are informal insurance associations that provide members with money to transport them to a health facility of their choice at the time of delivery. From participant statements of women

(expectant and recent mothers) in the focus groups in both sub counties, it was revealed that whereas all women attended at least one session of prenatal care, many of them started prenatal care during the fourth month and therefore did not complete the fourth prenatal visit. 20 out of the 28 women interviewed attested to having delivered their children assisted by a trained birth attendant, while the other eight were assisted by relatives. Based on verbal accounts, the evidence makes us cautiously confident in the validity of  $Y_2$  in our contribution claim,  $p(Y_2|e) = 0.75$ .

Although the two individual pieces of evidence seem to increase our confidence in  $Y_2$ , the evidence, when considered as a package, downgrades our confidence in the validity of  $Y_2$ ,  $p(Y_2|e) = 0.46$  relative to the theoretical prior,  $p(e|Y_2) = 0.50$ .

Having reasonably ascertained the presence of all theorised parts of the causal mechanism in the case, with the exception of outcome  $Y_2$  which will be analysed in more detail in Chapter 6, the next sub-section reviews the scope conditions that were theorised as necessary for the causal mechanism to operate.

### 5.3. Reviewing the scope conditions

As noted under Section 3 of this chapter, the scope conditions are the relevant aspects of a setting that are necessary for the theorised set of causes – the FOWODE GRB intervention – to produce the outcomes – improved and gender responsive maternal health service delivery and increased utilisation of maternal health care among rural women of Kabale District. This section discusses the theorised scope conditions for the causal mechanism and how they unfolded in the specific case of the FOWODE GRB intervention in Kabale District.

The theorised conditions that preceded the causal mechanism, as mentioned under Section 3.2 of this chapter, were that the legislature, executives and health service providers lacked awareness of GRB and gender-sensitive maternal health issues affecting communities and that there was a general lack of participation among citizens (more so women) in public decision-making processes. These initial scope conditions were confirmed by the findings from a baseline study which was commissioned by FOWODE in Kabale in 2009, particularly with regard to the district legislature and community members. The baseline survey found that whereas most councillors at district level were literate and able to scrutinise documents that were presented to the district council, they – mostly women councillors – had “a partial understanding of budgets” (FOWODE, 2009b: 12).

Other relevant findings were that the district essentially implemented central government priorities, which meant that local priorities were not getting funded; “gender as a cross-cutting issue” was not prioritised and that the planning and budgeting process at lower levels of local government often skipped the solicitation of community priorities due to limited funding (FOWODE 2009b: 14). At community level, the baseline survey (conducted in Kamwezi and Bubare sub



counties) revealed that citizens did not fully understand the budget process and were unaware “that they had the right to ask about local government budgets”, attend council meetings as observers or listen to budget debates (FOWODE 2009b: 20). There was also low participation of women in community-level meetings, and the few females who would be in attendance were women leaders. The baseline study found that the reasons for limited participation of women in community-level meetings were that women lacked information about the meetings given that the mobilisers of meetings only targeted men; men refused their spouses to attend public meetings; and some women felt they had no time to attend due to their heavy workload (FOWODE, 2009b). With regard to technocrats, the baseline study found that district-level technocrats were fairly knowledgeable of gender budgeting, but gaps still existed at lower levels of local government (FOWODE, 2009b).

Four scope conditions were theorised as necessary for the causal mechanism to produce the outcome, notably: a) an enabling legal, political and cultural environment for citizen participation (especially women) in public decision-making; b) institutional mechanisms in place to enforce compliance among health providers; c) good collaboration between local government actors and the civil society; and d) a reasonable degree of political will and commitment towards gender equity and accountability among technocrats and politicians. We now validate the scope conditions accordingly.

### **5.3.1. An enabling legal, political and cultural environment for citizen (women) participation**

Article 38(1) of the 1995 Constitution of Uganda accords every citizen “the right to participate in the affairs of government, individually or through his or her representatives, in accordance with the law.” Additionally, the Local Governments Act 1997 makes a provision of one-third representation of women on decision-making committees at lower local government and district council levels, as well as at community-level meetings. Citizen participation in public decision-making processes requires access to information, which is provided for by Article 5(1) of the Access to Information Act 2005, which grants every citizen the rights of access of information accordingly. Furthermore, the legal environment accords relative freedom of the press, which enabled citizens to voice out their grievances and obtain redress from technocrats and politicians.

According to the World Governance Indicators Website of the World Bank (2015), Uganda has a 30 percentile rank on the Voice and Accountability sub-indicator, implying that Uganda scores better than 30 per cent of the countries worldwide on citizens’ ability “to participate in selecting their government, as well as freedom of association and a free media.” Uganda also ranks better than many low income countries, whose average per centile rank is 25 as at 2014 (World Bank). The Social Institutions and Gender Index of Organisation for Economic Cooperation and Development (OECD)

similarly categorises Uganda as having relatively low restrictions on civil liberties with a score of 0.2554<sup>22</sup> as at 2014 (OECD, 2016). The OECD assessment, however, underlines that despite the absence of limitations on women's freedom of movement, their access to public space is constrained by the fact that many women customarily have to seek permission from their husbands before moving out of the home. The existence of laws that encourage citizen participation, including women, provided a favourable legal and political environment which was exploited by the FOWODE GRB initiative to accomplish results. The research, however, found that whereas the women exceeded men in form of physical attendance at community-level meetings, effective participation was restricted to mostly village budget club members who had undergone some form of training by FOWODE to harness their confidence in public speaking.

### **5.3.2. Institutional mechanisms exist to enforce compliance among health providers**

The district health system is guided by policies and procedures that provide checks in the management and delivery of services. All activities implemented in a financial year have to have been approved by the district council and are implemented in line with the approved budget and work plan for the given year. Funds that are disbursed to health facilities must be publicly displayed on the noticeboard to enable the community and other interested parties to monitor activities accordingly. As already noted, the supervision of health provider services at health facilities is conducted on a quarterly basis by higher level health units, health unit management committees, political leaders and the community. In addition, health unit management committees monitor the general administration of the health facility, approve annual health budgets prepared by health in-charges, monitor the performance of the approved health facility budget and ensure that the funds disbursed to the health facilities are properly accounted for. The compliance of health providers to the policies and guidelines, however, is dependent upon the vigilance of the respective supervisors and the community in identifying and reporting anomalies so as to obtain redress. The contentment expressed by the district health department, village budget club members and the community towards health provider activities points towards the institutional mechanisms having functioned accordingly.

### **5.3.3. Good collaboration between local government actors and the civil society**

The FOWODE office staff and district technocrats attested to having a collaborative relationship, which facilitated the achievement of the realised results. FOWODE has a memorandum of understanding with the district to implement the GRB initiative and the selection of the sub counties of operation (for the grassroots level intervention) is done in collaboration with the district administration. FOWODE also utilised government structures in the implementation of its activities,

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<sup>22</sup> A score of 0 (zero) implies that the law guarantees the same rights to freely move to men and women, while a score of 0.5 implies that the law guarantees the same rights to freely move to women and men, but there are some customary, traditional or religious practices that discriminate against women.

notably: working with local leaders to mobilise communities in the parishes to form village budget clubs; monitoring health facilities along with a health unit management committee member; as well as hosting district technocrats and female councillors on radio talk shows to clarify issues to the masses. The good collaboration between FOWODE and district level actors was also evidenced by the attendance of technocrats at interface meetings with the local communities.

#### **5.3.4. Political will and commitment among technocrats and politicians towards gender equity and accountability**

Interview statements made by the different categories of research participants established that there was some level of political will and commitment among district technocrats and councillors, as evidenced by their attendance of the FOWODE GRB trainings, followed by implementation of the acquired technical skills in the preparation of a district gender analysis of sectors and draft district gender policy. The failure to have the draft proposal approved by the District Council, since 2009, signals limited political will and threatens the sustainability of the implementation of a gender perspective in district policies, plans and budgets in the long term (Bamanyaki and Holvoet, 2016). FOWODE staff attested to making use of strategic partnerships with sympathetic allies in the District Council and Administration, who provided relevant information to help advance the objectives of the GRB intervention.

## 6. SUMMING UP

This chapter set out to answer the two exploratory central questions of this research, namely ‘how outside government GRB initiatives may influence gender-responsive maternal health service delivery and the use of maternal health services by rural women at local government level’, and ‘how the outside government GRB initiative in Kabale District contributed to gender-responsive maternal health service delivery and the use of maternal health services among rural women of reproductive age.’ The first central question utilised theory-based evaluation principles to explain the context of the case and develop a programme theory that explains the cause-and-effect sequence through which local-level outside government GRB initiatives may influence improved and gender-responsive maternal health service delivery and the use of skilled maternal health care among rural women. The presumed links in the cause-and-effect sequence of the programme theory provided the foundation for the theorisation of a case-specific plausible mechanism that explained how causal forces are transmitted in a sequence from the activities of the outside government GRB intervention to the anticipated outcomes of improved and gender-responsive maternal health service delivery and ultimately increased use of maternal health services among rural women.

Central question two was answered using theory-testing process tracing principles, which applied Bayesian logic in the evaluation of independent pieces of evidence for the theorised parts of the mechanism. Probabilities of observing independent pieces of evidence were assigned and the conclusions about the validity of each sub-part of the mechanism in the contribution claim were arrived at by calculating the product of the individual posterior probabilities. With the exception of the theorised outcome of increased utilisation of skilled maternal health care among rural women, all other parts (and sub-parts) provided us with at some level of confidence in the validity of the contribution claim regarding the FOWODE GRB intervention in the maternal health sub-sector of Kabale.

Judging from the evidence found, the noticeable contributions of the outside government GRB initiative towards maternal health in Kabale District are: 1) getting the district technocrats and councillors to reprioritise district plans, which resulted in the provision of maternal health equipment to Kagarama Health Centre II and the renovation of Kyogo Health Centre III maternity wing and rehabilitation of the Kyogo Bridge respectively; and 2) creating awareness and an appreciation of citizen rights among rural communities, which empowered them to hold duty bearers accountable for service delivery, as evidenced by the citizen’s petition to the Chief Administrative Officer over the Kyogo Bridge which was done after FOWODE had phased out direct support to the village budget club in Kamwezi. Other process-related achievements of the outside government initiative include effective capacity building of female councillors, whose lobbying through the district women’s caucus influenced revised budget allocations towards the health sector from 13.6 per cent in the draft budget to 15.5 per cent in the approved budget of financial

year 2013/14; as well as the annual construction of placenta pits at health centres II using locally generated district funds.

The found evidence, however, suggests that the commitment of district technocrats towards gender-responsive policies, budgets and service delivery reduced following FOWODE's shift in focus towards female councillors and grassroots citizens in 2010. This is substantiated by the fact that the district gender policy that was developed by technocrats in 2009 has never been presented before the district council for approval. The absence of a district gender policy weakens the sustainability of the adoption of a gender perspective in the preparation of district plans and budgets in the long term, especially with a change in political regime which could usher in new leaders. Overall the evidence found in the case makes us more confident than not that the FOWODE GRB initiative played a more than trivial role in contributing to gender responsive maternal health service provision in public health facilities of Kabale, but not in increasing the utilisation of maternal health care among rural women. It should, however, be noted that while the trends in maternal health indicators did not improve significantly at the public health facilities in the FOWODE programme area, women may have still have by-passed the health facilities in their sub counties to obtain the maternal health care from other health facilities. The demand-side effects of the outside government GRB initiative on the utilisation of maternal health service delivery are examined next in Chapter 6.

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## ANNEX IV.

**Table 13: Kabale District health infrastructure**

Health Unit	Ownership		Total
	Government	Private not for profit	
Hospital	1	1	2
Health Centre IV	7	1	8
Health Centre III	16	7	22
Health Centre II	71	20	92
Total	95	29	124

Source: Kabale District Council (2015: 25)

**Table 14: Administrative departments and respective mandates/functions in Kabale District**

Department	Mandate/ key responsibilities
1. Management Support Services. (Administration, human resource management, information and public relations, county administration, records management, administration police and internal audit).	<ul style="list-style-type: none"> <li>Enhance good governance, optimal use of resources and public accountability;</li> <li>Appointment, deployment and development of staff;</li> <li>Supervision and monitoring of government programmes;</li> <li>Mentoring of lower local governments;</li> <li>Coordination and integration of government and NGOs.</li> </ul>
2. Finance and Planning	<ul style="list-style-type: none"> <li>Facilitate the expansion of district revenue;</li> <li>Ensure improved financial management and accountability;</li> <li>Coordinate and facilitate the entire district planning system, including NGOs;</li> <li>Develop plans that address population issues at all levels of governance.</li> </ul>
3. Production and Marketing	<ul style="list-style-type: none"> <li>Provide technical advice to all farmers, traders and entrepreneurs to help them increase productivity and food security;</li> <li>Increase household income and competitiveness for the improvement of the welfare of the people;</li> <li>Provide and monitor revolving grants to farmers under the National Agricultural and Advisory Services (NAADS) Programme.</li> </ul>
4. Education and sports	<ul style="list-style-type: none"> <li>Provide equitable and accessible quality education;</li> <li>Inspection and monitoring of educational institutions in the district for compliance to education standards.</li> </ul>
5. Technical Services and Works	<ul style="list-style-type: none"> <li>Ensure that the district feeder roads are motor able throughout the year;</li> <li>Provide sustainable safe water and sanitation facilities that are within easy reach for all communities.</li> </ul>
6. Natural resources	<ul style="list-style-type: none"> <li>Enhance sustainable use of natural resources;</li> <li>Land registration and management;</li> <li>Physical planning and surveying.</li> </ul>

Department	Mandate/ key responsibilities
7. Public health	<ul style="list-style-type: none"> <li>• Attain good living health standards for the entire population;</li> <li>• Increase access to health facilities for the population within 5 kilometres;</li> <li>• Provide primary health care services;</li> <li>• Equip facilities with drugs and staff at all levels;</li> <li>• Construct accommodation for health facility staff.</li> </ul>
8. Community Based Services	<ul style="list-style-type: none"> <li>• Promote the rights of the elderly and persons with disabilities;</li> <li>• Mainstream gender in all sectors;</li> <li>• Increase community participation in service delivery;</li> <li>• Improve the performance of Functional Adult Literacy;</li> <li>• Promote legal protection of children.</li> </ul>

Source: Author's own summary based on Kabale District Local Government (2015)

**Table 15: Civil society organisations and contribution to the maternal health sub-sector/public accountability in Kabale District**

Civil society organisation	Mandate/activities related to maternal health
World Vision Uganda Rukiga Area Development Programme	<ul style="list-style-type: none"> <li>• World Vision operated in Rukiga County (including Kamwezi Sub County) from 1995 to 2012 with the goal of improving access to health services, safe water coverage, hygiene and sanitation.</li> <li>• World Vision supported health centres with drugs, equipment, solar panels, and infrastructure. Specific to Kyogo, World Vision constructed the maternity wing that led to the upgrade of Kyogo health facility from the level of health centre II to health centre III. World Vision also trained traditional birth attendants and community health workers to sensitise mothers about the need to visit health facilities and deliver under the care of trained health workers.</li> </ul>
AMREF Health Africa	<ul style="list-style-type: none"> <li>• AMREF, in partnership with We Care Solar and White Ribbon Alliance implemented a three-year Saving Lives at Birth Project in 64 health facilities of Kabale District (including Kagarama Health Centre II and Kyogo Health Centre III) from 2013 to 2015. The goal of the project was to reduce maternal and newborn deaths by installing solar lighting in the maternity wings of the 64 health facilities to facilitate night deliveries.</li> <li>• AMREF also trained selected village health team members attached to the health facilities and equipped them with registers to use in recording household details, as well as sensitise expectant mothers to deliver from health facilities.</li> <li>• AMREF further facilitated quarterly meetings at health facilities between health facility staff and village health teams to discuss the progress and challenges in working with communities.</li> <li>• AMREF also strengthened the capacities of health unit management committees to effectively supervise health facilities on behalf of government, and conducted on-job mentorship for midwives at the public health facilities.</li> </ul>
White Ribbon Alliance	<ul style="list-style-type: none"> <li>• White Ribbon Alliance handled the advocacy component of the tripartite arrangement involving AMREF and We Care Solar (2013 to 2015).</li> <li>• Under the project- Saving Lives at Birth - White Ribbon Alliance liaised with community representatives to collect information about the</li> </ul>

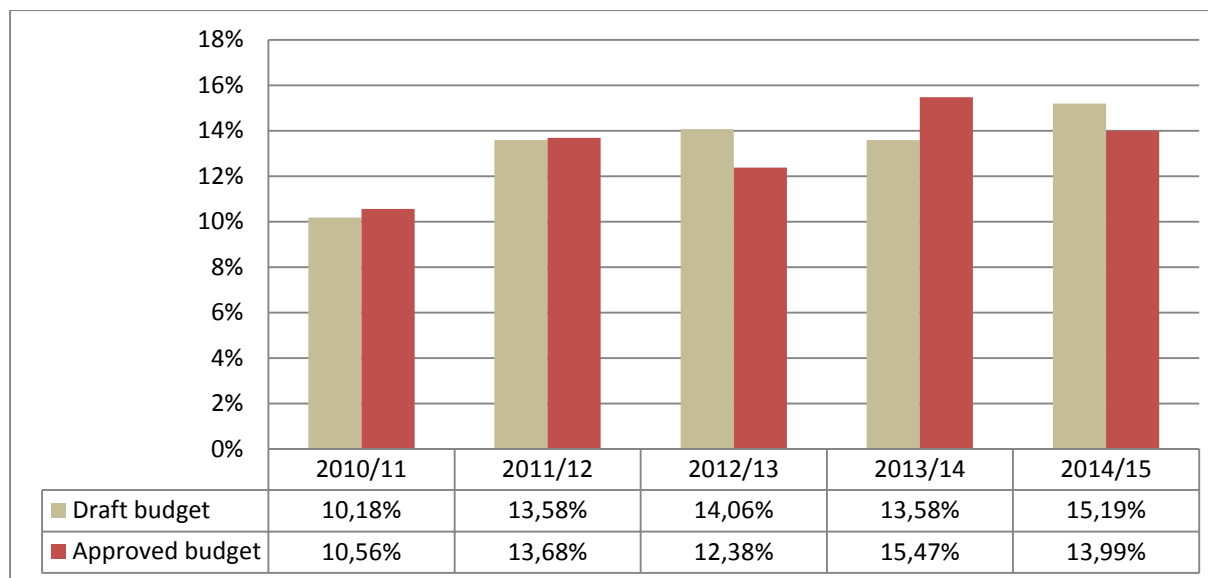
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	<p>issues affecting women's access to maternal health services at 43 public health facilities in three districts (including Kyogo and Kagarama in Kabale District). The information was synthesised and used to lobby at national level. With specific regard to Kabale, a petition was written to the Speaker of Parliament for the recruitment of doctors for health centres IV in Kabale in the year 2013. This resulted in the posting of six doctors to the district in 2014.</p>
Reproductive Health Uganda	<ul style="list-style-type: none"> <li>• Reproductive Health Uganda implemented the Community Based HIV Prevention and Care Project in Kabale District from 2010 to 2014.</li> <li>• Since August 2014, the project evolved to a clinic that specialises in offering reproductive health services at a subsidised rate. The principle services include family planning, HIV counselling and testing, sexually-transmitted infections testing and counselling. Although based in the Kabale District Municipality, Reproductive Health Uganda conducts outreaches to communities in sub counties to offer reproductive health services and health education, working in collaboration with village health teams. At the time of conducting this research, Reproductive Health Uganda had not operated in Kamwezi and Bubare.</li> </ul>
Kick Corruption out of Kigezi	<ul style="list-style-type: none"> <li>• Kick Corruption in Kigezi started in 2006 and operates in four districts, including Kabale. Kick Corruption out of Kigezi is an umbrella network of organisations at district level that coordinate the activities of community-based organisations engaged in advocating for governance, accountability and the promotion and protection of human rights.</li> <li>• Kick Corruption out of Kigezi engages in a wide range of activities, namely tracking public funds released to districts on a quarterly basis to ensure accountability; parliamentary watch – which involves mobilising communities to evaluate the performance of elected representatives in parliament and holding them to account for the promises made; and mobilising communities (referred to as neighbourhood assemblies) to generate a citizens manifesto of issues they would like to see their leaders address, among others.</li> <li>• Kick Corruption out of Kigezi held a public forum in Bubare Sub County, Kabale, which involved local leaders from village to sub county level discussing the approved national budget for 2014/15.</li> </ul>

Source: Author's own compilation based on qualitative interviews and official documents



**Figure 7: Draft versus approved budget allocations towards the health sector of Kabale District by financial year**



Source: Author's own compilation from Kabale District Local Government draft and approved budgets for financial years 2010/11 to 2014/15.

**Table 16: Summary of Bayesian updating for theorised parts of the causal mechanism of the FOWODE GRB initiative in the maternal health sub-sector of Kabale District**

Part/sub-part	Expectation/hope	p(h)	p(~ h)	p(e h)	p(e ~ h)	Test type	p(h e)	Product (sub-part)	Conclusion
X	1	0.95	0.05	0.8	0.35	hoop	0.98		
	2	0.95	0.05	0.85	0.2	hoop	0.99		
	3	0.95	0.05	0.2	0.05	smoking gun	0.99		
	4	0.95	0.05	0.1	0.01	smoking gun	0.99	0.95	High confidence, no updating
h11	1	0.9	0.1	0.8	0.4	hoop	0.95		
	2	0.9	0.1	0.6	0.1	hoop	0.98		
	3	0.9	0.1	0.6	0.2	hoop	0.96		
								0.90	High confidence, no updating
h12	1	0.5	0.5	0.95	0.2	hoop	0.83		
	2	0.5	0.5	0.9	0.15	hoop	0.86		
	3	0.5	0.5	0.9	0.02	hoop	0.98		
								0.69	More confident than not, moderate updating
h13	1	0.85	0.15	0.98	0.15	hoop	0.97		
	2	0.85	0.15	0.7	0.25	hoop	0.94		
	4	0.85	0.15	0.7	0.02	smoking gun	0.99		
								0.91	High confidence, moderate updating
h21	1	0.55	0.45	0.9	0.1	hoop	0.92		
	2	0.55	0.45	0.2	0.1	straw-in-the-wind	0.71		
	3	0.55	0.45	0.5	0.1	straw-in-the-wind	0.86		
								0.56	More confident than not, limited updating
h22	1	0.7	0.3	0.85	0.1	hoop	0.95		
	2	0.7	0.3	0.85	0.15	hoop	0.93		

Part/sub-part	Expectation/hope	p(h)	p(~ h)	p(e h)	p(e ~ h)	Test type	p(h e)	Product (sub-part)	Conclusion
	3	0.7	0.3	0.15	0.05	smoking gun	0.88		
								0.77	Cautious confidence, some updating
h23	1	0.7	0.3	0.9	0.15	hoop	0.93		
	2	0.7	0.3	0.7	0.2	hoop	0.89		
	3	0.7	0.3	0.2	0.01	smoking gun	0.98		
								0.81	High confidence, high updating
h24	1	0.5	0.5	0.9	0.1	hoop	0.90		
	2	0.5	0.5	0.75	0.2	straw-in-the-wind	0.79		
	3	0.5	0.5	0.85	0.15	hoop	0.85		
	4	0.5	0.5	0.8	0.15	hoop	0.84		
								0.51	More confident than not, limited updating
h31	1	0.55	0.45	0.7	0.2	hoop	0.81		
	2	0.55	0.45	0.7	0.15	hoop	0.85		
	3	0.55	0.45	0.35	0.1	straw-in-the-wind	0.81		
								0.56	More confident than not, limited updating
h32	1	0.6	0.4	0.8	0.2	hoop	0.86		
	2	0.6	0.4	0.7	0.25	hoop	0.81		
	3	0.6	0.4	0.85	0.1	hoop	0.93		
								0.64	More confident than not, limited updating
Y1	1	0.52	0.48	0.9	0.3	hoop	0.76		
	2	0.52	0.48	0.9	0.25	hoop	0.80		
	3	0.52	0.48	0.85	0.1	hoop	0.90		
								0.55	More confident than not, limited updating
Y2	1	0.5	0.5	0.4	0.25	straw-in-the-wind	0.62		
	2	0.5	0.5	0.6	0.2	hoop	0.75	0.46	No information

Source: Author's own summary table based on primary and secondary field data



## **CHAPTER 6**

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### **INVESTIGATING DEMAND-SIDE EFFECTS OF OUTSIDE GOVERNMENT GRB IN MATERNAL HEALTH**



## INTRODUCTION

This chapter employs quantitative methods to explore the demand-side effects of local-level outside government GRB initiatives in maternal health. The chapter answers the third central question of this research: ‘To what extent has the outside government GRB initiative influenced the demand for skilled maternal health care services among rural women in Kabale District?’ As explained in Chapter 4, this chapter utilises the findings from the qualitative phase (Chapter 5) to investigate specific aspects of the outside government GRB initiatives that were presumed to influence the utilisation of skilled maternal health care among rural poor women.

The programme theory (see Figure 5 in Chapter 5) provides the underlying framework to investigate three presumptions, notably that: (i) mass sensitisation of grassroots communities on gender, health service standards, rights and entitlements increases awareness among rural women of maternal health services, rights and entitlements (boxes 1b and 2b); (ii) knowledge of maternal health services, rights and entitlements influences utilisation of skilled maternal health care among rural poor women (boxes 2b and 4b); and (iii) grassroots citizen budget tracking and monitoring of maternal health service delivery influences improved and gender-responsive maternal health service provision (boxes 3b and 4a).

In order to investigate the above propositions, three specific sub-questions are posed as follows:

- 1) What is the effect of exposure to outside government gender budget initiatives on the knowledge of maternal health services, rights and entitlements among rural women of reproductive age?
- 2) How does the knowledge of maternal health services, rights and entitlements associate with the utilisation of skilled maternal health care among rural women of reproductive age?
- 3) What is the relationship between exposure to the outside government gender budget initiative and perceptions about the responsiveness of maternal health service delivery among rural women of reproductive age?

The above three sub-questions are investigated using a case study of the FOWODE GRB initiative in Kamwezi Sub County, Kabale District. The study was conducted one year after the intervention had phased out in Kamwezi and therefore utilises two counterfactual scenarios to evaluate some of the effects. With the treatment location being a sub county exposed to the outside government GRB initiative at district- and grassroots level, the first counterfactual scenario is a comparable sub county in the same district with the GRB intervention at district level but not at grassroots level – Nyamweru Sub County. The second counterfactual scenario is a comparable sub county in the neighbouring district of Kanungu with neither the district- nor grassroots-level GRB intervention – Mpungu Sub County. The rest of the chapter proceeds

as follows: Section 1 presents an overview of the socio-demographic characteristics of the study sample, including a descriptive summary of key variables that are used in the study. The next three sections –2 to 4 – present the findings and related discussion for each of the three sub-questions outlined above respectively. Finally, Section 5 concludes the chapter with a synthesis of the findings and summary of the effects of the outside government gender budget initiative on the demand for skilled maternal health care among rural poor women of Kabale District.

## 1. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

As explained in Chapter 4, the study participants are rural women of reproductive age residing in villages that form the catchment area for public health facilities (health centre III level and above) in a given sub county. A total of 500 women were interviewed, including 168 from Kamwezi, 162 from Nyamweru and 170 from Mpungu. Of the 500 women, 459 (91.8 per cent) had been residents of the respective villages for more than 24 months, implying that they were physically present during the duration of the grassroots level GRB initiative in Kamwezi. Nearly all the women in the three sub counties were from the Bakiga ethnic group (N=473, 94.6 per cent) followed by Banyankole (N=16, 3.2 per cent) and Banyarwanda (N=11, 2.2 per cent). Table 17 below summarises demographic information for the entire sample. Specific details pertaining to the respective sub counties are presented in Table 34, Annex IV.

**Table 17: Descriptive statistics of the study sample**

	N	Min	Max	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Respondent age	491	17	49	28.49	6.666	.774	.110	.034	.220
Birth order (Births by the respondent)	499	1	12	3.79	2.374	.869	.109	.279	.218
Age in months of youngest child	499	1	36	15.32	9.390	.303	.109	-.873	.218
Child care burden (children under age 5 in household)	496	1	3	0.72	.612	.350	.110	-.067	.219
Valid N (list wise)	486								

*Source: Author's own analysis of household survey data*

As shown in Table 17 above, the respondent ages ranged from 17 to 49 years with a mean of 28.49. On average, each woman interviewed had delivered four children, with the range being one to twelve births. The mean age of the youngest child born to the respondents was 15.32 months and the positively skewed distribution (.303) reveals that more children were born after 2014 (when FOWODE had phased out direct support to village groups in Kamwezi Sub County). The child care burden, defined as the number of children aged five years and below



residing in the respondent's household during the period of the most recent pregnancy, ranged from one to three children and, on average, each respondent had one child in this age bracket. The majority of women in the three sub counties (N=491, 95.2 per cent) were married in a monogamous (N=412, 82.6 per cent) or polygamous (N=63, 12.6 per cent) union. Fifteen women (3 per cent) were widows, while nine women (1.8 per cent) had never married. The breakdown of married women by sub county was 159 (94.6 per cent) in Kamwezi, 151 (93.2 per cent) in Nyamweru and 165 (97.4 per cent) in Mpungu respectively. Almost all respondents (N=491, 99 per cent) were Christian – Anglican, Catholic and Pentecostal – and only five (1 per cent) were Muslim.

With regard to education, the study sample comprised of mostly illiterate women (N=331, 66.4 per cent). In all the three sub counties, the highest level of education attained by more than half of the respondents (N=268, 53.8 per cent) was lower primary<sup>23</sup>, followed by those who had completed primary level (N=117, 23.5 per cent). Only 50 women across the three sub counties (9.4 per cent) had an education higher than primary level as shown in Table 18 below.

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<sup>23</sup> Lower primary in Uganda Curriculum refers to the first three (out of the seven) classes of primary education (National Curriculum Development Centre, 2016).

**Table 18: Respondent's level of education by Sub County**

		Sub_County			Total
		Kamwezi	Nyamweru	Mpungu	
1 Never attended formal school	Count	17	9	16	42
	% within Sub County	10.1%	5.6%	9.5%	8.4%
2 Attended adult literacy classes	Count	6	2	13	21
	% within Sub County	3.6%	1.2%	7.7%	4.2%
3 Attended primary but stopped in lower primary	Count	74	85	109	268
	% within Sub County	44.0%	52.8%	64.5%	53.8%
4 Attended and completed primary	Count	46	47	24	117
	% within Sub County	27.4%	29.2%	14.2%	23.5%
5 Attended and completed ordinary level <sup>24</sup>	Count	15	14	6	35
	% within Sub County	8.9%	8.7%	3.6%	7.0%
6 Attended and completed advanced level	Count	2	1	0	3
	% within Sub County	1.2%	0.6%	0.0%	0.6%
7 Completed tertiary college/university (1-3 years)	Count	8	3	1	12
	% within Sub County	4.8%	1.9%	0.6%	2.4%
Total	Count	168	161	169	498
	% within Sub County	100%	100%	100%	100%

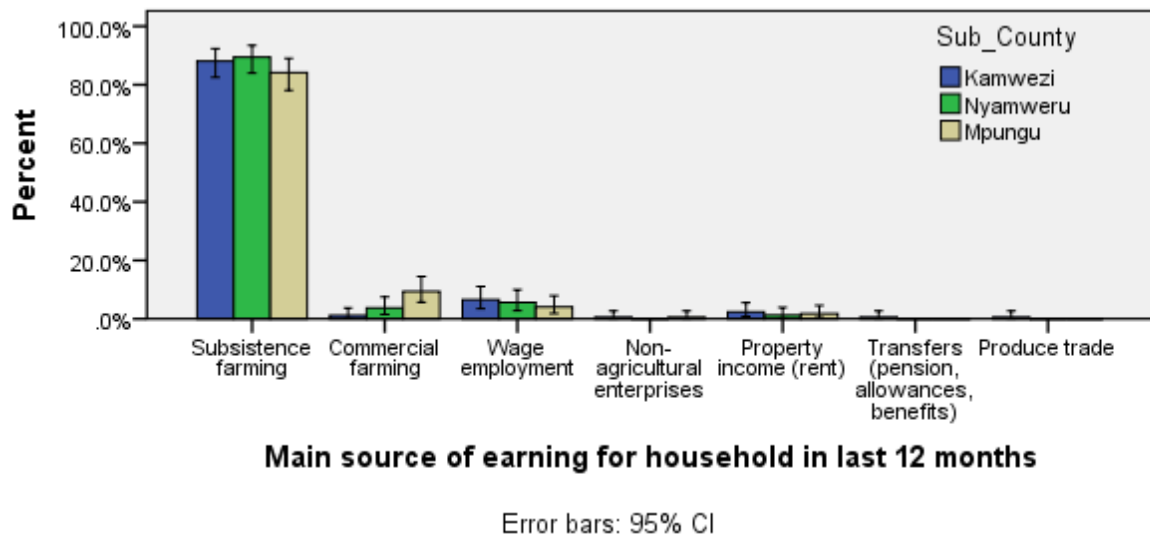
Source: Author's own analysis of household survey data

Similar to the female respondents, the highest level of education attained by the majority of household heads across the three sub counties was lower primary (N=206, 41.4 per cent), followed by those who had completed primary level (N=166, 33.4 per cent). Slightly more household heads (95.2 per cent male) attained an education higher than primary level (N=89, 17.9 per cent) compared to 9.4 per cent of the female respondents (see Table 35 in Annex IV).

Regarding socioeconomic characteristics, the main source of earning for most of the households in all the three sub counties (N=435, 87.2 per cent) was subsistence farming, followed by wage employment (N=27, 5.4 per cent) and commercial farming (N=24, 4.8 per cent) respectively (see Figure 8). Ninety three per cent of the respondent households own a piece of land (N=156, 92.9 per cent in Kamwezi; N=148, 91.4 per cent in Nyamweru and N=159, 93.5 per cent in Mpungu respectively). The mean land size owned per household was 1.33 acres in Kamwezi, 1.07 acres in Nyamweru and 1.10 acres in Mpungu. Given the dominant dependence on subsistence agriculture, household incomes were intermittent for most households.

**Figure 8: Main source of earning for households in the last 12 months by Sub County**

<sup>24</sup> Ordinary level refers to the first four out of six years of secondary education. Advanced level refers to the remaining two years of secondary education.



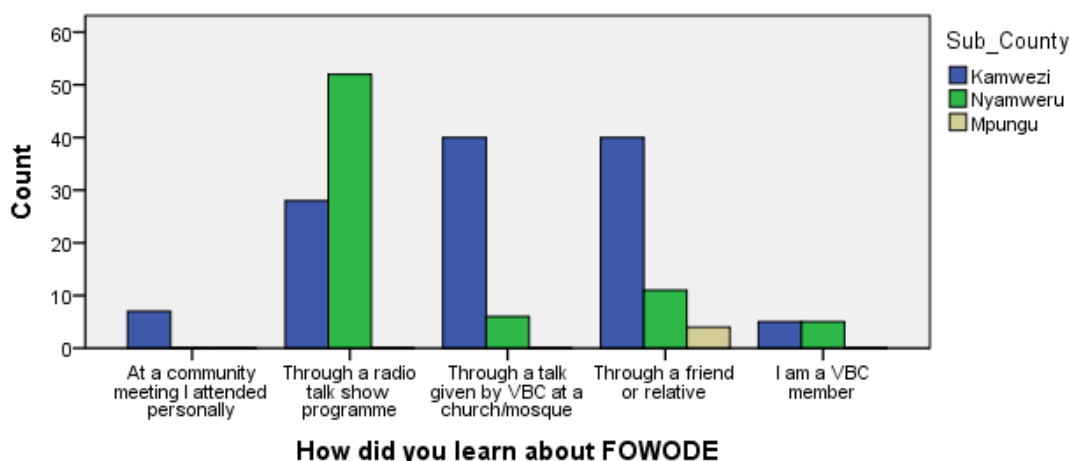
Source: Author's own analysis of household survey data

The majority of the recent mothers interviewed (N=363, 73.8 per cent) classified their present employment status as 'working but not earning'. Out of the 492 women who responded to the question, 114 (23.2 per cent) classified their employment status as 'working and earning', while 15 (3 per cent) did not do any work outside the home. From qualitative interviews, the category of women who earned a personal income mainly comprised those who offered their labour in the farms of wealthier community members, as well as those who were able to sell off surplus food from the family garden.

Concerning exposure to the FOWODE GRB initiative, 198 respondents (39.6 per cent) had heard about the FOWODE village budget club in their community, while 300 (60.1 per cent) were unaware. Overall, most of the respondents who were aware of the FOWODE GRB initiative (N=80, 40.4 per cent) learnt about it through local radio talk show programmes, followed by those who learnt about FOWODE through a friend or relative (N=55, 27.8 per cent), or from listening to a talk given by village budget club members at a place of worship (N=46, 23.2 per cent). Within the sub counties, an equal number of respondents in Kamwezi (N=40, 33.3 per cent) learnt about the FOWODE GRB initiative through a radio talk show or a friend/relative. Twenty eight respondents (23.3 per cent) learnt about FOWODE by listening to a radio talk show, while 7 respondents (5.8 per cent) personally attended community meetings organised by FOWODE. Only 5 respondents (4.2 per cent) were village budget club members. In Nyamweru, the majority of respondents learnt about FOWODE through the radio talk show programme (N=52, 70.3 per cent) or through a friend or relative (N=11, 14.9 per cent). Four out of 170 respondents (2.4 per cent) in Mpungu Sub County reported to have learnt about FOWODE from a relative or friend as illustrated in Figure 9 below. Given that the radio talk show programme was aired in Kabale District, respondents in Kamwezi – the sub county with the grassroots level initiative – and Nyamweru – the sub county without the grassroots level initiative – both had access to the sensitisation messages through listening to

radio. The coverage of the local radio station, however, did not reach Mpungu, thus 97.6 per cent of the respondents were unaware of FOWODE.

**Figure 9: Sources of information about the FOWODE grassroots level GRB initiative by Sub County**



Source: Author's own analysis of household survey data

On the topic of utilisation of maternal health care, nearly all women (N= 495, 99.6 per cent) attended at least one prenatal care session during their most recent pregnancy. Out of the 495 women, less than half (N= 221, 44.3 per cent) attended the recommended four or more prenatal care sessions. The number reduces further to 145 (29.1 per cent) who attended four or more prenatal care visits and started within the first trimester of pregnancy. The majority of women (N=420, 90.7 per cent) attended the prenatal care sessions at the nearest public health facility (within the sub county of residence). Regarding delivery care, 367 out of 499 women (73.5 per cent) delivered their youngest child from a medical institution (public or private health facility). Among the women who delivered their child from a medical institution, 240 (65.4 per cent) delivered from a government health centre that was closest to their home, followed by 76 (20.1 per cent) who delivered from the regional referral hospital. The remaining 51(13.9 per cent) delivered from private medical units respectively. 362 out of 488 women (74.2 per cent) had their births attended to by skilled health personnel. Postnatal care attendance following six weeks after delivery was low across the three sub counties. Out of 500 women, less than half (N=215, 43 per cent) attended postnatal care at a medical institution. The main mode of transport to access maternal health care was by foot/walking. Across the three sub counties, 436 out of 482 mothers who attended prenatal care (90.5 per cent) walked to the health facility, followed by 35 (7.3 per cent) who used a motorcycle and six women (2 per cent) who used a bicycle. Only five women (1 per cent) in all the three sub counties used a motor vehicle to access the health facility for prenatal care sessions. Similarly, 222 out of 371 mothers (59.8 per cent) who delivered from a medical institution walked to access delivery care. 72 mothers (19.4 per cent) used a motorcycle, 54 (14.6 per cent) used a public taxi, while the remaining 21 (5.7 per cent) used a motor vehicle to access delivery care.

Table 36 in Annex IV summarises the utilisation of the four dimensions of maternal health care services by Sub County respectively.

Having presented the demographic characteristics of the study sample, the remaining sections of this chapter examine the three propositions made about the hierarchical effects of outside government GRB initiatives on demand for maternal health.

## **2. EFFECT OF OUTSIDE GOVERNMENT GRB INITIATIVES ON AWARENESS OF MATERNAL HEALTH SERVICES, RIGHTS AND ENTITLEMENTS**

This section investigates the effects of grassroots level outside government GRB activities, particularly mass sensitisation of rural communities on gender, public health service standards, health rights and entitlements. Specifically, the section tests the presumption that mass sensitisation of grassroots communities influences increased awareness among rural women of maternal health services, rights and entitlements (sub-question 1). Treatment-effects estimation using propensity score matching in Stata 14.0 is applied to test this presumption. The section proceeds with a brief overview of propensity score matching and treatment-effects estimation, followed by a description of the variables used in estimation and ends with a presentation and discussion of the results from propensity score matching analysis.

### **2.1. An overview: propensity score matching**

[Propensity score matching is a statistical technique that has been widely applied to estimate the causal treatment effects of policies, programmes and other interventions in various fields (Caliendo and Kopeinig, 2008). Where experimental approaches are not feasible, propensity score matching is considered to be a rigorous analytical method, as it overcomes the problem of selection bias<sup>25</sup> (Akematsu and Tsuji, 2012). The fundamental evaluation problem involves estimating the effects of a given treatment on the observed outcomes of a group of individuals, yet it is impossible to observe how the individuals would have performed had they not received the treatment (Caliendo and Kopeinig, 2008). Propensity score matching offers a solution to this problem by constructing a statistically comparable (counterfactual) group to the treatment group on the basis of a wide range of observed characteristics that are not affected by the programme/treatment (Khandker et al., 2010). A propensity score is a single summary measure of the observed characteristics “that can be used to determine the extent to which one person is similar to another” (Peikes et al., 2008: 223) and represents the individual’s estimated probability of participating in the treatment (Khandker et al., 2010). Each individual in the treatment group is matched to one or more individuals in the comparison group on the basis of a single propensity score and “the average difference in outcomes across the two groups is compared to get the program[me] treatment effect” (Khandker et al., 2010: 54).

The use of propensity score matching to evaluate programme effects requires the satisfaction of two essential conditions. The first condition, referred to as ‘unconfoundedness’ or ‘conditional independence’ assumes that “the uptake of the program[me] is based entirely on

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<sup>25</sup> Selection bias refers to unobservable differences between programme participants and non-participants (including programme eligibility criteria) which may affect the decision to participate in a programme, as well as the outcomes (World Bank, 2016).

observable characteristics” and, “given a set of covariates  $X$  that are not affected by the treatment, potential outcomes  $Y$  are independent of treatment assignment  $[D]$ ” (Khandker et al., 2010: 55). This can be denoted as:

$$Y(1), Y(0) \perp D \mid X \quad (1)$$

where  $Y(1)$  and  $Y(0)$  are outcomes of the participating and non-participating groups and  $\perp$  denotes independence (Khandker et al., 2010).

The second condition, referred to as ‘common support’ or ‘overlap condition’ assumes that there is “a large and roughly equal number of participants and non-participant observations so that a substantial region of common support can be found” (Khandker et al., 2010: 56). This condition ensures that individuals with the same propensity score have positive probabilities of being participants or non-participants (Caliendo and Kopeinig, 2008).

$$0 < P(D = 1 \mid X) < 1 \quad (2)$$

If the above two conditions (unconfoundedness and a sizeable common support) are satisfied, then the treatment effect of the programme on the treated group can be specified as “the mean difference in [outcomes]  $Y$  over the common support, weighting the comparison units by the propensity score distribution of participants” (Khandker et al., 2010: 56). Logically the average treatment effect on the treated is expressed as:

$$\tau_{ATET}^{PSM} = E_{P(X) \mid D=1} \{E[Y(1) \mid D = 1, P(X)] - E[Y(0) \mid D = 0, P(X)]\} \quad (3)$$

For the case of a binary treatment variable, such as the present study, logit or probit models may be used to estimate the propensity scores (the probability of participating in the treatment or not participating) (Caliendo and Kopeinig, 2008). Caliendo and Kopeinig (2008: 38) further emphasise that the set of covariates  $X$  – used to estimate the propensity score – must satisfy the conditional independence assumption and should simultaneously influence the decision to participate and the outcome, but remain “unaffected by participation (or the anticipation of it)” so as to qualify for inclusion in the estimation model.

Following the estimation of propensity scores, different sets of criteria may be used to match participants to non-participants so as to predict the outcomes. The matching criteria include: (a) nearest neighbour matching – where an individual from the participating group is matched to one or more non-participants that are closest in terms of a propensity score; (b) calliper and radius matching – where a tolerance level of the maximum possible distance between the propensity score of the participant and non-participant is set prior to matching; (c) stratification and interval matching – where the region of common support is partitioned into set intervals and the treatment effects are calculated within each interval “by taking the mean

difference in outcomes between the treated and control observations” (Caliendo and Kopeinig, 2008: 42-43); and (d) kernel and local linear matching – where the weighted average of all individuals in the group of non-participants is used to construct a comparison for each participant).

This research applies ‘treatment-effects propensity score matching’ in Stata 14.0 to estimate the effect of exposure to the outside government GRB initiative on knowledge of maternal health services, rights and entitlements among rural women. In this study, individual women who were exposed to the outside government GRB initiative are matched with similar women who were not exposed to the outside government GRB initiative on the basis of a propensity score and the mean outcomes on knowledge scores are compared to determine the effect of the outside government GRB initiative. The propensity scores are matched using nearest-neighbour matching method. Consistency checks are also conducted by estimating treatments effects directly on nearest-neighbour observations without considering the propensity score.

## **2.2. Variable description**

### **2.2.1. The outcome variable (Y)**

As already indicated, the *outcome variable* denotes knowledge of maternal health services, rights and entitlements. This is a fractional outcome variable consisting of individual scores on a knowledge test that was orally administered to the survey respondents. The questions were tailored to suit the information that was delivered to communities during sensitisation and drew from documented and verbal sources obtained during the qualitative phase of this research.

The knowledge test had two sections; the first section consisted of three questions which tested the respondent’s knowledge of maternal health services with a maximum total score of eight points. The second section tested the respondent’s knowledge of maternal health rights and entitlements and consisted of seven questions with a maximum total score of seven points. Table 19 below presents the questions, correct responses and associated scores.



**Table 19: Test questions on knowledge of maternal health services, rights and entitlements<sup>26</sup>**

Question description	Correct response	Score
<b>Knowledge of maternal health services</b>		
1. Where can an expectant mother find maternal health services?	Health Centre III and above (HC II for Kabale only)	1
2. What type of services are you aware of that an expectant mother can get from a health facility?	Antenatal Immunisation (tetanus toxoid) Delivery Postnatal HIV testing (PMTCT) Malaria prevention (mosquito nets, fansidar)	1 1 1 1 1 1
3. Who may attend to an expectant mother at a health facility?	Midwife/doctor/enrolled nurse	1
<b>Sub-total</b>		<b>8</b>
<b>Knowledge of maternal health rights and entitlements</b>		
4. In your opinion, did you feel you had rights as an expectant mother when you visited the health facility?	Yes	1
5. In which month of the pregnancy should a woman start receiving antenatal check-ups?	Within the first three months	1
6. How many check-ups should a pregnant woman receive during the pregnancy?	At least 4	1
7. When should an expectant mother go to the health facility for delivery?	After getting the first contraction/ at nine months	1
8. Should a woman without complications during pregnancy deliver from a health facility?	Yes	1
9. What items are given freely at health facilities towards the time of delivery?	Mama kits	1
10. Who should be present at the health facility to assist expectant mothers during delivery?	Midwife/doctor/ enrolled nurse	1
<b>Sub-total</b>		<b>7</b>

Source: Author's own table based extracted from the household survey questionnaire

Three variables were created that sum up the individual total scores on knowledge of maternal health services; maternal health rights and entitlements; and maternal health services, rights and entitlements respectively. The three respective variables are presented as fractions with values ranging from zero to one<sup>27</sup>.

<sup>26</sup> Note: All these test questions are based on the information that was passed on to communities by the village budget club groups during sensitisation meetings. The information was generated from official FOWODE reports and village budget club minutes, as well as focus group discussions with village budget club group members.

<sup>27</sup> For example, an individual with a total score of 11 out of 15 points on knowledge of maternal health services, rights and entitlements has a score of 0.7333.

### 2.2.2. The treatment variable (*D*)

The *treatment variable* denotes exposure to the outside government GRB initiative. Exposure is a dummy variable that takes the value of one if the respondent had first-hand exposure to sensitisation messages from the outside government GRB initiative and the value of zero otherwise. Whereas survey respondents expressed different ways through which they learnt about the FOWODE village budget club (grassroots level GRB initiative) in their community, first-hand exposure was restricted to four modes, notably personal attendance at a community meeting organised by the FOWODE GRB initiative; attending a drama show/listening to a talk given by village budget club members at a place of worship in the sub county; participation in the activities of the outside government GRB initiative as a village budget club member; or listening to a local radio talk show programme hosted by FOWODE. The first three modes of exposure are hereafter referred to as direct exposure, owing to the direct interaction with the grassroots village budget club in the community. The fourth mode (listening to a FOWODE radio talk show programme) is hereafter referred to as indirect exposure to the outside government GRB initiative. Consequently, first-hand exposure excluded the respondents who expressed having learnt about FOWODE through a friend or relative and those who were unaware of the FOWODE GRB initiative. Given that a knowledge test was to be administered, the former category of respondents was excluded because it was difficult to verify the amount and validity of the information that was received through a friend or relative.

In the context of the three settings, first-hand exposure through any of the four modes (direct and indirect) was only possible in Kamwezi Sub County, while in Nyamweru Sub County, first hand exposure was limited to listening to a radio talk show programme hosted by FOWODE personally (indirect). Under this definition, none of the respondents in Mpungu qualified as having received first-hand exposure to the FOWODE programme (direct or indirect) because the grassroots level GRB initiative was non-existent in the sub county and the coverage of the local radio station did not reach Mpungu. Table 20 below summarises the three scenarios of investigation.

**Table 20: Distinguishing features of exposure to the outside government GRB initiative in the three sub counties**

Scenario	1) Kamwezi – treatment sub county	2) Nyamweru – counterfactual 1	3) Mpungu – counterfactual 2
Features of exposure	Direct + indirect	Indirect only	Neither direct nor indirect

Source: Author's own table

### 2.2.3. The covariates (X)

The *covariates* used to match the respondents in the treatment group to similar respondents in the two control groups are observable characteristics that are theorised to simultaneously influence exposure to the sensitisation messages and knowledge scores on maternal health services, rights and entitlements, but are unaffected by the outside government GRB initiative. Given that the target group of the FOWODE grassroots level GRB initiative was non-exclusive (various avenues were used – radio talk shows, talks and/or drama shows at places of worship, community meetings – to reach all rural women with the sensitisation messages) it seems appropriate to assume that conditional independence holds, whereby observable characteristics can be used to estimate the probability of exposure (the treatment). Accordingly, thirteen covariates are used to estimate the propensity score as outlined below:

- Duration of residence in the village
- Marital status
- Mother's age
- Number of biological children
- Child care burden
- Mother's education level
- Education level of the household head (where the mother resides)
- Mother's employment status (whether she works outside the home and earns a personal income)
- Mother's participation in decision-making at household level<sup>28</sup>
- Mother's participation in community level activities measured by membership of a community group
- Household ownership of a radio
- Household ownership of a mobile phone
- Main source of earning for the household.

Section 2.3 presents and discusses the results obtained using propensity score matching.

## 2.3. Findings and discussion

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<sup>28</sup> For this study, participation in decision making at household level is a score ranging from zero to seven indicating the woman's participation in seven decision items namely: household labour allocation, expenditure of household income, purchase/sale of household assets including land, gardening, the woman going anywhere outside the home and attending antenatal care, delivering at a health facility. In the rural Uganda setting, the first four items are typical household decisions, while the latter two questions were added specifically in relation to the present study.

As stated in the introduction of this chapter, two main counterfactual scenarios are used to evaluate the effects of exposure to the outside government GRB initiative on knowledge of maternal health services, rights and entitlements. To reiterate, Kamwezi is the treatment sub county in Kabale District with physical presence of the grassroots level outside government GRB initiative as well as exposure to the district level outside government GRB initiative. Nyamweru is the first counterfactual scenario representing a sub county in the same district as Kamwezi but without the physical presence of the grassroots level outside government GRB initiative. Mpungu is the second counterfactual scenario representing a sub county in a neighbouring district that is not exposed to the outside government GRB initiative at district or sub county level. A third scenario that compares Nyamweru and Mpungu sub counties is also analysed so as to estimate the effects of indirect exposure to the outside government GRB initiative on knowledge of maternal health services, rights and entitlements. For each of the three scenarios, analysis of the sub-effects of exposure to the outside government GRB initiative on knowledge of maternal health services and maternal health rights and entitlements are also made separately.

### **2.3.1. Scenario 1: Kamwezi and Mpungu Sub Counties**

This first scenario estimates the effect of direct and/or indirect exposure to the grassroots level outside government GRB initiative in comparison to no exposure at all (Kamwezi and Mpungu Sub Counties). From preliminary descriptive analysis, only 80 out of the 168 respondents from Kamwezi fitted the criteria of first-hand exposure to the FOWODE GRB initiative. In order to facilitate meaningful comparison between the treatment and control groups, a restricted dataset that excludes the 88 respondents who did not fit the criteria from Kamwezi was used for the analysis. The restricted dataset consists of 250 observations (N=80 in Kamwezi and N=170 in Mpungu). The results are analysed using treatment-effects estimation with probit and logit models respectively. A check for consistency of results was also made by estimating the treatment effect using nearest neighbour matching directly without weighting with the propensity score. Each observation from the treatment group is matched to six other nearest observations from the control group to minimise the standard error.

Following estimation of the propensity scores, the region of common support<sup>29</sup> consisted of 205 observations (N=71 in the treatment and N=134 in the control). Box 5 below presents the Stata output of treatment-effects estimation using probit, logit and nearest-neighbour matching on the basis of Euclidean distance<sup>30</sup> respectively.

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<sup>29</sup> Region of common support refers to the region where the distribution of propensity scores of programme participants and non-participants overlap. In this region, participants and non-participants have equal probabilities of participating in the programme on the basis of observable characteristics.

<sup>30</sup> Euclidean distance refers to the linear distance between two points; in this case it is the length of the straight line

**Box 5: Effect of exposure to the outside government GRB initiative on knowledge of maternal health services, rights and entitlements - Kamwezi and Mpungu**

Treatment-effects estimation				Number of obs	=	205
Estimator		: propensity-score matching		Matches: requested	=	6
Outcome model		: matching		min	=	6
Treatment model: logit				max	=	6

AvTKnowled~E	AI Robust					
	Coef.	Std. Err.	z	P> z	[95% Conf. Interval]	
ATET						
Exposure						
(1 vs 0)	.085759	.0120113	7.14	0.000	.0622173	.1093007

Treatment-effects estimation				Number of obs	=	205
Estimator		: propensity-score matching		Matches: requested	=	6
Outcome model		: matching		min	=	6
Treatment model: probit				max	=	6

AvTKnowled~E	AI Robust					
	Coef.	Std. Err.	z	P> z	[95% Conf. Interval]	
ATET						
Exposure						
(1 vs 0)	.086072	.0124184	6.93	0.000	.0617324	.1104116

Treatment-effects estimation				Number of obs	=	205
Estimator		: nearest-neighbor matching		Matches: requested	=	6
Outcome model		: matching		min	=	6
Distance metric: Euclidean				max	=	11

AvTKnowled~E	AI Robust					
	Coef.	Std. Err.	z	P> z	[95% Conf. Interval]	
ATET						
Exposure						
(1 vs 0)	.087811	.0167663	5.24	0.000	.0549497	.1206723

Source: Author's own analysis of household survey data

The results in Box 6 reveal that exposure to sensitisation messages of the outside government GRB initiative through direct interaction with the grassroots level initiative as well as through radio talk show programmes (direct + indirect exposure) has a statistically significant effect ( $p < 0.001$ ) on knowledge of maternal health services, rights and entitlements among rural women of reproductive age. On average, rural women who were exposed to the district- and grassroots-level outside government initiative were 8.6 per cent more knowledgeable about maternal health services, rights and entitlements than their counterparts who were not exposed to any outside government GRB initiative. The three estimation methods provided consistent results, making the findings reliable.

between each participant and the matched non-participant with the same propensity score.

# EVALUATING EFFECTS OF LOCAL-LEVEL OUTSIDE GOVERNMENT GENDER BUDGET INITIATIVES IN MATERNAL HEALTH

Next, we conducted a separate analysis of the sub-effects of exposure to outside government GRB initiative on knowledge of maternal health services among rural women as shown in Box 6 below.

## **Box 6: Effects of exposure to the outside government GRB initiative on knowledge of maternal health services - Kamwezi and Mpungu**

Treatment-effects estimation		Number of obs		=	205	
Estimator	: propensity-score matching	Matches: requested		=	6	
Outcome model	: matching	min		=	6	
Treatment model:	logit	max		=	6	

Av_knowled~S	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.0771714	.0152374	5.06	0.000	.0473067	.107036

Treatment-effects estimation		Number of obs		=	205	
Estimator	: propensity-score matching	Matches: requested		=	6	
Outcome model	: matching	min		=	6	
Treatment model:	probit	max		=	6	

Av_knowled~S	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.0821596	.0233062	3.53	0.000	.0364804	.1278389

Treatment-effects estimation		Number of obs		=	205	
Estimator	: nearest-neighbor matching	Matches: requested		=	6	
Outcome model	: matching	min		=	6	
Distance metric:	Euclidean	max		=	11	

Av_knowled~S	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.0650912	.0227068	2.87	0.004	.0205867	.1095957

Source: Author's own analysis of household survey data

The results obtained using logit and probit treatment-effects estimation in Box 6 above show a statistically significant effect ( $p < 0.001$ ) of exposure to the district and grassroots level GRB initiative through direct interaction as well as radio talk show programmes on knowledge of maternal health services among rural women. On average, rural women who were exposed to the grassroots level GRB initiative through direct interaction as well as indirectly through radio talk show programmes were more knowledgeable of maternal health services than

similar women with no exposure at all by an estimated eight per cent. The treatment effects estimation using nearest neighbour matching directly reveals a slightly lower effect of 6.5 per cent at a 95 per cent confidence level ( $p < 0.005$ ). The results, however, consistently reveal that exposure to the messages of the outside government GRB initiative directly as well as indirectly through radio talk show programmes only had a positive significant effect on knowledge of maternal health services among rural women.

With regard to knowledge of maternal health rights and entitlements, 207 observations ( $N=71$  in the treatment and  $N=136$  in the control) formed the region of common support and were used for analysis. Box 7 presents the output from the treatment-effects analysis.

The results in Box 7 show that exposure to the outside government GRB initiative has a statistically significant positive effect on knowledge of maternal health rights and entitlements among rural women by an estimated 9.5 per cent ( $p < 0.001$ ). The results obtained using nearest-neighbour matching directly are slightly higher at 10.5 per cent ( $p < 0.001$ ). The magnitude of the differences in results obtained using the different estimation methods are negligible, thereby confirming consistency.

**Box 7: Effects of exposure to the outside government GRB initiative on knowledge of maternal health rights and entitlements - Kamwezi and Mpungu**

Treatment-effects estimation				Number of obs	=	207
Estimator	: propensity-score matching			Matches: requested	=	6
Outcome model	: matching			min	=	6
Treatment model:	logit			max	=	6
Av_Knowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.0952381	.0216232	4.40	0.000	.0528575	.1376187
Treatment-effects estimation				Number of obs	=	207
Estimator	: propensity-score matching			Matches: requested	=	6
Outcome model	: matching			min	=	6
Treatment model:	probit			max	=	6
Av_Knowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.0915493	.0241222	3.80	0.000	.0442706	.138828
Treatment-effects estimation				Number of obs	=	207
Estimator	: nearest-neighbor matching			Matches: requested	=	6
Outcome model	: matching			min	=	6
Distance metric:	Euclidean			max	=	11
Av_Knowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.1056441	.0237787	4.44	0.000	.0590387	.1522495

Source: Author's own analysis of household survey data

Overall, the results indicate that exposure to the sensitisation messages on maternal health services, rights and entitlements of the outside government GRB initiative through direct interaction as well as radio talk show programmes had a slightly higher effect on knowledge of maternal health rights and entitlements among rural women as compared to the effect on knowledge of maternal health services. Although statistically significant at a 95 per cent confidence level, the overall effect of district- and grassroots-level exposure to the outside government GRB initiative on knowledge of maternal health services, rights and entitlements among rural women is, however, minimal at 8.6 per cent. The scale of operation of the grassroots level outside government GRB initiative was small (only two parishes out of six parishes in the sub county of operation) owing to funding challenges. Furthermore, as was seen in Chapter 5, the community dialogue meetings, interface meetings and radio talk shows



took place once each quarter for two years, as opposed to more often. The intermittence of sensitisation activities could, therefore, explain the minimal but positive effect.

### **2.3.2. Scenario 2: Kamwezi and Nyamweru Sub Counties**

The second scenario tests the hypothesis that direct interaction with the grassroots level outside government GRB initiative combined with indirect exposure through radio talk show programmes (Kamwezi Sub County) has an added effect on the knowledge of maternal health services, rights and entitlements among rural women as compared to indirect exposure through radio talk show programmes only (Nyamweru Sub County).

For this analysis, a restricted dataset comprising only observations that fit the criteria of first-hand exposure to the FOWODE GRB initiative in Kamwezi and Nyamweru Sub Counties respectively was used. The restricted dataset comprised 143 observations (N=80 in Kamwezi and N=63 in Nyamweru). Data observations from Nyamweru were recoded to zero in the merged dataset to reflect indirect exposure to the grassroots level outside government GRB initiative. The same procedure followed in the foregoing analysis (scenario one) is applied as presented below.

Out of the 143 observations, 120 observations (N=71 in Kamwezi and N=49 in Nyamweru) formed the region of common support. The treatment estimation matched observations from the treated group to the nearest six observations from the control group. Given that the eligible respondents in Nyamweru were fewer than those in Kamwezi, matching was done with replacement. This implies that a non-participant was matched to more than one participant, with the reverse also being true. Box 8 below presents the results.

**Box 8: Effects of direct exposure to the outside government GRB initiative on knowledge of maternal health services, rights and entitlements - Kamwezi and Nyamweru**

Treatment-effects estimation				Number of obs	=	120
Estimator	: propensity-score matching			Matches: requested	=	6
Outcome model	: matching			min	=	6
Treatment model:	logit			max	=	6

AvTKnowled~E	AI Robust					
	Coef.	Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.0388106	.0132079	2.94	0.003	.0129236	.0646977

Treatment-effects estimation				Number of obs	=	120
Estimator	: propensity-score matching			Matches: requested	=	6
Outcome model	: matching			min	=	6
Treatment model:	probit			max	=	6

AvTKnowled~E	AI Robust					
	Coef.	Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.0384977	.0119356	3.23	0.001	.0151043	.061891

Treatment-effects estimation				Number of obs	=	120
Estimator	: nearest-neighbor matching			Matches: requested	=	6
Outcome model	: matching			min	=	6
Distance metric:	Euclidean			max	=	11

AvTKnowled~E	AI Robust					
	Coef.	Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.026686	.019141	1.39	0.163	-.0108297	.0642017

Source: Author's own analysis of household survey data

Box 8 above shows consistent and statistically significant results ( $p < 0.005$ ) of treatment-effects estimation using propensity score matching with probit or logit. On average, rural women who were exposed to the outside government GRB initiative directly as well as indirectly through radio talk show programmes were 3.8 per cent more knowledgeable about maternal health services, rights and entitlements than their counterparts who were exposed indirectly through radio talk show programmes only. The results obtained using nearest neighbour matching, however, were lower (2.6 per cent) and statistically insignificant. Consistent results using two estimation methods matched on the basis of propensity scores suggest that direct interaction with the grassroots level GRB initiative, notably attending

community meetings, watching drama shows presented by the village budget club and/or listening to talks given by village budget club members at places of worship, had a small but added positive effect on knowledge of maternal health services, rights and entitlements among rural women compared to listening to radio talk programmes shows alone.

A closer examination of the sub effects relating to knowledge of maternal health services and maternal health rights and entitlements separately reveals that the added positive effect relates more to knowledge of maternal health rights and entitlements than knowledge of maternal health services as shown in the following Box 9 and Box 10 respectively.

**Box 9: Effects of direct exposure to the outside government GRB initiative on knowledge of maternal health services**

Treatment-effects estimation				Number of obs	=	120
Estimator		: propensity-score matching		Matches: requested	=	6
Outcome model		: matching		min	=	6
Treatment model: logit				max	=	6
<hr/>						
AvTKnowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET						
Exposure						
(1 vs 0)	.0388106	.0132079	2.94	0.003	.0129236	.0646977
<hr/>						
Treatment-effects estimation				Number of obs	=	120
Estimator		: propensity-score matching		Matches: requested	=	6
Outcome model		: matching		min	=	6
Treatment model: probit				max	=	6
<hr/>						
AvTKnowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET						
Exposure						
(1 vs 0)	.0384977	.0119356	3.23	0.001	.0151043	.061891
<hr/>						
Treatment-effects estimation				Number of obs	=	120
Estimator		: nearest-neighbor matching		Matches: requested	=	6
Outcome model		: matching		min	=	6
Distance metric: Euclidean				max	=	11
<hr/>						
AvTKnowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET						
Exposure						

Source: Author's own analysis of household survey data

EVALUATING EFFECTS OF LOCAL-LEVEL OUTSIDE GOVERNMENT GENDER  
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Box 9 above shows that there is no statistically significant difference between knowledge of maternal health services among rural women who were exposed to the grassroots level outside government GRB initiative directly as well as indirectly through radio talk show programmes and rural women who were exposed indirectly through radio talk show programmes only. Box 10 below shows the additive effect of direct exposure on knowledge of maternal health rights and entitlements.

**Box 10: Effects of exposure to the outside government GRB initiative on knowledge of maternal health rights and entitlements - Kamwezi and Nyamweru Sub Counties**

Treatment-effects estimation		Number of obs		=	120	
Estimator	: propensity-score matching	Matches: requested		=	6	
Outcome model	: matching	min		=	6	
Treatment model:	logit	max		=	6	
<hr/>						
Av_Knowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET						
Exposure						
(1 vs 0)	.0680751	.0245651	2.77	0.006	.0199284	.1162218
<hr/>						
Treatment-effects estimation		Number of obs		=	120	
Estimator	: propensity-score matching	Matches: requested		=	6	
Outcome model	: matching	min		=	6	
Treatment model:	probit	max		=	6	
<hr/>						
Av_Knowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET						
Exposure						
(1 vs 0)	.0694165	.0199911	3.47	0.001	.0302347	.1085983
<hr/>						
Treatment-effects estimation		Number of obs		=	120	
Estimator	: nearest-neighbor matching	Matches: requested		=	6	
Outcome model	: matching	min		=	6	
Distance metric:	Euclidean	max		=	11	
<hr/>						
Av_knowled~S	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET						
Exposure						
(1 vs 0)	-.0045703	.0241258	-0.19	0.850	-.051856	.0427155

Source: Author's own analysis of household survey data

Treatment-effects estimation using probit and logit methods (see Box 10) show a statistically significant effect of exposure to the outside government GRB initiative directly as well as indirectly through radio and talk show programmes on knowledge of maternal health rights and entitlements when compared to exposure through radio talk show programmes alone ( $p < 0.01$ ). On average, rural women in Kamwezi Sub County (with direct exposure and indirect exposure to the grassroots level GRB initiative) had higher knowledge of maternal health rights and entitlements than similar rural women in Nyamweru (exposed indirectly through radio talk show programmes only) by 6.8 per cent. Although the results obtained using nearest neighbour matching were statistically insignificant, the consistent findings obtained after matching on the basis of a propensity score using the logit and probit methods seem reliable.

The overall conclusion drawn from the comparison of findings from Kamwezi and Nyamweru is that the physical presence of the grassroots level outside government GRB initiative in the sub county, combined with exposure through radio talk show programmes had a statistically significant effect on knowledge of maternal health services, rights and entitlements among rural women compared to passive exposure through radio talk show programmes alone. The effect was also more pronounced for knowledge of maternal health rights and entitlements than knowledge of maternal health services. These findings concur with findings obtained from focus group discussions with rural women in Kamwezi who repeatedly articulated knowledge of their entitlements to free mama kits towards delivery, when they were asked what they had learnt from FOWODE. It appears that the sensitisation by village budget club members based on fact-based information obtained from monitoring public health facilities within the sub county enhanced knowledge among rural women of Kamwezi of what to expect in terms of service quality and entitlements.

### **2.3.3. Scenario 3: Nyamweru and Mpungu Sub Counties**

Lastly, the third scenario compares Nyamweru - a sub county in Kabale District with indirect exposure to the outside government GRB initiative through radio talk show programmes – and Mpungu – a sub county in the neighbouring Kanungu district with no exposure to the outside government GRB initiative. In this scenario, we examine whether indirect exposure to the outside government GRB initiative has a significant effect on knowledge of maternal health services, rights and entitlements among rural women as compared to women with no exposure at all.

The dataset used in this analysis is restricted to observations that fit the criteria of indirect exposure through listening to the outside FOWODE GRB radio talk show programme in Nyamweru Sub County, and all the observations from Mpungu Sub County, making a total of 233 observations (N=63 in Nyamweru and N=170 in Mpungu). Out of the 233 observations, 208 observations (N= 55 in Nyamweru and N=153 in Mpungu) formed the region of common support as shown in Box 11.

**Box 11: Effects of indirect exposure to the outside government GRB initiative on knowledge of maternal health services, rights and entitlements**

Treatment-effects estimation		Number of obs		=	208	
Estimator	: propensity-score matching	Matches: requested		=	6	
Outcome model	: matching			min	=	6
Treatment model:	logit			max	=	6
<hr/>						
AvTKnowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET Exposure (1 vs 0)	.0509091	.0245264	2.08	0.038	.0028382	.09898
<hr/>						
Treatment-effects estimation		Number of obs		=	208	
Estimator	: propensity-score matching	Matches: requested		=	6	
Outcome model	: matching			min	=	6
Treatment model:	probit			max	=	6
<hr/>						
AvTKnowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET Exposure (1 vs 0)	.0515152	.0264359	1.95	0.051	-.0002982	.1033285
<hr/>						
Treatment-effects estimation		Number of obs		=	208	
Estimator	: nearest-neighbor matching	Matches: requested		=	6	
Outcome model	: matching			min	=	6
Distance metric:	Euclidean			max	=	8
<hr/>						
AvTKnowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET Exposure (1 vs 0)	.0588218	.0181358	3.24	0.001	.0232762	.0943673
<hr/>						

Source: Author's own analysis of household survey data

From Box 11, it can be seen that the two estimation methods of treatment effects (logit and nearest-neighbour matching) provide statistically significant results ( $p < 0.05$ ) of an estimated 5.1 per cent and 5.8 per cent higher knowledge of maternal health services rights and entitlements among women who were exposed to radio talk show programmes of the outside government GRB initiative compared to women with no exposure at all respectively. The result obtained using probit estimation (5.2 per cent) is also consistent, although statistically significant at 10 per cent significance level. Similar to the preceding two scenarios, we now

examine the sub-effects on knowledge of maternal health services and maternal health rights and entitlements respectively (see Box 12 and Box 13).

**Box 12: Effects of indirect exposure to the outside government GRB initiative on knowledge of maternal health services - Nyamweru and Mpungu Sub Counties**

Treatment-effects estimation		Number of obs =		208		
Estimator : propensity-score matching		Matches: requested =		6		
Outcome model : matching		min =		6		
Treatment model: logit		max =		6		
Av_knowled~S	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.0840909	.0376164	2.24	0.025	.0103642	.1578177
Treatment-effects estimation		Number of obs =		208		
Estimator : propensity-score matching		Matches: requested =		6		
Outcome model : matching		min =		6		
Treatment model: probit		max =		6		
Av_knowled~S	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.0833333	.0366329	2.27	0.023	.0115341	.1551325
Treatment-effects estimation		Number of obs =		208		
Estimator : nearest-neighbor matching		Matches: requested =		6		
Outcome model : matching		min =		6		
Distance metric: Euclidean		max =		8		
Av_knowled~S	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
ATET Exposure (1 vs 0)	.0651725	.0220932	2.95	0.003	.0218706	.1084743

Source: Author's own analysis of household survey data

Starting with an examination of the sub-effect of indirect exposure on knowledge of maternal health services among rural women, the treatment-effects estimations using logit, probit and nearest-neighbour matching methods (Box 12) consistently show a statistically significant positive effect ( $p < 0.05$ ). The results using logit and probit estimation show that rural women who were exposed to sensitisation messages of the grassroots level outside government GRB initiative were 8.3 per cent more knowledgeable of maternal health services than similar rural women who were not exposed to the radio talk show programmes. Box 13 investigates the sub-effects of indirect exposure to the grassroots level outside government GRB initiative on knowledge of maternal health rights and entitlements.

**Box 13: Effects of indirect exposure to the outside government GRB initiative on knowledge of maternal health rights and entitlements - Nyamweru and Mpungu Sub Counties**

Treatment-effects estimation		Number of obs		=	210	
Estimator	: propensity-score matching	Matches: requested		=	6	
Outcome model	: matching			min	=	6
Treatment model	: logit			max	=	6
<hr/>						
Av_Knowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET Exposure (1 vs 0)	.017316	.0203697	0.85	0.395	-.0226079 .05724	
<hr/>						
Treatment-effects estimation		Number of obs		=	210	
Estimator	: propensity-score matching	Matches: requested		=	6	
Outcome model	: matching			min	=	6
Treatment model	: probit			max	=	6
<hr/>						
Av_Knowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET Exposure (1 vs 0)	.0225108	.0144393	1.56	0.119	-.0057896 .0508113	
<hr/>						
Treatment-effects estimation		Number of obs		=	210	
Estimator	: nearest-neighbor matching	Matches: requested		=	6	
Outcome model	: matching			min	=	6
Distance metric	: Euclidean			max	=	8
<hr/>						
Av_Knowled~E	Coef.	AI Robust Std. Err.	z	P> z	[95% Conf. Interval]	
<hr/>						
ATET Exposure (1 vs 0)	.0478962	.0277806	1.72	0.085	-.0065528 .1023451	
<hr/>						

Source: Author's own analysis of household survey data

The estimation of treatment effects using the three methods (Box 13) consistently reveals a very negligible and statistically insignificant difference in knowledge of maternal health rights and entitlements between women who were indirectly exposed to the outside government GRB initiative through radio talk show programmes and women who were not exposed at all ( $p > 0.05$ ). These findings corroborate the conclusions reached in the preceding two analyses (parts (i) and (ii) of this section) that the physical presence of the grassroots level outside government GRB initiative in a sub county enhanced knowledge of maternal health rights and entitlements among rural women as compared to indirect or no exposure at all. Indirect exposure through radio talk show programmes, however, appears to have enhanced the knowledge of maternal health services among rural women compared to non-exposed rural



women. Table 21 aligns the results of the three scenarios to facilitate a more generalised conclusion.

**Table 21: Summary of treatment effects by levels of exposure**

Scenarios of exposure	Treatment effects		
	MHSRE	MHS	MHRE
Direct + indirect versus no exposure	8.6 per cent	8.0 per cent	9.5 per cent
Direct + indirect versus indirect only	3.8 per cent	Not significant	6.8 per cent
Indirect only versus no exposure	5.1 per cent	8.3 per cent	Not significant

*Note: MHSRE = maternal health services, rights and entitlements; MHS = maternal health services; MHRE = maternal health rights and entitlements*

*Source: Author's own summary table*

As shown in Table 21, the effects of the grassroots outside government GRB initiative are generally highest in the scenario comparing direct combined with indirect exposure to the grassroots level GRB initiative to no exposure at all. Starting with the overall knowledge of maternal health services, rights and entitlements, the results show that there is an added positive effect provided by the physical presence of the grassroots level outside government GRB initiative in a sub county when compared to indirect exposure through radio talk show programmes only (3.8 per cent) and no exposure at all (8.6 per cent) respectively. Exposure to the grassroots outside government GRB initiative indirectly through radio talk show programmes alone had a positive, though smaller, effect (5.1 per cent) on knowledge of maternal health services, rights and entitlements among rural women compared to no exposure at all.

An examination of the sub-effects of exposure to the grassroots level outside government GRB initiative reveals higher effects with regard to knowledge of maternal health rights and entitlements as compared to knowledge of maternal health services among rural women. In the two counterfactual scenarios to the treatment sub county, direct exposure to the outside government GRB initiative coupled with radio talk show programmes resulted in higher knowledge of maternal health rights and entitlements among rural women by 9.5 per cent compared to where there was no exposure at all; and by 6.8 per cent where exposure was only through listening to radio talk show programmes. The results relating to the sub-effect of knowledge of maternal health services are relatively similar for the cases of direct combined with indirect exposure through radio talk show programmes versus no exposure; and indirect exposure through radio talk show programmes versus no exposure (8 per cent).

The absence of a significant difference in knowledge of maternal health services among rural women with direct combined with indirect exposure to the grassroots level outside government GRB initiative and rural women with only indirect exposure leads us to the conclusion that the radio talk show programmes were just as effective in enhancing

knowledge of maternal health services among rural women. Furthermore, it was the mandate of the district health department to sensitise all communities on maternal health services through health facility outreaches and village health teams. The insignificant difference in knowledge of maternal health rights and entitlements among women indirectly exposed to the outside government GRB initiative through radio talk show programmes only and women with no exposure at all results in the conclusion that the monitoring and advocacy activities of grassroots community groups play a central role in enhancing knowledge of maternal health rights and entitlements among rural women. The results therefore strongly support the theory that grassroots level advocacy activities lead to increased knowledge of maternal health services, rights and entitlements among rural women, and more so maternal health rights and entitlements. The question of whether knowledge of maternal health services, rights and entitlements would lead to increased utilisation of maternal health care among rural women is investigated next in Section 3.

### **3. INFLUENCE OF KNOWLEDGE OF MATERNAL HEALTH SERVICES, RIGHTS AND ENTITLEMENTS ON UTILISATION OF MATERNAL HEALTH CARE**

This section examines the association between knowledge of maternal health services, rights and entitlements and the utilisation of skilled maternal health care among rural women of reproductive age. Having ascertained that outside government GRB initiatives can influence knowledge of maternal health services, rights and entitlements among rural women, this section expounds on the research by exploring whether knowledge of maternal health services, rights and entitlements, in turn, has a significant influence on rural women's decision to utilise skilled maternal health care. In doing so, the section attempts to extrapolate the potential effects of advocacy activities of local-level outside government GRB initiatives on the demand for/utilisation of skilled maternal health care among rural women.

Four dimensions of maternal health service utilisation are investigated, notably prenatal care, delivery at a medical institution, delivery assisted by a skilled birth attendant and postnatal care respectively. Given the general objective of establishing the relationship between knowledge of maternal health services, rights and entitlements and the utilisation of maternal health care among rural women, this section does not distinguish between exposed and unexposed sub counties, but rather utilises the merged dataset of 500 observations to facilitate the generalisation of findings. Binary logistic regression and odds ratio analysis are applied to investigate the association of knowledge of maternal health services, rights and entitlements with the utilisation of the four dimensions of maternal health services.

#### **3.1. An overview: Binary logistic regression**

Binary logistic regression method was chosen because it allows us to estimate the probability of a woman utilising a maternal health service if she has knowledge of maternal health services, rights and entitlements, while holding other predictors known to determine maternal health care utilisation fixed. Logistic regression models also do not have the strict requirement for normal distribution of predictors and response variables, and permit the inclusion of covariates that may be dichotomous, discrete and continuous in the same model (Tabachnick and Fidell, 2007; Simonoff, 2014).

The response variable ( $\hat{Y}$ ) denotes the estimated probability of utilisation or non-utilisation of a maternal health care service “based on a non-linear function of the best linear combination of predictors; with two outcomes” (Tabachnick and Fidell, 2007: 438). Maximum likelihood estimation is used to determine the linear combination of predictors that best fits the responses/outcomes that are observed in the data. The parameter estimates derived through maximum likelihood estimation “maximise the probability of finding the sample data that has actually been found” (Hox, 2002 cited in Tabachnick and Fidell, 2007: 439). Accordingly, the logistic functions for each of the four outcomes are modelled as follows:

$$\hat{Y}_i = \frac{e^s}{1 + e^s} \quad (4)$$

where  $\hat{Y}_i$  is the estimated probability that the  $i$ th case falls in one of the two outcome categories.  $s$  is the linear regression equation below:

$$s = \omega + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_m X_m \quad (5)$$

where  $\omega$  denotes the constant;  $\beta_j$  are the coefficients for predictors  $X_j$ ; and  $m$  are the number of predictors ( $j = 1, 2, \dots, m$ ). Equations 4 and 5 above generate the logit function or log of odds, defined as “the probability of being in one group divided by the probability of being in the other group” (Equation 6) (Tabachnick and Fidell, 2007: 438).

$$\ln\left(\frac{\hat{Y}}{1-\hat{Y}}\right) = \omega + \sum \beta_j X_{ij} \quad (6)$$

The next sub-sections describe the predictors that were used in the four logistic regression models (section 3.2), followed by the presentation and discussion of the output obtained from binary logistic regression using Stata 14.0 (section 3.3).

## 3.2. Variable description

### 3.2.1. The outcome variables ( $\hat{Y}$ )

The first outcome variable ( $\hat{Y}_{1i}$ ) relates to the utilisation of prenatal care. The definition of utilisation of prenatal care adopts the conventional standard set by the World Health Organisation (n.d.) of at least four prenatal care visits attended during the term of a pregnancy. Consequently,  $\hat{Y}_{1i}$  is a binary response variable that takes the value of one if the mother attended four or more prenatal care visits during the most recent pregnancy and the value of zero if the mother attended less than four prenatal care visits.

The second outcome ( $\hat{Y}_{2i}$ ) relates to the utilisation of delivery care.  $\hat{Y}_{2i}$  is defined as delivery at a medical institution that is mandated to conduct deliveries in accordance with the health system regulations of Uganda.  $\hat{Y}_{2i}$  takes the value of one if the mother delivered from a government health centre, regional referral hospital, private not for profit health unit, or other licensed private medical unit. All other places of delivery, notably at home or along the way to the health facility take the value of zero.

The third outcome ( $\hat{Y}_{3i}$ ) relates to, and is defined as, the utilisation of skilled birth attendants during the most recent birth.  $\hat{Y}_{3i}$  takes the value of one if the mother was assisted by a qualified doctor, auxiliary nurse/ midwife, or medical assistant/clinical officer during the delivery and the value of zero if the birth was assisted by a traditional birth attendant

(qualified or not), a relative or friend, a nursing aide, or if the mother delivered with no one present to assist.

The fourth outcome ( $\hat{Y}_{4i}$ ) relates to the utilisation of postnatal care. For this study,  $Y_{4i}$  is defined as the examination of the mother by a professional health worker within six weeks after delivery of the youngest child.  $\hat{Y}_{4i}$  takes the value of one if the mother was examined by a qualified midwife, doctor, clinical officer or auxiliary nurse after delivery, and the value of zero otherwise (including mothers who were examined by traditional birth attendants).

### 3.2.2. The predictors (X)

The variables selected as potential predictors for the logistic regression models draw from the literature reviewed under Chapter 3 of this thesis. In Chapter 3, the factors that affect the demand for/use of maternal health care were categorised into four, namely geographic accessibility, availability, affordability and acceptability (see Table 4 in Chapter 3). As was discussed, geographic accessibility relates to distance to the health facility; the mode of transport to access maternal health care and any indirect costs to the household related to accessing the health facility. Availability relates to the mother's level education and access to information about maternal health care services; while affordability relates to household resources and willingness to pay; the opportunity costs of accessing care; and the regularity of cash flow in the household. Lastly, acceptability relates to cultural preferences regarding maternal health care practices; self-esteem and assertiveness of the mother; stigma and health awareness respectively (Jacobs, 2012).

On the basis of the above four factors, backed by evidence from existing studies (Kabakyenga et al., 2012; Kawaguchi et al., 2014; Rutaremwa et al., 2015), the predictors for utilisation of the four types of maternal health care services were chosen as follows. The predictors relating to geographic accessibility included presence of a health facility within the mother's parish of residence; distance to the health facility and the mode of transport used to access maternal health care. The predictors relating to availability were mother's education, knowledge score of maternal health services, rights and entitlements and access to information about maternal health services. Concerning affordability, the selected predictors were household wealth status; total household income<sup>31</sup>; main source of earning for the household; household size – used as a proxy to measure household willingness to pay; mother's employment status and child care burden during the term of the most recent pregnancy – used as proxies for measuring the opportunity cost of accessing maternal care. Regarding the dimension of acceptability, predictors included the social status of the mother in the household; the mother's participation in community activities as a member of a community group; the

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<sup>31</sup> Total household income was measured as the total income for the household from all sources during the month preceding August 1, 2015. This was used as a rough estimate for the household's income level.

mother's participation in community meetings; access to information about women's rights; health awareness about the importance of delivering from health facilities; health awareness about the importance of attending prenatal care; and the mother's perceived need of delivery at a health facility if a pregnancy term had no complications. The measure for assertiveness was captured under the knowledge score of maternal health services, rights and entitlements in the question that asked whether the mother felt she had rights when she visited the health facility while pregnant.

Other predisposing factors selected as predictors were individual characteristics such as mother's age, birth order, whether the mother has ever lost a child, marital status, and the education level of the household head.

Table 22 below lists and defines 27 predictors that were considered for the four bivariate logistic regression models. Although 27 predictors are listed, preliminary bivariate correlation analysis run on each of the four outcome variables and the 27 predictors led to the exclusion of some predictors that were found to have extremely low and statistically insignificant correlation coefficients with the respective outcome variables. Furthermore, predictors that were statistically insignificant and did not seriously affect the explanatory power of the logistic models were also removed so as to avoid having too many predictors compared to the number of cases.

**Table 22: Predictor variables used in modelling utilisation of maternal health care among rural women**

Variable	Description
<b>Mother's education</b>	Categorical variable indicating the level of education completed by the mother No formal education (reference category) Lower primary Completed primary Above primary
<b>Household head education</b>	Categorical variable indicating the level of education completed by the head of the household No formal education (reference category) Lower primary Completed primary Above primary
<b>Mother's age</b>	Categorical variable indicating the mother's age in completed years 17 to 20 (reference category) 21 to 30 31 to 40 Above 40
<b>Birth order</b>	Continuous variable indicating the number of births/biological children of the mother

Variable	Description
<b>Lost a child</b>	Dichotomous variable indicating whether the mother has ever lost a biological child No (reference category) Yes
<b>Child care burden</b>	Continuous variable indicating the total number of children under the age of five years that were residing in the household during the duration of the most recent pregnancy
<b>Household size</b>	Continuous variable indicating the total number of residents of the household
<b>Knowledge level</b>	Categorical variable indicating the level of knowledge of maternal health services, rights and entitlements Average knowledge [6 to 10 points] (reference category) High knowledge [11 to 15 points]
<b>Social status in household</b>	Categorical variable indicating the mother's score on participation in decision making at household level on seven aspects (labour allocation, expenditure of resources, mother's movement outside the home, gardening, prenatal care attendance, health facility delivery and purchase/sale of land and household assets) Low participation [1 – 2] (reference category) Moderate participation [3 – 5] High participation [6 – 7]
<b>Community participation</b>	Dichotomous variable indicating whether the mother attended at least one community meeting in the past three years No (reference category) Yes
<b>Community group member</b>	Dichotomous variable indicating whether the mother is a member of any group within the community No (reference category) Yes
<b>Marital status</b>	Dichotomous variable indicating the mother's marital status Unmarried (reference category) Married
<b>Mother's employment status</b>	Dichotomous variable indicating whether the mother works outside the home and earns a personal income No income (reference category) Earns income
<b>Main earning source</b>	Categorical variable indicating the main source of income for the household Farming (reference category) Wage employment/trade
<b>Household wealth status</b>	Continuous variable indicating the household wealth index that was generated using principal components analysis. Items include mobile phones; radio; floor type; solar panel; livestock; type of housing; bicycle; motorcycle; land size and poultry

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Variable	Description
<b>Household total income</b>	Continuous variable indicating the total household income from all sources during the past month
<b>Distance</b>	Continuous variable indicating distance (in kilometres) to the maternal health facility of choice for the mother
<b>Transport mode</b>	Dichotomous variable <sup>32</sup> indicating the mode of transport to access maternal health care services Foot/walking (reference category) Not walking [bicycle/car/motorcycle]
<b>Maternal health services information</b>	Dichotomous variable indicating whether the mother ever received information about maternal health services available No (reference category) Yes
<b>Prenatal care information</b>	Dichotomous variable indicating whether the mother ever received information about the importance of attending prenatal care No (reference category) Yes
<b>Health facility delivery information</b>	Dichotomous variable indicating whether the mother ever received information about the importance of delivering from a health facility No (reference category) Yes
<b>Entitlements information</b>	Dichotomous variable indicating whether the mother ever received information about the entitlements at health facilities No (reference category) Yes
<b>Women's rights information</b>	Dichotomous variable indicating whether the mother ever received information about women's rights No (reference category) Yes
<b>Free Mother's passport</b>	Dichotomous variable indicating whether the mother received a free prenatal care health card (mother's passport) during the most recent pregnancy No (reference category) Yes
<b>Free mama kit</b>	Dichotomous variable indicating whether the mother received a free mama kit during the most recent pregnancy No (reference category) Yes
<b>Perceived need</b>	Dichotomous variable indicating the mother's opinion about whether it is necessary for a woman without complications during pregnancy to deliver from a health facility No (reference category) Yes

<sup>32</sup> For the case of postnatal care where there are relatively substantial observations utilising bicycle/motorcycle and cars, transport mode is treated as a categorical variable with foot/walking as the reference category; bicycle/motorcycle as the second category; and motor vehicle as the third category.



Variable	Description
<b>Health facility</b>	Dichotomous variable indicating whether there is a health facility offering maternal health care within the mother's parish of residence No (reference category) Yes

*Source: Author's own table*

Section 3.3 presents the results and discussion of the four bivariate logistic regression procedures.

### 3.3. Findings and Discussion

The key objective of this sub-section is to evaluate the association between knowledge of maternal health services, rights and entitlements and the utilisation of prenatal care, delivery care, skilled birth attendance and postnatal care among rural women, while holding other predictors constant. The output of the four binary logistic regression models is presented and discussed sequentially.

#### 3.3.1. Association between knowledge of maternal health services, rights and entitlements and utilisation of prenatal care.

A direct logistic regression analysis was performed on attendance of four or more prenatal care visits as the outcome variable and 19 predictor variables. A list wise exclusion of cases with missing values resulted in 312 observations that were used in the analysis. A goodness-of-fit test of the full model against a null (constant-only) model was statistically significant, chi-square = 62.82,  $p = .000$  with a confidence interval of 95 per cent, implying that the predictors as a group are a better fit for the observed outcomes than the null model. Box 14 presents the results of the analysis.

**Box 14: Bivariate logistic regression model predicting utilisation of at least four prenatal care visits by rural women**

Logistic regression		Number of obs	=	312		
		Wald chi2 (24)	=	62.82		
		Prob > chi2	=	0.0000		
Log pseudolikelihood = -122.15908		Pseudo R2	=	0.2002		
UtilisedANC1	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
Mothersecl						
Lower primary	.6995389	.3613934	-0.69	0.489	.2541365	1.925558
Upper primary	2.862453	1.928971	1.56	0.119	.7640548	10.72389
Above primary	.9008876	.8058155	-0.12	0.907	.1560622	5.200481
AgeCategory1						
21 - 30	1.167689	.8741578	0.21	0.836	.269215	5.06472
31 - 40	.6588133	.545981	-0.50	0.615	.1298203	3.343352
41+	7.337728	8.479141	1.72	0.085	.7619953	70.65956
Lost_a_child						
Yes	.5459334	.2087028	-1.58	0.113	.2580697	1.154894
ChildburdenHH	1.669781	.5217518	1.64	0.101	.9050801	3.080577
HHsize	.84692	.08725	-1.61	0.107	.692072	1.036414
Knowledgelevel						
High knowledge	5.160247	1.901417	4.45	0.000	2.506252	10.62469
TPartpn_decisions						
Moderate participation	2.023136	2.129084	0.67	0.503	.2571862	15.91485
High participation	1.137912	1.181076	0.12	0.901	.1488057	8.701583
Attend_meeting						
Yes	1.511641	.6625085	0.94	0.346	.6403117	3.568664
Earns_personal_income						
Yes	.4468776	.2360187	-1.53	0.127	.1587179	1.258204
2.Main_earning2	.5577654	.4191175	-0.78	0.437	.1278909	2.43256
HH_wealth_status	1.537095	.2942522	2.25	0.025	1.056213	2.236915
Dist_2transformed	.4090994	.2345398	-1.56	0.119	.1329929	1.25843
_48d_MH_services_available						
Yes	1.815072	.9676084	1.12	0.263	.6384415	5.160198
_48e_Importance_of_ANC						
Yes	.7618527	.447537	-0.46	0.643	.240906	2.40932
_48f_Importance_of_Hfdelivery						
Yes	1.148519	.7281208	0.22	0.827	.3315175	3.978965
_48b_women_rights						
Yes	.4759263	.272264	-1.30	0.194	.1550927	1.460455
Health_facility						
Yes	.5023256	.1826449	-1.89	0.058	.2463143	1.024427
Received_free_passport						
Yes	.5767606	.3842367	-0.83	0.409	.1562885	2.128454
Free_mamakiti						
Yes	1.51233	.6033674	1.04	0.300	.6919053	3.305572
_cons	8.161248	13.88573	1.23	0.217	.2907386	229.0923

Source: Author's analysis of household survey data

Holding other predictors constant, Box 14 shows that knowledge of maternal health services, rights and entitlements and household wealth status were significantly associated with the utilisation of four or more prenatal care visits among rural women. The odds that a rural woman with high knowledge of maternal health services, rights and entitlements utilised four or more prenatal care visits were 5.16 times higher than the odds for a rural woman with average knowledge at one per cent significance level ( $p = .000$ ). Likewise, a unit increase in the composite household wealth status increased the odds that a woman utilised four or more prenatal care visits by 1.54 times. Although the mother's education level was statistically

significant overall, chi-square (3) =8.11,  $p = .044$ ), there was no significant difference in the odds of utilisation of four or more prenatal care visits among women with different levels of education. This could be partly explained by the fact that 53.8 per cent of the women had attained up to lower primary education and only 9.4 per cent of the women had above primary level education. Bbaale and Guloba (2011), in a study conducted on Uganda Demographic and Health Survey data of 2006, found that post-secondary maternal education was the strongest predictor for utilisation of maternal health care. The results, however, seem to suggest that women who had completed primary education were 2.86 times more likely to have utilised four or more prenatal care visits compared to women with no formal education ( $p = .119$ ).

Having a health facility within the parish of residence of the mother was not significantly associated with utilisation of four or more prenatal care visits, odds ratio (OR) =.50 (.246, 1.024),  $p = .058$ . Descriptive analysis of the survey data showed that 90.7 per cent (N=420) of the women who attended at least one prenatal care visit went to the health facility nearest to their home and the mean distance was 3.79 kilometres, which was not too far. Whereas 99.6 per cent (N=495) of the women attended the first prenatal care visit, only 44.3 per cent (N=221) attended four or more visits. These findings are also not different from national-level statistics that indicate that utilisation of four or more prenatal care visits among women was 36.6 per cent as at 2014/15.

Qualitative evidence from interviews held with district technocrats and health facility staff in the Kabale and Kanungu revealed that many women attended the first prenatal care visit to obtain the mother's passport (a mandatory requirement for delivery at the health facility) and only returned to the facility if they got a complication during the pregnancy term. Descriptive analysis of survey data also revealed that 192 women (38 per cent) started the first prenatal care visit during the second trimester of the pregnancy and delivered before they could attend the fourth prenatal visit. Other predictors that appeared to increase the odds of rural women utilising four or more prenatal care visits, although statistically insignificant, were participation in decision making at household level, attendance of community level meetings, access to information about maternal health services available, access to information about the importance of delivering at a medical institution, all of which are widely affirmed by existing literature (Grossman-Kendall, 2001; Matsuoka et al., 2010; Kawaguchi et al., 2014; Rutaremwa et al., 2015).

From the above results, we conclude that knowledge of maternal health services, rights and entitlements has a positive and significant association with utilisation of four or more prenatal care visits, holding other predictors constant.

### **3.3.2. Association between knowledge of maternal health services, rights and entitlements and delivery at health facilities**

With regard to the second outcome, a direct logistic regression analysis was performed on delivery at a medical institution as the outcome variable and 18 predictor variables. For this model, 322 observations were used in the analysis. A goodness-of-fit test of the full model against a constant-only model was statistically significant, chi-square = 86.86,  $p = .000$  with a confidence interval of 95 per cent, indicating that the set of predictors were a better fit for predicting the outcome than the constant-only model. Three predictors in the model were significantly associated with utilisation of delivery care at a medical institution at five per cent level of significance, namely the presence of a health facility within the mother's parish of residence OR = 2.67 (1.077, 6.590),  $p = .003$ ; receipt of a free mama kit, OR = 18.26 (7.360, 45.315),  $p = .000$ ; and distance to the health facility, OR = .11 (.002, .062),  $p = .000$ . Box 15 presents the logistic regression results.

**Box 15: Bivariate logistic regression model predicting utilisation of delivery care by rural women**

Logistic regression		Number of obs	=	322		
		Wald chi2(20)	=	86.86		
		Prob > chi2	=	0.0000		
Log pseudolikelihood = -90.111798		Pseudo R2	=	0.3438		
Institutional_delivery1	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
EDUCHEAD						
Lower primary	.2335493	.2309358	-1.47	0.141	.0336281	1.622015
Upper primary	1.341229	1.33806	0.29	0.769	.1898074	9.477483
Above primary	.5430437	.5809167	-0.57	0.568	.066722	4.419781
_7_Biological_children	.8347489	.1040008	-1.45	0.147	.6538908	1.06563
ChildburdenHH	1.105263	.4526796	0.24	0.807	.4952695	2.466551
HHsize	.979831	.1451129	-0.14	0.891	.7329736	1.309827
Knowledgelevel						
High knowledge	.7708256	.4033778	-0.50	0.619	.2763866	2.149786
Attend_meeting						
Yes	.6757289	.3317669	-0.80	0.425	.2581384	1.768855
Marital_status_1						
Married	.5619849	.6713113	-0.48	0.630	.0540672	5.841382
Earns_personal_income						
Yes	.9873708	.5911342	-0.02	0.983	.3054006	3.192204
2.Main_earning2	.8315363	.6867238	-0.22	0.823	.1647847	4.196098
HH_wealth_status	1.03805	.1858392	0.21	0.835	.7308526	1.47437
Dist_2transformed	.1115758	.0675051	-3.62	0.000	.0340863	.365225
_48d_MH_services_available						
Yes	.5747406	.4054431	-0.79	0.432	.1442126	2.290555
_48e_Importance_of_ANC						
Yes	1.139876	.8210728	0.18	0.856	.2777938	4.677276
_48f_Importance_of_Hfdelivery						
Yes	.3145006	.342851	-1.06	0.289	.0371269	2.66412
_48c_Entitlements_atHC						
Yes	.7157174	.3833433	-0.62	0.532	.250514	2.044801
Health_facility						
Yes	2.664525	1.231125	2.12	0.034	1.077279	6.590393
Free_mamakit						
Yes	18.2621	8.467956	6.26	0.000	7.359648	45.31526
1.Without_complications	.5109893	.6975123	-0.49	0.623	.0351967	7.418594
_cons	196.6112	345.0778	3.01	0.003	6.304357	6131.626

Source: Author's analysis of household survey data

Receipt of a free mama kit had the strongest association with rural women's utilisation of delivery care at a medical institution. The odds that a woman who received a free mama kit towards delivery utilised delivery care from a medical institution were 18.26 times higher than the odds of a woman who did not receive a free mama kit. Similarly, the presence of a health facility within the parish of the mother's residence increased the odds that a woman delivered at a medical institution by a factor of 2.67. Conversely, an additional kilometre between the mother's residence and the health facility reduced the odds of the mother delivering from a medical institution by .11 times.

Interviews with district technocrats from the health departments of the Kabale and Kanungu, as well as health facility staff and village budget club members in Kamwezi affirmed that rural women who were unable to afford requirements for a safe delivery such as gloves, baby

wrappers, cotton wool, a polythene sheet and laundry soap, shunned delivery at medical institutions for fear of being ridiculed by the health workers. The foregoing results strongly affirm that provision of free mama kits significantly increased the likelihood of rural poor women delivering from medical institutions. The rugged terrain of the three research locations predisposed walking as the main mode of transport to health facilities. It is thus not surprising that the presence of a health facility within the parish of residence increased the odds of women utilising delivery care at medical institutions.

Holding other predictors fixed, knowledge of maternal health services, rights and entitlements was not significantly associated with delivery at a medical institution OR = .77 (.276, .365),  $p = .619$ . Likewise, access to information about maternal health services available, the importance of attending prenatal care, the importance of delivery at a health facility and entitlements at health facilities did not increase the odds of rural women's utilisation of delivery care at medical institutions. Although statistically insignificant, a unit increase in the composite household wealth status appeared to increase the odds that a woman delivered from a medical institution OR = 1.04 (.731, 1.474),  $p = .835$ .

The above results point to the conclusion that the utilisation of delivery care was driven more by factors related to availability of health services and affordability of necessary requirements for delivery than knowledge of maternal health services, rights and entitlements and access to information about the importance of delivery at medical institutions. These findings confirm earlier studies (Ensor and Cooper, 2004; Gill et al., 2007; Ogunjuyigbe and Liasu, 2007; Rutaremwa et al., 2015) that strongly associate utilisation of delivery care to income levels and wealth status of households.

### **3.3.3. Association between knowledge of maternal health services, rights and entitlements and utilisation of skilled birth attendants.**

For the third outcome, a direct logistic regression analysis was performed on delivery attended by a skilled birth attendant as the outcome variable and 19 predictors. A list wise exclusion of cases with missing values resulted in 272 observations that were used for the analysis. A goodness-of-fit test of the full model against a constant-only model was statistically significant, chi-square = 69.49,  $p = .000$  with a confidence interval of 95 per cent. Four of the predictors in the model were significantly associated with utilisation of skilled birth attendants among rural women, namely birth order (biological children), OR = .74 (.585, .940),  $p = .013$ ; presence of a health facility in the parish of residence OR = 3.92 (1.177, 13.037),  $p = .026$ ; distance to the health facility, OR = .12 (.028, .513),  $p = .004$ ; and receipt of a free mama kit, OR = 25.49 (8.088, 80.327),  $p = .000$ . Box 16 presents the results from logistic regression analysis.

**Box 16: Bivariate logistic regression model predicting utilisation of skilled birth attendants by rural women**

Logistic regression		Number of obs	=	272		
		Wald chi2(19)	=	69.49		
		Prob > chi2	=	0.0000		
Log pseudolikelihood = -77.551319		Pseudo R2	=	0.3727		
Skilled_delivery	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
Mothersedn						
Lower primary	.303827	.2576433	-1.40	0.160	.0576518	1.601178
Upper primary	.4609068	.4544681	-0.79	0.432	.0667272	3.183638
Above primary	.2224573	.2998723	-1.12	0.265	.0158426	3.123675
EDUCHEAD						
Lower primary	.2533274	.228484	-1.52	0.128	.043247	1.483911
Upper primary	1.778524	1.670576	0.61	0.540	.2821776	11.20978
Above primary	.562962	.5509993	-0.59	0.557	.0826733	3.833478
_7_Biological_children	.7412842	.0898044	-2.47	0.013	.5846072	.9399511
Lost_a_child						
Yes	1.402245	.7878549	0.60	0.547	.4662017	4.21768
Knowledgelevel						
High knowledge	.7526283	.3895325	-0.55	0.583	.2729168	2.075539
TPartpn_decisions						
Moderate participation	2.453827	2.656899	0.83	0.407	.2938999	20.48748
High participation	1.400847	1.358229	0.35	0.728	.2094521	9.369071
Attend_meeting						
Yes	.5929432	.3233738	-0.96	0.338	.203607	1.726766
Earns_personal_income						
Yes	.6743508	.4816538	-0.55	0.581	.1663094	2.734355
HH_total_income	2.440812	1.488535	1.46	0.143	.7386297	8.065695
Dist_2transformed	.1200908	.0889583	-2.86	0.004	.0281174	.5129138
_48c_Entitlements_atHC						
Yes	1.700261	.9428017	0.96	0.338	.5734832	5.040926
Health_facility						
Yes	3.916458	2.403068	2.22	0.026	1.176553	13.03693
_29_Member_community_group						
Yes	.1429336	.1656188	-1.68	0.093	.0147515	1.384941
Free_mamakit						
Yes	25.48831	14.92765	5.53	0.000	8.087622	80.32694
_cons	.9868952	3.543139	-0.00	0.997	.0008676	1122.65

Source: Author's analysis of household survey data

As shown in Box 16, receipt of a free mama kit was most significantly associated with the utilisation of skilled birth attendants during delivery. The odds that a woman who received a free mama kit utilised the services of skilled birth attendants during delivery were 25.49 times higher than the odds of a woman who did not receive a free mama kit. Likewise, the presence of a health facility within the parish of the mother's residence increased the odds that an expectant mother utilised the services of a skilled birth attendant during delivery by 3.92 times, compared to the odds of a woman who resided in a parish without a maternal health facility. As anticipated, an additional kilometre away from the health facility reduced the odds that a woman utilised skilled birth attendants by a factor of .12. The results also reveal that the odds that a mother utilised skilled birth attendants reduced with each subsequent birth by a factor of .74. Existing studies link this finding to mothers basing their need for skilled birth attendance on their experience with previous uncomplicated births (Cham et al., 2005); while

others found that in South Western Uganda (the region under study), cultural values considered women to be powerful if they were not assisted during the birthing process (Kabakyenga et al., 2011; Rutaremwa et al., 2015).

Considering that delivery assisted by skilled birth attendants predominantly takes place at medical institutions, it is not surprising that the predictors that are associated with the utilisation of skilled birth attendants and delivery care are similar. Knowledge of maternal health services, rights and entitlements among rural women was correspondingly not significantly associated with the utilisation of skilled birth attendants during delivery, OR = .75 (.273, .940),  $p = .013$ . The model in Box 16 shows that other predictors that potentially increased the odds of utilisation of skilled birth attendants but were not statistically significant included the loss of a biological child, the woman's social status in the household, household income status and access to information about entitlements at public health facilities.

The foregoing results reaffirm the significant association between accessibility to maternal health facilities and affordability of maternal health equipment (through provision of free mama kits) and the utilisation of delivery care and skilled birth attendants. While not statistically significant, we believe that awareness creation about maternal health services, maternal health rights and entitlements, particularly free mama kits, plays a facilitative role in enhancing use of skilled delivery care among rural women.

#### **3.3.4. Association between knowledge of maternal health services, rights and entitlements and utilisation of postnatal care**

Regarding postnatal care, a direct logistic regression analysis was performed on postnatal care as the outcome variable and 15 predictors. A total of 279 observations were used in the analysis. A goodness-of-fit test of the full model against a null model was statistically significant, chi-square = 71.41,  $p = .000$  with a confidence interval of 95 per cent. Four predictors in the model were significantly associated with utilisation of postnatal care at a five per cent significance level, namely household total income, OR = 2.52 (1.151, 5.521),  $p = .021$ ; transport mode to the health facility, OR = 4.79 (.585, .940),  $p = .013$ ; access to information about maternal health services available, OR = .34 (.124, .908),  $p = .032$ ; and access to information about the importance of delivering at a health facility, OR = .06 (.008, .399),  $p = .004$ . A test for overall significance of mother's education was not significant, chi-square (3) = 4.85,  $p = .183$ . Box 17 presents the logistic regression results.



**Box 17: Bivariate logistic regression model predicting utilisation of postnatal care by rural women**

Logistic regression		Number of obs	=	279		
		Wald chi2(17)	=	71.41		
		Prob > chi2	=	0.0000		
Log pseudolikelihood = -142.98896		Pseudo R2	=	0.2604		
Postnatal_attendancel	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
Mothersedn						
Lower primary	.369835	.1701819	-2.16	0.031	.1500798	.9113677
Upper primary	.471947	.2596777	-1.36	0.172	.1605239	1.387544
Above primary	.3593556	.2603513	-1.41	0.158	.0868627	1.486673
_7_Biological_children	.9076109	.0698964	-1.26	0.208	.7804544	1.055485
ChildburdenHH	.9025504	.2530438	-0.37	0.715	.5209837	1.563575
Knowledgelevel						
High knowledge	.5463805	.1762665	-1.87	0.061	.2903295	1.028251
Attend_meeting						
Yes	1.801721	.7049278	1.50	0.132	.8368597	3.879022
Earns_personal_income						
Yes	.5840476	.2598162	-1.21	0.227	.2442235	1.396719
HH_wealth_status	1.376255	.2512481	1.75	0.080	.9622863	1.968311
HH_total_income	2.520843	1.008211	2.31	0.021	1.151086	5.520568
Transportmode						
Not walking (bicycle/car/motorcycle)	4.792481	2.813592	2.67	0.008	1.516467	15.14564
_48d_MH_services_available						
Yes	.3362295	.1704971	-2.15	0.032	.1244526	.9083802
_48f_Importance_of_Hfdelivery						
Yes	.055813	.0560103	-2.88	0.004	.0078078	.3989744
_48c_Entitlements_atHC						
Yes	1.602521	.6776103	1.12	0.265	.6996508	3.670506
Health_facility						
Yes	.9399899	.3021272	-0.19	0.847	.5006497	1.764869
Free_mamakit						
Yes	1.644358	.6423047	1.27	0.203	.7647292	3.53578
1.Without_complications	.4217053	.2666489	-1.37	0.172	.1221195	1.456241
_cons	1.564852	4.105473	0.17	0.864	.0091475	267.6986

Source: Author's analysis of household survey data

Holding other predictors constant, knowledge of maternal health services, rights and entitlements was not significantly associated with the utilisation of postnatal care among rural women at a five per cent significance level, OR = .55 (.290, 1.028),  $p = .061$ . A closer examination of the package of sensitisation messages delivered to rural women revealed that more emphasis was placed on raising awareness about maternal health service standards, rights and entitlements related to prenatal care and delivery care than on postnatal care. Significant predictors in the model suggest that a unit increase in total household income increased the odds that a rural woman attended postnatal care by 2.52 times; while the odds of utilising postnatal care were 4.79 times higher for a rural woman who did not walk to the health facility to deliver as compared to a rural woman who walked. Figure 20 further reveals that rural women who received information about maternal health services available were .34 times less likely to have utilised postnatal care than rural women who had no access to information; and that rural women who received information about the importance of

delivery at the health facility were .06 times less likely to have utilised postnatal care than rural women who did not have access to this information. The latter two findings seem to reaffirm that knowledge of maternal health services is not associated with postnatal care attendance.

Descriptive statistics of the survey data revealed that less than half of the women interviewed (N = 215, 43 per cent) attended postnatal care within six weeks after delivery of the youngest child. Focus group discussions with rural women in Kabale revealed that it was common practice for women not to return to the health facilities for postnatal check-ups after delivery unless they experienced complications. These findings were confirmed by interviews with health workers at the health facilities in all the three sub counties, as well as district technocrats from the health departments, who stated that postnatal attendance was low. Health workers in the two districts revealed that the strategies devised to encourage postnatal care attendance were sensitisation during health outreaches in the villages, as well as conducting check-ups on mothers when they brought their children to the facility for first immunisation. From descriptive analysis of survey data, 54 per cent (N=182) of the women who attended meetings in their community in the past three years reported that they had attended health outreaches. Although insignificant in the model, the sensitisation made during health outreaches might explain the higher odds of a woman who attended a community meeting in the past three years having utilised postnatal care, OR = 1.80 (.837, 3.879),  $p = .132$ .

The conclusion drawn from the above analysis is that knowledge of maternal health services, rights and entitlements was not significantly associated with utilisation of postnatal care among rural women. Whereas women from richer households were predisposed to utilising postnatal care, the results seem to indicate that women from poorer households were motivated by the perceived need which was attached to complications after delivery. The lack of association between knowledge of maternal health services, rights and entitlements and the utilisation of postnatal care should also be probably expected, considering that the emphasis of sensitisation messages on maternal health services, rights and entitlements focuses on prenatal and delivery care.

#### **4. EFFECT OF THE OUTSIDE GOVERNMENT GRB INITIATIVE ON USER PERCEPTIONS ABOUT THE QUALITY OF MATERNAL HEALTH SERVICE DELIVERY**

This section examines the presumption that citizen budget tracking and monitoring of maternal health service provision at public health facilities leads to improved and gender-responsive maternal health service delivery (see boxes 3b and 4a of Figure 5 [programme theory]). Qualitative evidence discussed in Chapter 5 reasonably confirmed that maternal health service provision at public health facilities in sub counties with the active presence of the outside government GRB initiative in Kabale had improved and was more responsive to the gender needs of rural poor women. This section triangulates and expounds on the qualitative findings by investigating the responsiveness of maternal health service provision, as viewed by service users – rural poor women. Maintaining consistency with Section 3, the scope of maternal health services referred to under this section include prenatal care, delivery care, delivery assisted by a skilled birth attendant and postnatal care.

Across the three research sites – Kamwezi, Nyamweru and Mpungu – recent mothers of children aged three years and below were asked to rate the quality (responsiveness) of maternal health service delivery at public health facilities, with specific reference to their experience during the most recent pregnancy. In keeping with the objective of exploring the effects of the outside government GRB initiative, the aspects of maternal health service quality were restricted to specific issues that were identified by the village budget club groups and raised as demands for redress by district technocrats and health service providers. On the basis of a five-point Likert Scale with 1 = strongly disagree up to 5 = strongly agree, recent mothers were asked to rank six indicators of gender-responsive maternal health service delivery. The six statements were as follows:

When I visited the health facility while pregnant (with the most recent pregnancy):

- the doctors/midwives handled me with respect and compassion;
- the doctors/midwives were open with me (communicated clearly and addressed my concerns well);
- the equipment for maternal health care was adequate (drugs, supplies, mama kit);
- the doctors/midwives were adequate;
- the examination room and delivery rooms were adequate;
- I did not wait for long to be attended to.

The above six aspects are widely affirmed by existing literature (Thaddeus and Maine, 1994; Grossman-Kendall et al., 2001; Wallace, 2012; Jacobs et al., 2012) as health facility-level constraints to the utilisation of skilled maternal health care by rural poor women, as was discussed in Chapter 3. The six items exclude the constraint related to affordability of maternal health care, given the Ugandan context of free maternal health care provision at rural public health facilities. Exploratory factor analysis and non-parametric (Kruskal-Wallis H

and post-hoc Mann-Whitney U) tests were used for the analysis. The objectives and description of the two forms of analysis (exploratory factor analysis and non-parametric tests), along with the presentation and discussion of the results are presented in sub-sections in 4.1 and 4.2 respectively.

#### **4.1. Overview, findings and discussion – exploratory factor analysis**

This sub-section employs exploratory factor analysis using principal components extraction with orthogonal rotation in SPSS version 23 to empirically summarise the variations in perceptions of maternal health service quality at public health facilities among rural women located in different sub counties.

Tabachnick and Fidell (2007: 607) describe factor analysis as a statistical technique that is “applied to a single set of variables when the researcher is interested in discovering which variables in the set form coherent subsets that are relatively independent of one another”. According to Tabachnick and Fidell (2007: 608), factor analysis may be used to accomplish four different goals, namely:

“to summarise patterns of correlations among observed variables, to reduce a large number of variables to a smaller number of factors, to provide an operational definition (a regression equation) for an underlying process by using observed variables, or to test a theory about the nature of underlying processes.”

Exploratory factor analysis has the goal to “describe and summarise data by grouping together variables that are correlated” (Tabachnick and Fidell, 2007: 609). Exploratory factor analysis with principal components extraction produces “several linear combinations of observed variables”, referred to as components (Tabachnick and Fidell, 2007: 608), which summarise the patterns of correlations among variables that “are thought to reflect underlying processes” (Tabachnick and Fidell, 2007: 607). Five steps are involved when conducting exploratory factor analysis, namely (i) selection and measurement of a set of variables; (ii) preparation of the correlation matrix; (iii) extraction of a set of factors from the correlation matrix; (iv) determination of “the number of factors, (probably) rotating the factors to increase interpretability”; and (v) interpretation of the results (Tabachnick and Fidell, 2007: 608). The rotation of factors to increase interpretability may either be orthogonal, “so that all the factors are uncorrelated with each other”, or oblique, “so that the factors themselves are correlated” (Tabachnick and Fidell, 2007: 609).

The presentation of findings using exploratory factor analysis proceeds as follows. First, the underlying structures of components that describe the responsiveness of maternal health service delivery are presented for each sub county. Second, a visual comparison of principal components is made between the sub counties to establish whether variations in the

perceptions of maternal health service quality, in general, differ among rural women residing in sub counties directly exposed to the grassroots level outside government GRB initiative and those residing in a sub county without the grassroots level initiative.

A reliability analysis of the six items yielded a Cronbachs alpha of .791 (above .7), confirming good internal consistency reliability for the scale that was used for this study sample. Prior to conducting exploratory factor analysis, three criteria were used to verify the suitability of the data from the three sub counties, notably correlation matrices showing at least some coefficients of  $r = .3$  or greater; Kaiser-Meyer-Olkin (KMO) Measures of Sampling Adequacy (KMO) of .6 or greater (Kaiser 1970; 1974); and Bartlett's Tests of Sphericity that are significant ( $p = .05$  or less) (Bartlett, 1954). A list-wise exclusion of cases with missing values from the initial dataset of 500 observations resulted in a dataset of 491 observations. Multivariate detection of outliers using Mahalanobis distance in linear regression analysis was conducted on the 491 observations, which resulted in the further deletion of 15 cases that exceeded the critical value 20.054 ( $p < .001$ ). This reduced the dataset to 475 observations (N=155 in Kamwezi, N=155 in Nyamweru and N=165 in Mpungu) respectively.

In line with the three criteria, a visual inspection of the six-item correlation matrices for each of the three sub counties revealed coefficients of  $r = .3$  or greater for Kamwezi and Nyamweru, while all the correlation coefficients in the matrix for Mpungu were less than .3 (see Tables 38 to 40 in Annex 5). Additionally, while KMO values for Kamwezi and Nyamweru were .743 and .619 respectively, Mpungu had the lowest KMO value of .475. The Bartlett's test of sphericity was significant for all the three sub counties at  $p < .001$ . On the basis of these preliminary results, exploratory factor analysis could only be feasibly conducted for two sub counties, notably Kamwezi and Nyamweru in Kabale District respectively. Noting that the primary focus of this inquiry was to provide an empirical summary of the perceptions about maternal health service quality among rural women residing in a district that was exposed to the outside government GRB initiative (directly as well as indirectly through radio talk show programmes), exploratory factor analysis proceeds on the data collected from Kamwezi (N=155) and Nyamweru (N=155) Sub Counties in Kabale District only.

#### **4.1.1. User perspectives about maternal health service quality at public health facilities in Kamwezi Sub County**

Principal components extraction with orthogonal Varimax rotation was first conducted on the data from Kamwezi to estimate the likely number of components with Eigen values greater than one. Two components with Eigen values greater than one were extracted and accounted for 58.9 per cent of the total explained variance. In order to facilitate an optimal interpretation of perceptions about maternal health service quality and later compare the two sub counties, the number of components to be extracted was set to three components accounting for 71.9 per cent of the total variance explained. Component one had an Eigen value of 2.499

accounting for 41.7 per cent of the total variance, followed by component two with an Eigen value of 1.032 accounting for 17.2 per cent of total variance explained. The third component had an Eigen value of .781 accounting for 13 per cent of the total variance (see Table 23 below).

**Table 23: Total variance explained by principal components in Kamwezi Sub County**

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	2.499	41.650	41.650	2.499	41.650	41.650	1.968	32.801	32.801
2	1.032	17.206	58.856	1.032	17.206	58.856	1.323	22.049	54.851
3	.781	13.011	71.867	.781	13.011	71.867	1.021	17.016	71.867
4	.690	11.493	83.360						
5	.574	9.571	92.931						
6	.424	7.069	100.000						

*Extraction Method: Principal Component Analysis.*

*Source: Author's analysis of household survey data*

According to Tabachnick and Fidell (2007: 649), higher loadings on a particular variable reflect that “the variable is a pure measure of the factor [or component]”. Comrey and Lee (1992) cited in Tabachnick and Fidell (2007: 649) further propose that “loadings in excess of .71 (50% overlapping variance) are considered excellent, .63 (40% overlapping variance) very good, .55(30% overlapping variance) good, .45 (20% overlapping variance) fair, and .32 (10% overlapping variance) poor.” Given the rather small sub sample size (N =155), the cut off was set at .55 to be able to explain good measures of the extracted components.

The output of principal component analysis with Varimax rotation is presented in Table 24 below. The rotated matrix shows high positive factor loadings on four items for component one and one item each for components two and three respectively. Component one loads highly on adequate examination and delivery rooms (.852), adequate maternal health equipment (.670), openness of health staff (.621) and adequate staffing (.611) respectively. Component two loads highly on respect and compassion (.948), while component three loads highly on short waiting period (.975).

**Table 24: Matrix of principal components extracted with Varimax rotation -  
Kamwezi Sub County**

Item	Rotated components			Communalities	Mean	SD
	Component 1	Component 2	Component 3			
Exam/delivery rooms adequate	.852			.731	4.18	.777
Adequate equipment	.670			.483	3.97	.797
Openness	.621			.659	4.30	.706
Adequate staffing	.611			.553	4.13	.827
Respect/compassion		.948		.902	4.48	.648
Short waiting period			.975	.984	4.35	1.023

*Note: Extraction method: Principal Component Analysis; Rotation method: Varimax with Kaiser Normalisation; Component loadings with absolute values less than .55 are suppressed  
Three components extracted; SD – standard deviation.*

*Source: Author's analysis of household survey data*

The component loadings represent the correlations between the items and the underlying components, thus items that load highly on a single component provide an explanation of a unifying underlying concept. The underlying concept revealed by component one relates to maternal health infrastructure, staffing and equipment at public health facilities, as well as health worker- to-patient communication, accounting for 33 per cent of the rotated variance. The second component relates to interpersonal skills of health providers toward expectant mothers, accounting for 22 per cent of the rotated variance; while the third component relates to internal management of maternal health service delivery at public health facilities, accounting for 17 per cent of the rotated variance.

The column of communalities indicates the proportion of variance in an item that overlaps with the variation in the underlying component. Put differently, communalities reflect “the variance in a variable that is predictable from the factors underlying it” (Tabachnick and Fidell, 2007: 643). The high communality values for all the six items indicate that the items are well-explained by the underlying component by 48.3 to 98.4 per cent. The mean scores for the individual six items range from 3.97 to 4.48, indicating that a large proportion of recent mothers in Kamwezi Sub County generally ranked “agree” to “strongly agree” on the responsiveness of maternal health service delivery at public health facilities to their personal needs.

The above results lead us to the conclusion that whereas recent mothers in Kamwezi generally rated maternal health service quality positively, greater emphasis was placed on adequacy of maternal health infrastructure, equipment and staffing and communication between health workers and expectant mothers. Qualitative findings ascertained that renovations had been made to the maternity wing of Kamwezi Health Centre III; a placenta pit had been constructed; and a midwife had been posted to the health facility between the years 2013 and 2014. Focus group discussions with rural women and interviews with local leaders had also attested to an

improvement in health worker handling of patients. These exploratory findings thus corroborate with the qualitative findings that maternal health service delivery became more responsive to needs of rural women in Kamwezi.

Sub-section 4.1.2 replicates the analysis done for Kamwezi in the second research site of Nyamweru Sub County, also in Kabale District.

#### 4.1.2. User perspectives about maternal health service quality at public health facilities in Nyamweru Sub County

Principal components extraction of three components with orthogonal Varimax rotation produced two components with an Eigen value above one accounting for 58.3 per cent of the total variance. Component one had an Eigen value of 2.208 and accounted for 36.8 per cent of the total variance explained, while component two had an Eigen value of 1.288 and explained 21.5 per cent of the total variance. The third component had an Eigen value close to one (.966) and explained 16.1 per cent of the total variance. The three components combined accounted for 74.4 per cent of the total variance (see Table 25).

**Table 25: Total variance explained by principal components in Nyamweru Sub County**

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	2.208	36.796	36.796	2.208	36.796	36.796	1.703	28.383	28.383
2	1.288	21.470	58.266	1.288	21.470	58.266	1.549	25.812	54.196
3	.966	16.105	74.371	.966	16.105	74.371	1.211	20.175	74.371
4	.664	11.072	85.443						
5	.480	8.008	93.451						
6	.393	6.549	100.000						

*Extraction Method: Principal Component Analysis.*

*Source: Author's analysis of household survey data*

The output of principal component analysis with Varimax rotation is presented in Table 26 below. The empirical structure of rotated principal components for Nyamweru Sub County shows an equal distribution of two items per component with factor loadings above .6. The first component loads highest on two items (adequate equipment, .839 and adequate staffing, .796) and lower on adequacy of examination and delivery rooms (.561). The second components loads highly on respect and compassion (.877) and openness (.828), while the third component loads highly on waiting period (.915) and less highly on adequacy of examination and delivery rooms (.572) respectively. The relatively similar size of loadings on the item related to adequacy of examination and delivery rooms in Nyamweru suggests that



the item does not fit well with any of the three components. This is further evidenced by item six having the lowest communality value (.665) compared to the other five other items.

**Table 26: Matrix of principal components extracted with Varimax rotation -  
Nyamweru Sub County**

Item	Rotated components			Comm unalities	Mean	SD
	Component 1	Component 2	Component 3			
Adequate equipment	.839			.717	3.77	.794
Adequate staffing	.796			.732	3.84	.849
Respect/compassion		.877		.770	4.51	.724
Openness		.828		.735	4.35	.771
Short waiting period			.915	.843	4.23	.826
Exam/delivery adequate rooms	.561		.572	.665	3.90	1.024

*Extraction method: Principal Component Analysis; Rotation method: Varimax with Kaiser Normalisation;  
Component loadings with absolute values less than .55 are suppressed; Three components extracted; SD –  
standard deviation.*

*Source: Author's analysis of household survey data*

The concepts explaining the components that underlie the six items bear some similarity with the components of Kamwezi Sub County, with the exception of adequacy of maternal health infrastructure. The adequacy of maternal health equipment, staffing and – to a lesser extent – examination and delivery rooms account for 28.3 per cent of the rotated variance. Interpersonal skills of maternal health personnel and health worker-to-patient communication account for 25.2 per cent of the rotated variance, while internal management of maternal health service delivery at public health facilities accounts for 18.4 per cent of the total rotated variance. The communalities for each of the six items are also high, ranging from 67 to 84 per cent, which signals good overlaps between the items and the respective components that underlie them.

The above results lead us to the conclusion that recent mothers in Nyamweru generally rated the responsiveness of maternal health service delivery during their most recent pregnancy positively. The mean ranks ranged from 3.77 to 4.51, indicating that recent mothers generally rated “agree” to “strongly agree”. Almost equal emphasis was placed on the adequacy of maternal health equipment, staffing and health worker interpersonal skills towards patients (rotated total variances of 28.3 and 25.2 per cent respectively). The misfit of adequacy of maternal health infrastructure with the three components indicates a possibility of dissatisfaction among the women regarding this item. Physical observation of Bwindi Health Centre III in Nyamweru, as well as documentary evidence, verified that the maternity wing of the health facility had been converted into an office for the sub county chief, as well as police post, pending construction of sub county headquarters close to the health facility (Kushaba,

2013). At the time of data collection, the maternity wing was still being used as a sub county office and mothers were being delivered from a smaller room.

Overall, the findings reveal that rural women are generally satisfied with the quality and/or responsiveness of maternal health service delivery at public health facilities within the two sub counties. A visual inspection of rotated component loadings for component one in both sub counties (component one has the largest total variance explained) seems to suggest that recent mothers in Kamwezi Sub County are more satisfied with maternal health infrastructure and health worker- to-patient communication at the public health facility than recent mothers in Nyamweru Sub County. In both sub counties, recent mothers concurrently appeared to be satisfied with the adequacy of staffing and maternal health equipment respectively. On the basis of these exploratory findings, it is prudent to conclude that the presence of the grassroots level outside government GRB initiative in the district may have an effect on gender responsive maternal health service delivery at public health facilities, as well as user perceptions regarding maternal health service delivery. Furthermore, the generally high rankings on maternal health service quality by service users in Kamwezi compared to service users in Nyamweru seems to suggest that the active presence of the grassroots level village budget club groups in a sub county (tracking budgets and monitoring maternal health service provision at public health facilities) enhanced responsiveness among technocrats and health care providers, as compared to sub counties that were indirectly exposed to the outside government GRB initiative. Section 4.2 adds observations from Mpungu Sub County to the analysis and tests whether significant differences exist in the rankings of the quality/responsiveness of maternal health services at public health facilities by recent mothers across the three sub counties.

#### **4.2. Contrasting variances of user perspectives of maternal health service quality at public health facilities by Sub County**

This part of the analysis uses the Kruskal-Wallis H test, followed by post-hoc Mann-Whitney U Tests to determine whether the rankings of the six indicators of maternal health service quality/responsiveness by rural women significantly differ across the three sub counties. The comparison of rankings using the Kruskal-Wallis H and Mann-Whitney U Tests includes all the three sub counties because the two non-parametric tests are not limited by the KMO requirement.

Kruskal-Wallis H Test and Mann-Whitney U Test are non-parametric tests that are used to conduct one-way analysis of variance among/between independent groups. The Kruskal-Wallis H Test compares scores on ordinal or continuous variables of three or more independent groups, while the Mann-Whitney U Test makes the same comparison between two independent groups only (Pallant, 2010). The Kruskal-Wallis H Test provides us with information about the variables with statistically significant differences in rankings for the

three groups but does not tell us which groups are significantly different from one another. Post-hoc Mann-Whitney U Tests conducted on pairs of the three independent groups allows us to determine how the groups significantly differ from one another.

Three assumptions must be met by the data for the valid application of the above two tests, namely: (i) the dependent variable is measured on an ordinal or continuous scale; (ii) all observations in the data are independent, implying that no relationship exists between observations within groups and across different groups; and (iii) the distributions of the dependent variables have the same skewed shape across the groups. Tables 27 and 28 present the output of the Kruskal-Wallis H Test using SPSS version 23 respectively.]

**Table 27: Ranks and median scores on indicators of maternal health service quality for Kamwezi, Nyamweru and Mpungu Sub Counties**

	Sub County	N	Mean Rank	Median
Respect/compassion	Kamwezi	162	245.98	5.00
	Nyamweru	153	259.07	5.00
	Mpungu	166	219.48	4.00
	Total	481		
Openness	Kamwezi	162	233.58	4.00
	Nyamweru	153	250.35	5.00
	Mpungu	166	239.62	4.00
	Total	481		
Adequate equipment	Kamwezi	161	259.23	4.00
	Nyamweru	151	238.38	4.00
	Mpungu	165	219.82	4.00
	Total	477		
Adequate staffing	Kamwezi	162	258.73	4.00
	Nyamweru	153	221.89	4.00
	Mpungu	165	239.86	4.00
	Total	480		
Exam/delivery rooms adequate	Kamwezi	162	246.33	4.00
	Nyamweru	153	230.05	4.00
	Mpungu	166	245.89	4.00
	Total	481		
Short waiting period	Kamwezi	162	261.13	5.00
	Nyamweru	153	248.39	4.00
	Mpungu	166	214.55	4.00
	Total	481		

Source: Author's analysis of household survey data

**Table 28: Kruskal-Wallis H Test statistics comparing service quality ranking for Kamwezi, Nyamweru and Mpungu Sub Counties**

	Respect/ compassion	Openness	Adequate equipment	Adequate staffing	Exam/delivery rooms adequate	Short waiting period
Chi-Square	8.523	1.412	7.602	6.325	1.600	11.422
df	2	2	2	2	2	2
Asymp. Sig.	.014	.494	.022	.042	.449	.003

Source: Author's analysis of household survey data

A visual inspection of the mean ranks column of Table 27 suggests that Kamwezi Sub County (with the grassroots level outside government GRB initiative) had the highest scores on four items, namely adequate equipment, adequate staffing, adequacy of examination/delivery rooms and short waiting period, compared to Nyamweru and Mpungu Sub Counties. Nyamweru Sub County had the highest scores on openness and respect/compassion of maternal health workers. Kamwezi and Nyamweru Sub Counties (in Kabale District) recorded a higher median score (Md = 5) than Mpungu Sub County in Kanungu District (Md = 4) on the indicator of respect and compassion; while Kamwezi Sub County recorded a higher median score (Md = 5) on the indicator of short waiting period than Nyamweru and Mpungu Sub Counties (Md = 4) respectively.

The Kruskal-Wallis H Test results in Table 28 revealed statistically significant differences in rankings across the three sub counties on four items, namely respect/compassion, chi-square (2, N = 481) = 8.52,  $p = .014$ ; adequacy of maternal health equipment, chi-square (2, N = 477) = 7.60,  $p = .022$ ; adequacy of staffing, chi-square (2, N = 480) = 6.33,  $p = .042$ ; and short waiting period, chi-square (2, N = 481) = 11.42,  $p = .003$  respectively. Post-hoc Mann-Whitney U Tests on pairs of the three sub counties are needed to establish how perceptions of service users in the three sub counties significantly differ from one another.

In order to control for making a Type 1 error (rejecting the null hypothesis that there is no significant difference between two groups when it is in fact true), we apply a Bonferroni adjustment<sup>33</sup> to the alpha level and use the adjusted alpha level to judge statistical significance (Tabachnick and Fidell, 2007; Pallant, 2010). Given the initial alpha level of .05, and three comparisons to be made, the Bonferroni adjusted alpha level to judge statistical significance is .05 divided by 3, which equals .017. As stated in Pallant (2010: 230), the effect sizes for the statistically significant differences found,  $r$ , can then be computed as:

$$r = \text{z-value divided by the square root of } N, \text{ where } N \text{ is the total number of cases.}$$

<sup>33</sup> Bonferroni adjustment sets a more stringent alpha level for each comparison, which involves dividing the alpha level by the number of comparisons to be made (Pallant, 2010).

Cohen (1988) provides classification criteria for the computed effect sizes as follows: an effect size of .1 is considered to be a small effect; an effect size of .3 is considered to be a medium effect; while an effect size of .5 is considered to be a large effect. Tables 29 to 33 present the Mann-Whitney U Test statistics for the three sets of comparisons respectively.

**Table 29: Mann-Whitney U Test statistics comparing Kamwezi and Nyamweru Sub Counties**

	Respect/co mpassion	Openness	Adequate equipment	Adequate staffing	Exam/delivery rooms adequate	Short waiting period
Mann-Whitney U	11701.500	11541.500	11058.000	10648.500	11632.500	11574.500
Z	-.978	-1.152	-1.480	-2.278	-.998	-1.118
Asymp. Sig. (2- tailed)	.328	.249	.139	.023	.319	.264

*Source: Author's analysis of household survey data*

On the basis of the adjusted alpha value,  $p \leq .017$ , Table 29 shows that there is no statistically significant difference between the rankings of maternal health service quality among rural women in Kamwezi and Nyamweru Sub Counties in Kabale District.

Tables 30 and 31 present the test statistics comparing Kamwezi and Mpungu Sub Counties followed by a discussion of the results.

**Table 30: Ranks and median scores on indicators of maternal health service quality  
- Kamwezi and Mpungu**

	Sub County	N	Mean Rank	Sum of Ranks	Median
Respect/compassion	Kamwezi	162	173.75	28147.50	5.00
	Mpungu	166	155.47	25808.50	4.00
	Total	328			
Openness	Kamwezi	162	162.34	26299.00	4.00
	Mpungu	166	166.61	27657.00	4.00
	Total	328			
Adequate equipment	Kamwezi	161	176.91	28483.00	4.00
	Mpungu	165	150.41	24818.00	4.00
	Total	326			
Adequate staffing	Kamwezi	162	171.46	27776.50	4.00
	Mpungu	165	156.68	25851.50	4.00
	Total	327			
Exam/delivery rooms adequate	Kamwezi	162	165.14	26752.50	4.00
	Mpungu	166	163.88	27203.50	4.00
	Total	328			
Short waiting period	Kamwezi	162	179.57	29091.00	5.00
	Mpungu	166	149.79	24865.00	4.00
	Total	328			

Source: Author's analysis of household survey data

**Table 31: Mann-Whitney U Test statistics comparing Kamwezi and Mpungu Sub Counties**

	Respect/com passion	Openness	Adequate equipment	Adequate staffing	Exam/delivery rooms adequate	Short waiting period
Mann-Whitney U	11947.500	13096.000	11123.000	12156.500	13342.500	11004.000
Z	-1.958	-.450	-2.702	-1.528	-.131	-3.062
Asymp. Sig. (2-tailed)	.050	.653	.007	.126	.895	.002

a. Grouping Variable: Sub County

Source: Author's analysis of household survey data

With the exception of the indicator of openness (health worker-to-patient communication), the mean ranks column of Table 31 shows higher scores for Kamwezi Sub County than Mpungu Sub County on the remaining five items. Using the adjusted alpha level of  $p \leq .017$ , Table 31 shows that statistically significant differences exist in the rankings on adequacy of maternal health care equipment between Kamwezi (Md = 4.00, n = 161) and Mpungu (Md = 4.00, n = 165),  $U = 11123$ ,  $Z = -2.70$ ,  $p = .007$ ,  $r = .15$ ; and the rankings on short waiting period between Kamwezi (Md = 5, n = 162) and Mpungu (Md = 4, n = 166),  $U = 11004$ ,  $Z = -3.06$ ,  $r = .17$ .

The results above suggest that rural women in Kamwezi have a higher satisfaction with adequacy of maternal health equipment and internal management of maternal health services

at public health facilities than rural women in Mpungu. The effect size of the difference, according to Cohen (1988) criteria, however, is small ( $.1 < r < .3$ ).

Tables 32 and 33 below present the Mann-Whitney U Test statistics comparing Nyamweru and Mpungu Sub Counties.

**Table 32: Ranks and median scores on indicators of maternal health service quality  
- Nyamweru and Mpungu**

	Sub County	N	Mean Rank	Sum of Ranks	Median
Respect/compassion	Nyamweru	153	173.55	26553.00	5.00
	Mpungu	166	147.51	24487.00	4.00
	Total	319			
Openness	Nyamweru	153	163.78	25058.50	5.00
	Mpungu	166	156.52	25981.50	4.00
	Total	319			
Adequate equipment	Nyamweru	151	165.15	24938.00	4.00
	Mpungu	165	152.41	25148.00	4.00
	Total	316			
Adequate staffing	Nyamweru	153	152.29	23301.00	4.00
	Mpungu	165	166.18	27420.00	4.00
	Total	318			
Exam/delivery rooms adequate	Nyamweru	153	154.02	23565.00	4.00
	Mpungu	166	165.51	27475.00	4.00
	Total	319			
Short waiting period	Nyamweru	153	172.74	26429.50	4.00
	Mpungu	166	148.26	24610.50	4.00
	Total	319			

Source: Author's analysis of household survey data

**Table 33: Mann-Whitney U Test statistics comparing Nyamweru and Mpungu Sub Counties**

	Respect/com passion	Openness	Adequate equipment	Adequate staffing	Exam/delivery rooms adequate	Short waiting period
Mann-Whitney U	10626.000	12120.500	11453.000	11520.000	11784.000	10749.500
Z	-2.822	-.776	-1.329	-1.448	-1.190	-2.525
Asymp. Sig. (2-tailed)	.005	.438	.184	.148	.234	.012

Source: Author's analysis of household survey data

The mean ranks column of Table 32 shows generally higher scores for Nyamweru Sub County than Mpungu Sub County, particularly with regard to respect/compassion of maternal health workers, health worker-to-patient communication (openness), adequacy of maternal health equipment and waiting period. Table 32 also shows that Nyamweru had higher median scores (Md = 5) than Mpungu (Md = 4) with regard to respect/compassion and openness of maternal health care providers respectively. The Mann-Whitney U Test statistics in Table 33, however, show that the indicators with statistically significant differences ( $p \leq .017$ ) in rankings between the two sub counties relate to respect/compassion (Md = 5,  $n = 153$  in Nyamweru and Md = 4,  $n = 166$  in Mpungu),  $U = 10626$ ,  $Z = -2.82$ ,  $r = .16$ ; and short waiting period (Md = 5,  $n = 153$  in Nyamweru and Md = 4,  $n = 166$  in Mpungu),  $U = 10749.5$ ,  $r = .14$  respectively. Similar to the results in the preceding comparison between Kamwezi and Mpungu Sub Counties, the effect sizes of the statistically differences, according to Cohen (1988) criteria were small ( $.1 < r < .3$ ).

In summary, the Kruskal-Wallis H Test results in Section 4.2 reveal generally higher mean ranks on the six items for Kamwezi Sub County than Nyamweru and Mpungu Sub Counties. While the items with statistically significant differences across the three sub counties are respect/compassion, adequate maternal health equipment, adequate staffing and short waiting periods, Mann-Whitney U Tests conducted on pairs of sub counties with a Bonferroni adjusted alpha level of  $p \leq .017$  reveal no statistically significant differences in the ranking of maternal health service quality between rural women in Kamwezi and rural women in Nyamweru Sub County. Comparisons between Kamwezi and Mpungu, however, revealed statistically significant differences in ranking between the two sub counties, with Kamwezi Sub County having higher rankings than Mpungu with regard to adequacy of maternal health equipment and short waiting period at the health facility when accessing maternal health care. Similarly, Nyamweru Sub County had higher rankings than Mpungu Sub County with regard to respect/compassion of maternal health care providers and short waiting periods at the health facility to receive maternal health care.

The findings of Section 4 in general seem to support the theory that advocacy activities of grassroots-level outside government GRB initiatives in a district influence improved and gender-responsive maternal health service delivery at public health facilities. Although no



statistically significant differences were found in the rankings of the six items between Kamwezi and Nyamweru Sub Counties, the generally higher mean ranks in Kamwezi than Nyamweru signal higher satisfaction among rural women. The combined higher rankings of items relating to adequate maternal health equipment, respect/compassion of maternal health workers towards expectant mothers and the short waiting periods at public health facilities in Kabale District than in Mpungu Sub County, Kanungu District, point towards more gender-responsive maternal health service delivery in sub counties exposed to the outside government GRB initiative (directly at grassroots level or indirectly through district-level stakeholders and radio talk show programmes).

## 5. CONCLUDING REMARKS

This chapter has analysed the demand-side effects of advocacy activities of local-level outside government GRB initiatives in maternal health. The analysis was hierarchical in nature and started with an evaluation of the direct activities of the outside government GRB initiative, notably sensitisation of rural communities on maternal health services, rights and entitlements with the aim of increasing knowledge among rural women and stimulating demand for gender-responsive maternal health care at public health facilities.

Different forms of exposure to the outside government GRB initiative were contrasted, namely direct interaction with the grassroots level outside government GRB initiative combined with exposure through radio talk show programmes; exposure to the outside government GRB initiative through radio talk show programmes only; and no exposure at all. The results showed that the mass sensitisation of grassroots communities on gender, maternal health service standards, rights and entitlements had an overall significant effect of increased knowledge of maternal health services, rights and entitlements among rural women, with the effects higher when a sub county with direct and indirect exposure was contrasted with a sub county with no exposure at all. The findings also showed that the sub effects of knowledge of maternal health rights and entitlements were highest among rural women who were exposed to the outside government GRB initiative directly, as well as indirectly through radio talk show programmes, when compared to rural women exposed through radio only or with no exposure at all. Indirect exposure to the outside government GRB initiative through radio talk show programmes only also had a significant effect on increased knowledge of maternal health services among rural women but not on maternal health rights and entitlements. The conclusion drawn from this analysis was that the physical presence of a grassroots level outside government GRB initiative in a sub county significantly enhanced awareness among rural women, especially with regard to knowledge of maternal health rights and entitlements.

The second level of investigation focused on assessing the influence of knowledge of maternal health services, rights and entitlements on the utilisation of four dimensions of maternal health care, namely prenatal, delivery, delivery assisted by a skilled birth attendant and postnatal care respectively. The results obtained using binary logistic regression on the four outcomes with various predictors known to influence maternal health service utilisation revealed that knowledge of maternal health services, rights and entitlements was significantly associated with attendance of four or more prenatal care visits, but was not associated with utilisation of delivery care, delivery assisted by a skilled birth attendant and postnatal care. Besides accessibility to a health facility and household wealth status which are predictors that are widely affirmed to be associated with the utilisation of delivery care and skilled birth attendance, a strongly significant predictor that was revealed by this study to be associated with utilisation of delivery care and skilled birth attendance was receipt of a free mama kit. Considering that mama kits are given to mothers at the fourth prenatal care visit, we may

project that knowledge of rights and entitlements to free mama kits enhances attendance of four or more prenatal care visits, which potentially avails mothers with free mama kits, leading to increased utilisation of delivery care and delivery assisted by skilled birth attendants. Postnatal care attendance seemed to be beyond the scope of messages passed on related to maternal health services, rights and entitlements, which could explain the lack of association. The utilisation of postnatal care seemed to be more prevalent among richer households that were able to afford costs associated with traveling to the health facility.

The third level of analysis explored the perceptions of users of maternal health services in Kabale District, with the objective of confirming qualitative statements made about the improvement and responsiveness of maternal health service delivery at public health facilities following advocacy by the grassroots level outside government GRB initiative. The investigation also sought to explore whether variations existed in the perceptions among rural women regarding the quality of maternal health service delivery between a sub county with physical presence of the grassroots level outside government GRB initiative and a sub county without the initiative within the same district. The findings obtained from exploratory factor analysis with principal components extraction revealed a general satisfaction among rural women with maternal health service quality in both sub counties, especially with regard to adequacy of maternal health equipment and maternal health staffing. Respondents in the sub county with physical presence of the grassroots level outside government GRB initiative additionally emphasised the adequacy of maternal health infrastructure and health worker-to-patient communication, which was not as pronounced in the sub county without the GRB initiative.

Non-parametric tests conducted to compare the variations in rankings of maternal health service quality/responsiveness revealed statistically significant differences in rankings across the three sub counties, particularly with regard to respect/compassion of health workers towards expectant mothers, adequacy of maternal health equipment at public health facilities, adequacy of maternal health staffing and waiting periods to receive maternal health care. While no statistically significant differences were found in the rankings between the two sub counties exposed to the outside government GRB initiative at district level and at grassroots level (directly as well as indirectly through radio talk show programmes), statistically significant differences were found in the rankings of adequacy of maternal health equipment, respect and compassion and waiting period at public health facilities between sub counties exposed to the outside government GRB initiative (directly as well as indirectly) and sub counties with no exposure at all.

The overall conclusion derived from these three levels of analysis is that the sensitisation activities of the local-level outside government GRB initiative had a significant, although small, effect on increasing awareness among rural women of maternal health services, rights and entitlements, which contributed to increased utilisation of four or more prenatal care visits

among rural women, but did not have a significant effect on the utilisation of delivery care, delivery assisted by skilled birth attendants and postnatal care respectively. The statistically significant association between receipt of free mama kits and the utilisation of delivery care and skilled birth attendance, however, projected a potential positive effect of sensitisation of rural women about maternal health rights and entitlements. Postnatal care attendance, on the other hand, appeared to be beyond the scope of influence of messages related to maternal health rights and entitlements. The overall findings seem to reflect the responsiveness of maternal health service delivery to the expectations of rural women residing in sub counties exposed to the outside government GRB initiative and confirmed qualitative phase findings.

Having concluded the analysis, Chapter 7 synthesises the findings from both the qualitative and quantitative phases of this research and makes conclusions and recommendations for future policy and research respectively.

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## ANNEX V.

**Table 34: Demographic characteristics of study sample by Sub County**

	Kamwezi				Nyamweru				Mpungu			
	N	Min	Max	Mean	N	Min	Max	Mean	N	Min	Max	Mean
Respondent age (years)	168	17	46	28.64	158	18	49	28.83	165	18	49	28.02
Birth order (Births by the respondent)	168	1	12	3.61	162	1	12	3.81	169	1	11	3.95
Age of youngest child (months)	168	1	36	14.88	162	1	36	14.61	164	1	36	15.07
Child care burden (children under age 5 in household)	168	1	3	1.68	161	1	3	1.75	167	1	4	1.74
Valid N (listwise)												

Source: Author's analysis of household survey data

**Table 35: Household head level of education by Sub County**

			Sub County			Total
			Kamwezi	Nyamweru	Mpungu	
Household head level of education	1 Never attended formal school	Count	6	8	9	23
		% within Sub County	3.6%	5.0%	5.4%	4.6%
	2 Attended adult literacy classes	Count	3	3	7	13
		% within Sub County	1.8%	1.9%	4.2%	2.6%
	3 Attended primary education but stopped in lower primary	Count	63	65	78	206
		% within Sub County	37.5%	40.4%	46.4%	41.4%
	4 Attended and completed primary	Count	54	52	60	166
Household head level of education		% within Sub County	32.1%	32.3%	35.7%	33.4%
	5 Attended and completed ordinary level	Count	31	21	10	62
		% within Sub County	18.5%	13.0%	6.0%	12.5%
	6 Attended and completed advanced level	Count	5	5	2	12
		% within Sub County	3.0%	3.1%	1.2%	2.4%
	7 Completed college/university (1-3 years)	Count	6	7	2	15
		% within Sub County	3.6%	4.3%	1.2%	3.0%
Total		Count	168	161	168	497
		% within Sub County	100.0%	100.0%	100.0%	100.0%

Source: Author's analysis of household survey data



**Table 36: A summary of utilisation of skilled maternal health care by Sub County**

	Kamwezi		Nyamweru		Mpungu		Total	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent
1. Attended 4 or more ANC visits	75	44.9	65	40.1	81	47.6	221	44.3
2. Attended 4 or more visits and started in first trimester	46	27.5	46	28.4	53	31.2	145	29.1
3. Attended ANC visits at nearest health facility (within sub county)	135	82.3	144	95.4	141	95.3	420	90.7
4. Delivered inside a medical institution	137	82.0	104	64.2	126	74.1	367	73.5
5. Delivered at government health centre within sub county (out of total deliveries)	83	49.7	54	33.3	103	60.6	240	48.2
6. Recent birth attended to by skilled health personnel	136	82.4	106	65.4	120	74.5	302	74.2
7. Attended postnatal care six weeks after delivery	75	44.6	56	34.6	84	49.4	215	43.0

Source: Author's analysis of household survey data

**Table 37: Correlation matrix of maternal health service indicators in Kamwezi Sub County**

Correlation

	Respect/compassion	Openness	Adequate equipment	Adequate staffing	Exam/delivery rooms adequate	Short waiting period
Respect/compassion	1.000	.401	.163	.307	.096	.057
Openness	.401	1.000	.349	.422	.456	.194
Adequate equipment	.163	.349	1.000	.330	.354	.242
Adequate staffing	.307	.422	.330	1.000	.438	.253
Examination/delivery rooms adequate	.096	.456	.354	.438	1.000	.255
Short waiting period	.057	.194	.242	.253	.255	1.000

Note: Only cases for which Sub County = Kamwezi are used in the analysis phase.

Source: Author's analysis of household survey data

**Table 38: Correlation matrix of maternal health service indicators in Nyamweru Sub County**

Correlation

	Respect/compassion	Openness	Adequate equipment	Adequate staffing	Exam/delivery rooms adequate	Short waiting period
Respect/compassion	1.000	.500	.111	.240	.102	-.009
Openness	.500	1.000	.185	.316	.233	-.076
Adequate equipment	.111	.185	1.000	.466	.252	.029
Adequate staffing	.240	.316	.466	1.000	.505	.089
Exam/delivery rooms adequate	.102	.233	.252	.505	1.000	.279
Short waiting period	-.009	-.076	.029	.089	.279	1.000

*Note: Only cases for which Sub County = Nyamweru are used in the analysis phase.*

*Source: Author's analysis of household survey data*

**Table 39: Correlation matrix of maternal health service indicators in Mpungu Sub County**  
**Correlation**

	Respect/compassion	Openness	Adequate equipment	Adequate staffing	Exam/delivery rooms adequate	Short waiting period
Respect/compassion	1.000	.291	.092	.080	.021	.067
Openness	.291	1.000	.051	-.140	-.037	.294
Adequate equipment	.092	.051	1.000	.113	-.117	.187
Adequate staffing	.080	-.140	.113	1.000	.186	.064
Exam/delivery rooms adequate	.021	-.037	-.117	.186	1.000	-.034
Short waiting period	.067	.294	.187	.064	-.034	1.000

*Note: Only cases for which Sub County = Mpungu are used in the analysis phase.*

*Source: Author's analysis of household survey data*

## **CHAPTER 7**

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### **CONCLUSIONS AND RECOMMENDATIONS**

Note: Part of the implications for evaluation methodology presented in this section are reproduced from Bamanyaki and Holvoet (2016:77-78) with a few changes.



## INTRODUCTION

Having elaborated the research problem, reviewed existing literature and presented the study findings in relation to the research questions, this chapter now focuses on drawing conclusions and implications for future policy and research. To be able to do this, the chapter starts by recapitulating the study processes and main findings; followed by a synthesis of the findings obtained from the two phases of the research. The chapter ends with conclusions and recommendations to inform policy, evaluation and future research.

### 1. REVIEWING THE STUDY PROCESSES AND FINDINGS

#### 1.1. Study overview

Existing literature widely affirms that maternal mortality is a pronounced problem in the developing world, particularly in Sub-Saharan Africa and Southern Asia. Whereas decades have witnessed the implementation of interventions targeted at strengthening health systems delivery of maternal health care, growing literature upholds that poor maternal health outcomes (maternal morbidity and deaths) result not just from bio-medical factors, but also socioeconomic, cultural and structural factors. Inequities at regional, community and household levels affect access and utilisation of skilled maternal health care by women.

Since the 1990s, GRB gained prominence as an effective tool for governments to address gender inequality in economic, as well as social sectors. According to proponents, GRB permits the analysis of specific needs and priorities of females and males belonging to different social groups and informs the design of responsive policies and programmes, as well as the prioritisation of budget allocations to address the identified needs. Some GRB initiatives also empower citizens – particularly the poor and marginalised – to articulate demands and engage directly with bureaucrats and public service providers, potentially enhancing state responsiveness and effectiveness. Irrespective of the origin and political location of GRB initiatives (inside or outside government), the concentration has mainly been on the sectors of health and education and specifically on addressing issues that affect women directly. To date, however, there is limited empirical evidence of the effectiveness and impact of GRB initiatives and most of the available literature is reported at national level.

This research premised on this background to explore the effects of outside government GRB initiatives at local government level in the maternal health sub-sector. A case study of the FOWODE GRB initiative in Kabale, Uganda was used to investigate the broad question “*how and to what extent do local-level outside government GRB initiatives in health influence gender-responsive maternal health service delivery and the use of skilled maternal health care among rural women of reproductive age?*” To ably answer this broad question, three central questions were posed as follows: (i) How may outside government GRB initiatives influence

gender-responsive maternal health service delivery and the use of maternal health care services by rural women at local government level? (ii) How have outside government GRB initiatives contributed to gender-responsive maternal health service delivery and the use of maternal health care services among rural women in Kabale District? (iii) To what extent have outside government GRB initiatives influenced the demand for skilled maternal health care among rural women of Kabale District?

## **1.2. Methodological approach**

A sequential exploratory mixed methods design was adopted for the study, which started with a qualitative phase and ended with a quantitative phase. The two phases were separated by an intermediate phase, which utilised the findings of the qualitative phase to inform the development of specific research questions and sampling strategies for the quantitative phase.

In answering the first central question, theory-based evaluation principles were integrated with theory-testing process tracing methods (explained in chapters four and five) to develop a programme theory and theorise a case-specific causal mechanism that explains how outside government GRB initiatives may influence gender-responsive maternal health service delivery and the utilisation of skilled maternal health care among rural women at local government level. Theory-testing process tracing was also used to answer the second central question, which involved the application of formal Bayesian logic to enable us update our confidence in the validity of successive parts of the causal mechanism functioning to produce the observed changes to maternal health service delivery and the utilisation of maternal health care among rural women of Kabale respectively.

The third central question focused on the demand side of maternal health care and applied quantitative methods to investigate the extent to which the outside government GRB initiative influenced the utilisation of skilled maternal health care among rural women of Kabale District. Qualitative phase findings revealed that the direct effects of the outside government GRB initiative at grassroots level relating to maternal health were restricted to sensitisation of rural communities (mostly women) on maternal health services, rights and entitlements. Consequently, propensity score matching method was employed to estimate the average treatment effects of exposure to the grassroots level outside government GRB initiatives on knowledge of maternal health services, rights and entitlements among rural women. Knowledge levels were computed on the basis of scores on a knowledge test which was specifically designed to reflect the information that was passed on to the communities by FOWODE-supported grassroots women groups. The average knowledge scores were contrasted across three research sites, namely the treatment location (Kamwezi) – a sub county with the active presence of the grassroots-level outside government GRB initiative as well as the district-level initiative; one control sub county (Nyamweru) in the same district but

without the grassroots level initiative; and a second control sub county (Mpungu) in a separate district with no exposure to any GRB initiative at district-nor grassroots-level. A total of 500 women constituted the survey.

The second level of analysis utilised the full dataset of 500 observations to investigate the association between scores on knowledge of maternal health services, rights and entitlements (irrespective on the source of information) and the utilisation of prenatal care, delivery care, delivery assisted by a skilled birth attendant and postnatal care respectively. The objective of this analysis was to be able to make projections about the potential of sensitisation activities of grassroots level outside government GRB initiatives on the utilisation of the four types of maternal health care among rural women. Binary logistic regression analysis was used for this investigation.

A third investigation sought to expound on and triangulate the qualitative findings by utilising the perspectives of the users of maternal health care at public health facilities to determine whether the advocacy and monitoring activities of the grassroots level GRB initiative contributed to improved and gender-responsive maternal health service delivery. Exploratory factor analysis with principal components extraction was used to empirically summarise the perceptions of maternal health service quality/responsiveness among rural women in Kabale District. This was followed by the use of Kruskal-Wallis H Test and post-hoc Mann-Whitney U Tests to determine whether the rankings on six indicators of maternal health service quality were significantly different across the three sub counties. The main findings from the qualitative and quantitative phases of the research are presented next in Section 1.3.

### **1.3. Main findings**

#### **1.3.1. How local-level outside government GRB initiatives may influence gender-responsive maternal health service delivery and the use of maternal health care among rural women**

The literature reviewed in Chapter 3 revealed that very few GRB initiatives worldwide have specialised in the maternal health sub-sector, and these initiatives are predominantly located outside government. Although the majority of GRB initiatives have used technical approaches and tools, other GRB initiatives, such as the FOWODE initiative in this case study, have also applied participatory approaches involving the empowerment of grassroots communities to demand for gender accountability in maternal health care from duty bearers in government.

In accordance with the Social Determinants Approach to Maternal Health framework (discussed in the introduction chapter), outside government GRB initiatives generally make use of existing laws on gender equality and ratified international human rights commitments to hold governments to account. At the structural level, outside government GRB initiatives

seek to influence gender-sensitive health policies and programmes; the allocation of adequate resources to implement gender-sensitive health policies and programmes; and the prioritisation of resources allocated to the health sector in a way that benefits the regions, communities and social groups with the most need. Outside government GRB initiatives also seek to transform perverse culture and social values by placing emphasis on enhancing the status of women at society and community levels. In order to accomplish these structural-level objectives, the findings of this case study revealed that local-level outside government GRB initiatives implement activities, including: training technocrats and politicians (female councillors) on the concept of gender, gender analysis and GRB; providing technical assistance to technocrats on GRB implementation; conducting independent gender analyses of the health sector followed by dissemination of the findings to technocrats to inform their planning and budget processes; as well as enhancing the skills of female councillors in public speaking and confidence building, including guiding them to form a women's caucus at the district council for effective lobbying of women's the consideration of women's issues in policies, plans and budgets.

With regard to the intermediary determinants of maternal health outcomes at health facility and community levels, outside government GRB initiatives seek to influence the availability, accessibility, affordability and acceptability of gender-responsive maternal health services. Outside government GRB initiatives also seek to develop the capacity of community members (especially women) to demand for gender-responsive maternal health care and accountability at public health facilities. According to the findings from this case study, the activities undertaken to accomplish these objectives include mobilising women-dominated groups at grassroots level and sensitising them on the concept of gender, gender advocacy, local government planning and budget processes and maternal health services, rights and entitlements; facilitating these women groups to monitor service delivery at public health facilities for gender-responsiveness; facilitating the women groups to sensitise the wider community on gender equality, maternal health services, rights and entitlements; and facilitating the women groups to hold community dialogues and interface meetings that involve community members, technocrats from the district health department, health workers from public health facilities and local leaders respectively.

The sensitisation of communities, and more so, women of reproductive age targets to address the household level and individual attributes that affect maternal health outcomes relating to knowledge. It is also anticipated that the awareness created at community level regarding gender equality and maternal health services, rights and entitlements trickles down to household level, ultimately leading to increased utilisation of maternal health care among rural women.



### **1.3.2. Contribution of local-level outside government GRB initiatives to gender-responsive maternal health service delivery and utilisation of skilled maternal health care among rural women of Kabale**

The evaluation of the independent pieces of evidence found in the case using formal Bayesian logic generally makes us more confident than not (51 to 70 per cent confident) in the validity of the claim that the outside government GRB initiative contributed to the observed changes in maternal health service delivery. One strong part in the causal mechanism that appears to have facilitated the realisation of the observed results in gender-responsive maternal health service delivery, according to Bayesian updating (81 per cent confidence), was the holding of interface meetings that brought together technocrats, politicians, community members and health care providers. At these meetings, community members engaged directly with duty holders and voiced demands, which were further publicised over the media, putting pressure on the respective actors on the supply side to take actions to make services more responsive. These findings concur with previous studies from the field of Social Accountability (Björkman and Svensson, 2009, Murthy, 2008; Papp et al., 2013).

While some demands – especially the ones requiring substantial funds such as construction of staff accommodation at health facilities – were not met, noticeable responses from the district executive and council included the provision of a delivery bed, examination bed and the posting of a midwife to Kagarama Health Centre II in Bubare Sub County in 2011; rehabilitation of the dilapidated Kyogo Bridge in Kamwezi and the posting of a second midwife to Kyogo Health Centre III in Kamwezi Sub County in the financial year of 2013/14; the reworking of the Kyogo bridge in financial year 2014/15 following a petition signed by community members over shoddy work; and the prioritisation of construction of placenta pits at health centres II each financial year using locally generated district revenue. At health facility level, noticeable improvements were regularity of operation hours at health facilities with at least one health worker available round-the-clock to attend to expectant mothers; provision of full mama kits to expectant mothers at no cost; and improvement in health worker attitudes towards expectant mothers.

With regard to utilisation of skilled maternal health care among rural women, the evidence found in the case reveals that the trends of utilisation of prenatal care, delivery care, delivery assisted by a skilled attendant and postnatal care at the health facilities did not significantly improve. These findings are in support of numerous other studies, including the systematic review of 278 studies by Dettrick et al. (2013), which found very limited evidence linking improvements to the quality of health care at health facilities to improved maternal health outcomes (increased utilisation of maternal health care). While more research is needed on this, these findings from the case seem to reinforce the argument that the socio-cultural factors play a large part in influencing the utilisation of skilled maternal health care among rural women, particularly community norms on acceptable behaviour during pregnancy and

child birth. As noted in the introduction chapter, studies conducted in some parts of Uganda (Kyomuhendo, 2003) have found that women, who deliver by themselves or with the help of a relative at home, are regarded with high esteem; while women who seek skilled medical help are seen to display weakness. A significant improvement to maternal health care utilisation in such cultures would, therefore, require interventions that specifically target to transform norms and values.

### **1.3.3. Effects of the outside government GRB initiative on the demand and utilisation of maternal health care among rural poor women of Kabale District**

As mentioned before, the direct effects of the outside government GRB initiative on the demand-side of maternal health care were restricted to sensitisation of rural women on maternal health services, rights and entitlements, with the assumption that knowledgeable women would increase their utilisation of skilled maternal health care. With three research sites, namely two sub counties in Kabale District (one with the grassroots level GRB initiative and the other without) and one sub county in a separate district (Kanungu) with no GRB initiative at district- nor grassroots-level; the analysis sought to establish whether statistically significant differences existed in the average scores on knowledge of maternal health services rights and entitlements across the sub counties. The distinguishing factor across the sub counties was exposure to the sensitisation messages of the grassroots level GRB initiative. The treatment sub county in Kabale District combined direct exposure (direct interaction with the grassroots level GRB initiative) and indirect exposure (listening to radio talk show programmes hosted by the FOWODE GRB initiative). Exposure in the second sub county of Kabale district was only indirect (radio talk show programmes), while the third sub county in Kanungu District had no form of exposure.

The findings revealed that rural women who had direct interaction with the outside government GRB initiative and/or listened to radio talk show programmes were significantly more knowledgeable of maternal health services, rights and entitlements than rural women with indirect exposure alone by 3.8 per cent; and significantly more knowledgeable than women with no exposure at all by 8.6 per cent respectively. The comparison of indirect exposure alone with no exposure at all revealed a statistically significant difference of 5.1 per cent more knowledge in favour of rural women with indirect exposure to the outside government GRB initiative. Higher sub-effects of knowledge of maternal health rights and entitlements were found compared to the sub-effects of knowledge of maternal health services. These findings suggested that the physical presence of the grassroots level outside government GRB initiative in a sub county enhanced awareness among rural women of maternal health services, rights and entitlements, with the effects being higher for knowledge of maternal health rights and entitlements. Seen in this way, and in line with the Social Determinants Approach to Maternal Health, it can be inferred that the outside government

GRB initiative in Kabale District also had an effect on individual attributes of rural women within households relating to knowledge.

The findings further revealed that, holding other predictors fixed, the receipt of a mama kit by the expectant mother was a statistically significant predictor for the utilisation of delivery care at a medical institution (OR = 18.26(7.360, 45.315),  $p = .000$ ) and delivery assisted by a skilled birth attendant (OR = 25.49 (8.088, 80.327),  $p = .000$ ). According to qualitative findings, mama kits were provided to expectant mothers at the fourth prenatal care visit or towards delivery. This leads us to the projection that knowledge of maternal health services, rights and entitlements enhances attendance of at least four prenatal care visits, which potentially avails expectant mothers with free mama kits and increases their probability of utilising delivery care and delivery assisted by skilled birth attendants. The importance of postnatal care attendance seemed to be beyond the scope of sensitisation messages of the outside government GRB initiative and was more prevalent among rural women from wealthier households. While more research is needed, the generally low postnatal care attendance rate at national level of 33 per cent further seems to suggest that maternal interventions in general have not been as successful in promoting the utilisation of postnatal care.

Lastly, perceptions of the responsiveness of maternal health service delivery at public health facilities among rural women in Kabale District revealed that rural women were generally satisfied with the quality/responsiveness of maternal health service delivery, especially with regard to adequacy of maternal health equipment (drugs, supplies, mama kit) and maternal health staffing, with rural women residing in the sub county with the presence of the grassroots level outside government GRB initiative additionally emphasising adequacy of maternal health infrastructure and health worker-to-patient communication. Non parametric (post-hoc Mann Whitney U) tests revealed statistically insignificant differences in the rankings on the quality/responsiveness of maternal health service delivery among rural women residing in a sub county with the grassroots level outside government GRB initiative and rural women in a sub county without the grassroots level GRB initiative within the same district. These results seemed to suggest that district-level efforts to improve the quality and responsiveness of maternal health service delivery possibly cut across the different sub counties.

Post-hoc Mann-Whitney U Tests comparing the rankings of maternal health service quality/responsiveness in the two sub counties of Kabale District and the sub county in Kanungu District with no exposure to the outside government GRB initiative, however, revealed statistically significant in rankings on adequacy of maternal health equipment, short waiting periods and respect and compassion of maternal health care providers towards expectant mothers. The sub counties in Kabale generally had higher rankings than Mpungu in Kanungu district, although the effect sizes of the differences, according to Cohen (1988) criteria, were small. These results seemed to support the theory that advocacy activities of

grassroots level outside government GRB initiatives in a district may influence gender-responsive maternal health service delivery. The next section synthesises the qualitative and quantitative phase findings and draws conclusions on the effects of the outside government GRB initiative at local government level.

## 2. CONCLUSIONS

The double-pronged approach adopted by the local-level outside government GRB initiative in this case seems to have enhanced the achievement of the observed contributory effects. The combination of pressure mounted by citizens on technocrats and health care providers as grassroots level for gender accountability in health service delivery and strategic lobbying through the women's caucus at district level appears to have fostered the prioritisation of women's gender-related priorities in district policies, plans and budgets. As was proposed by the International Labour Organisation (2006) the diversity of actors involved in the local-level outside-government GRB initiative appeared to have contributed to the achievement of observed results in maternal health service delivery. A noticeable gap in this approach, however, was the non-inclusion of health care providers as direct beneficiaries in the gender and GRB trainings, which could have enhanced the results. As such, it appears that the gender-responsiveness of maternal health service delivery in the respective health facilities was more of reactionary than pre-arranged. In comparison with other types of GRB interventions in maternal health, which adopted purely technical approaches (reviewed in Section 4.1 of Chapter 3), the double-pronged approach seems to be more effective in strengthening state responsiveness in maternal health service delivery by affording the direct voicing of felt needs and priorities by women to duty holders in government. The approach also had the added benefit of empowering female councillors and rural women during the process.

The formal evaluation of the independent pieces of evidence for the different parts of the causal mechanism using Bayesian updating showed lower confidence levels for the parts that involved technocrats as the entity, as compared to the parts involving female councillors and the women groups. This suggested that varying degrees of effort and commitment were exerted by the different actors to contribute to producing the observed outcomes. The implementation of GRB among technocrats could not easily be verified and was blamed on standardised reporting formats that were not gender-sensitive. Previous GRB evaluations (Budlender, 2005; Sharp, 2003; UN Women, 2010) similarly note the limited success of GRB implementation in government policy and budget processes. Additionally, qualitative evidence revealed a reduced zeal or total lack of continuity of grassroots level activities following the phase out of direct support to the grassroots women groups by the outside government GRB initiative. While studies that evaluate the sustainability of donor-funded projects, such as Busiinge (2010), suggest a dependency-syndrome amongst community members, the findings of the present case point towards three issues, notably (i) the groups were not empowered enough to manage on their own; (ii) the groups did not fully own and appreciate the initiative and its importance for the community; and (iii) funding challenges hindered effective monitoring and sensitisation of communities. Qualitative interviews revealed that the outside government GRB initiative was at the forefront of organising the grassroots level events (making radio announcements about the meetings, organising radio

talk shows, formerly inviting and transporting technocrats from the district headquarters) and that the village budget club members dutifully carried out responsibilities.

Related to the objective of empowerment of rural communities to demand for gender accountability in the health sector from government, qualitative and quantitative findings consistently reveal that the physical presence of the outside government GRB initiative had a significant, but relatively small, effect of increasing awareness of maternal health services, rights and entitlements among rural women. Descriptive statistics of survey data from Kamwezi revealed that 10 respondents (7 per cent) had personally attended meetings organised by the outside government GRB initiatives in the community. Visual recordings of some of the interface meetings also revealed that the women who raised issues for redress at the meetings were mostly leaders and a few members of the village budget clubs. While it might be argued that the women voiced their demands through their elected leaders, focus group discussions with village budget club members also revealed that not all the members fully understood the GRB concepts that were taught to them and the monitoring of health facilities was routinely done by three to four members of the village budget clubs, who were predominantly leaders. Çağatay et al. (2000) observed that inadequate literacy skills, numeracy skills and technical knowledge limited the participation of ordinary citizens in budgetary processes. The conclusion from these study findings is that whereas rural women may have knowledge of maternal health services, rights and entitlements; empowerment to demand gender accountability from duty bearers was restricted to a few community members, who already had some level of exposure in form of literacy. These findings may also explain the limited successes of other interventions in maternal health which tend to focus on a particular small group while neglecting other important groups, such as the lack of male engagement in maternal health as was discussed in the introduction chapter.

Regarding the effects of the outside government GRB initiative on maternal health service delivery, qualitative and quantitative findings confirmed improvements and gender-responsiveness of maternal health services at public health facilities relating to the four aspects of availability, acceptability, affordability and accessibility, with further room for improvement. The findings, however, reveal that the improvements were constrained by inadequate funding at district level, a fact that is prevalent among other districts in the country and the health sector in general. An analysis of the content of district budgets over the five-year period from 2010/11 to 2014/15 showed that the district relied on the central government for funding of 96 per cent of its budget. This meant that central government policies and priorities took precedence over district priorities. As such, responses to citizen demands had to be in tandem with existing district and national plans. This restricted the effects of the outside government GRB initiative on district health plans and budgets to reprioritisation and reallocation of budgets during the five year district planning period, possibly at the expense of other needy communities that were not empowered to openly voice out demands.

The study findings also indicate that the positive effects of the local-level outside government GRB initiative were more pronounced on the supply side of maternal health care than on the demand side. These results are not so surprising considering that the principal aim of the outside government GRB initiative was to empower grassroots women leaders to participate in political and budgetary processes so as “to demand gender accountability of government budgets” (FOWODE 2009: 15); track local government budgets to ensure transparency and accountability and “the efficiency and effectiveness of government programmes” (FOWODE 2009:16). These findings reveal that in as much as the outside government GRB initiative prioritises advocacy to improve maternal health service delivery to ensure that it is responsive to gender needs, it does not actively set out to ensure that the gender-responsive services are being utilised by the intended users – the rural poor women. The sensitisation of rural women in this case appeared to have had the purpose of justifying claims for improvements to service delivery by providing first-hand evidence of women’s voices. The gap in knowledge of the effects of the local-level outside government GRB initiative on the end-users of the services challenges the justification for such initiatives among sceptics.

In conclusion, it should be noted that the observed effects in maternal health service delivery resulted from the efforts of diverse actors, including the central government (institutionalising the deliveries in Health Centres II in hard-to-reach areas; raising awareness about sexual reproductive health and the importance of skilled maternal health care through Village Health Teams and health facility outreaches to communities) and non-governmental organisations engaged in the maternal health sub-sector that supplemented government efforts (training midwives on obstetric care, strengthening capacities of health unit management committees, providing drugs, equipment, renovation of health infrastructure and provision of solar power to maternity health wings).

### **3. RECOMMENDATIONS**

#### **3.1. Implications for policy and programming**

Drawing from the synthesised findings above, three strategies are recommended for future policy and programming as follows:

##### **3.1.1. Target to include health providers in gender mainstreaming interventions**

Gender-responsive maternal health service delivery can benefit from a health workforce that appreciates the socioeconomic and cultural issues that affect women's access and utilisation of maternal health services. While health policies, plans and programmes may incorporate a gender perspective, the effective implementation of gender-sensitive health service delivery would require the formal training of health workers on gender.

##### **3.1.2. Institutionalise a gender dimension on the output budgeting tool for local governments**

The study findings showed that the activities of the outside government GRB initiative facilitated elements of gender-responsiveness in health budgets and maternal health service provision in Kabale District. Responses of technocrats and district councillors, however, were constrained by the limited room for manoeuvre in as far as making changes to health policies and budgets were concerned. Empirical evidence collected over a thirteen year period in the district (since 2003) was sporadic and difficult to systematically track, especially with regard to GRB implementation among district technocrats and health care providers. While verbal claims were made by some technocrats of GRB implementation, the evidence was masked by standardised reporting formats which were developed at central government level that did not provide for gender-disaggregated reporting.

As rightly proposed by Holvoet and Inberg (2008), integrating a gender dimension into all facets of the Output Budgeting Tool<sup>34</sup> from the level of central government (MoFPED) with clear guidelines and indicators for evaluating progress would make GRB implementation mandatory among district departments.

While it is evident that the government of Uganda has laws in place that emphasise mainstreaming gender into all policies, programmes and budgets and across economic sectors – including the recently passed Public Finance Management Act that requires all Budget Framework Papers to be certified by the MoFPED and the Equal Opportunities Commission as

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<sup>34</sup> The output budgeting tool is used by local governments to prepare annual sectoral work plans, budgets and report performance.



being gender-and-equity responsive – the disconnect between regulatory requirements and reporting formats threatens the effective implementation and tracking of devised plans.

### **3.1.3. Scale up and empower grassroots community groups to be sustainable**

The study findings demonstrated that where grassroots community groups were physically present and engaged in activities of budget tracking, monitoring health service delivery and sensitising communities about maternal health services, rights and entitlements; health service improvements were achieved and the level of awareness of maternal health services rights and entitlements was higher than in locations without the grassroots groups. A challenge that emerged, however, was that the activities of the grassroots groups either reduced in intensity or ended following completion of direct support from the outside government GRB initiative. Three issues were noted to explain this, namely inadequate empowerment of groups to manage activities on their own; inadequate ownership and appreciation of the benefits of the grassroots level outside government GRB initiative for the community; and funding gaps, which hindered the continuity of monitoring activities.

Possible solutions to these three challenges are inherent in the design of the GRB initiative. First, whereas the outside government GRB initiative sought to empower communities to demand for gender accountability, it maintained its position at the forefront as the principal advocate for marginalised communities in the district and was viewed as such by technocrats, politicians and community members. The Kabale programme Office of the outside government GRB initiative scheduled community dialogues and interface meetings, hosted radio talk shows, invited technocrats to attend interface meetings and covered their transport costs to the respective sub counties. Community members were thus not empowered to coordinate activities on their own. A remedy to this is, therefore, for the outside government GRB initiative to effectively build the leadership capacities of the grassroots community groups and provide technical and strategic advice, while the groups take the lead in coordinating activities. This would orient the group members towards ownership of the initiative in the community, build their confidence in demanding accountability from government and increase their visibility at district level, with the potential of ensuring sustainability of the initiative in the communities.

Second, sustainability strategies need to be incorporated into the design of the grassroots level GRB initiatives. Grassroots groups need to be adequately prepared to continue with the GRB activities from inception of the initiative in the community. While new grassroots groups are being supported to start group income generating activities, this was not the case for older groups featured in this study. The results of this undertaking by FOWODE are yet to be seen.

Third, cultivating ownership and appreciation of the grassroots level GRB initiative among the community should entail capacity and confidence building of group members who lack literacy

and numeracy skills as well. It was noted that the monitoring of health facilities was predominantly done by leaders who were literate. One strategy would be to involve such members in monitoring activities by mixing some leaders with alternate group members, as well as availing them with the opportunity to present issues on behalf of other members of the group at community meetings. This would reduce the passiveness of some grassroots group members and further the agenda of the outside government GRB initiative of empowering disadvantaged communities to demand for gender accountability, which currently appears to be concentrated among few members.

Lastly, if the grassroots community groups are scaled up to all sub counties within a district and are sustainable, they have the potential to enhance the responsiveness of duty bearers to improve service delivery and be more accountable to citizens.

#### **3.1.4. Actively target to influence utilisation of maternal health services**

Considering that the objective of advocacy activities of local-level outside government GRB initiatives is to ensure responsiveness of health policies, budgets and service delivery for rural poor and marginalised segments of society, it becomes imperative to move beyond just sensitising communities about health services, rights and entitlements to routinely evaluating whether the realised improvements actually benefited the intended targets. Given the funding limitation faced by outside government GRB initiatives that depend on donations, collaborative arrangements with other organisations that specialise on the demand side of maternal health care would enhance efforts to reduce maternal mortality among the rural poor. The interventions that target to improve the utilisation of skilled maternal health care, especially among rural women, should target to transform negative traditions that extol women who do not seek skilled care. Strategies to address this may include programmes that target to sensitise older women who pass on the traditions to the younger generations.

### **3.2. Implications for evaluation methodology**

The integration of theory-based evaluation principles with process tracing enables us to evaluate diverse kinds of GRB initiatives in their specific contexts. As noted in Bamanyaki and Holvoet (2016: 77):

“[g]iven the diverse nature of GRB initiatives, [theory-based evaluation] enables us to develop a programme theory that is applicable to the specific intervention under evaluation. [Theory-based evaluation] utilises information from various sources in the development of the programme theory – notably interviews with programme architects, managers, practitioners; reviews of programme documents and other relevant policy and academic literature; site visits to observe and understand the context of programme implementation – providing us with a comprehensive understanding of the causal chain of events from the GRB initiative inputs and

activities to the intended outcome (influencing gender-responsive maternal health service delivery), along with relevant assumptions underlying the theory (White, 2000). [Theory-based evaluation] approaches, however, do not make explicit the causal links between events in the causal chain from the intervention's inputs to the intended outcome, leaving us in the dark about the actual causal forces responsible for producing the outcome (Delahais and Toulemonde, 2012; Befani and Mayne, 2014; Schmitt and Beach, 2015).

[Process tracing methodology] makes the assumed links in the programme theory more explicit by theorising a case-specific plausible causal mechanism that develops how each part is logically linked to subsequent parts in terms of entities engaging in activities (Schmitt and Beach, 2015: 432). As suggested by Beach and Pedersen (2013), [process tracing methodology] enables us to capture the transmission of causal forces whereby X contributes to producing Y, forcing us to investigate not only inputs, outputs and outcomes in the causal chain, but also the theoretical process linking X to Y. PTM further provides clear guidance on the type of evidence to be collected and relevant criteria with which to judge the strength of the evidence found in the case (Befani and Mayne, 2014). Additionally, the empirical evaluation of evidence using [formal] Bayesian logic strengthens our [confidence in the validity of] the causal mechanism linking the GRB intervention to the observed changes in maternal health service delivery (Beach and Pedersen, 2013)."

The combination of quantitative methods with the preceding qualitative method permits the investigation of demand-side effects of the GRB initiative at household level, thereby enriching the findings from the evaluations.

Lastly, whereas this research adopted a dialectical pluralism stance, growing literature on Feminist and gender-responsive evaluation suggests that evaluations of advocacy interventions with a gender focus should adopt a transformative stance, which seeks to enhance gender equality and women's empowerment by "incorporating gender and women's rights dimensions into evaluation approaches, methods, processes and use"(UN Women, 2015: 4). The evaluation process should be inclusive, participatory and culturally responsive (recognising the voices of the diverse rights holders and duty bearers) (UN Women, 2015), with measurements of "the different starting situations of women and men" and an analysis of "how the development actions contribute to reducing inequalities." (Espinosa, 2013: 174). Evaluations of maternal health programmes on the basis of the Social Determinants Approach framework would benefit from such a transformative stance.

### **3.3. Implications for future research**

An extensive review of literature in chapters 2 and 3 of this study suggested that utilisation of skilled maternal health care among rural women was affected by factors linked to poverty and gender inequality at household and community level. The empirical findings of this study, as well as other studies (Dettrick et al., 2013; Gage, 2007; Saha and Kabir, 2006) however, have indicated that even when strides are taken by governments to improve the quality and responsiveness of maternal health care, the effect in terms of increased utilisation of maternal health care among rural women is negligible. One fundamental question for future research arises that: in a setting where maternal health care is gender-responsive and accessible at no cost, including the provision of free mama kits, what additional factors hinder the utilisation of skilled maternal health care among rural women? How can the utilisation of skilled maternal health care be boosted in such settings?

Second, the empirical findings from this study revealed that the progression of adopted GRB principles among the diverse actors targeted by the outside government GRB initiative tended to decline following the completion of direct support from the initiative. An important question for future research, therefore, is: What impedes the sustainability of the acquired GRB practices among targeted beneficiaries of outside government GRB initiatives? How can outside government GRB initiatives ensure the continuity of GRB practices among diverse actors beyond the lifespan of the outside government GRB initiative in the community/location?

The third question for future research relates to the limitations of this study. The study used a narrow definition of exposure to the outside government GRB initiative, which involved 'first-hand' exposure either directly through personal interaction with the outside government GRB initiative and/or indirectly by listening to radio talk show programmes hosted by the outside government GRB initiative. The narrow definition was imposed in order to increase the validity of scores of the knowledge test on maternal health services, rights and entitlements that was administered to respondents. Outside government GRB initiatives, however, may also rely on messages being passed on to the wider community by ordinary individuals who participated in activities organised by the initiative, as well as other modes of exposure. Future research may, therefore, investigate the same research questions at household level using a wider definition of exposure to the outside government GRB initiative and compare the results.

#### **4. A CONCLUDING REFLECTION**

As I conclude this study, puzzling questions still remain, notably: why have there been limited attempts to empirically evaluate the effectiveness and impact of GRB initiatives despite over two decades of implementation at state/federal and/or lower levels of government? If outside government GRB initiatives are not actively seeking to influence the utilisation of gender-responsive public services among the rural poor, in whose interests are they established? Is it worthwhile to invest substantial resources in GRB activities when sustainability of the effects among targeted beneficiaries seems to be short-lived?

A review of the empirical findings of this study revealed that outside government GRB initiatives at local government level play a necessary role in influencing gender-responsive maternal health service delivery and have the potential to influence the demand for skilled maternal health care among rural poor women by widening the scope of their mandate to include elements that focus on service users. It is anticipated that this study will stimulate more empirical research on the effectiveness and impact of GRB initiatives operating in different sectors, different contexts, focusing on different targets, and employing different approaches, as well as influence GRB programme architects to focus on the rural poor end-users of public services. It is also hoped that more studies will employ process tracing methods in the evaluation of complex interventions.

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## SAMENVATTING (SUMMARY IN DUTCH)

De voorbije twee decennium is er een toenemend bewustzijn ontstaan bij nationale overheden, bilaterale en multilaterale donoren en academici dat ongelijkheid tussen mannen en vrouwen de economische en sociale ontwikkeling belemmert. **Gender-gebaseerde ongelijkheid op het vlak van gezondheid** uit zich onder meer in een grotere sterfte bij meisjes (in vergelijking met jongens), verschillen in levensverwachting die tegengesteld zijn aan wat biologisch kan verwacht worden en **hoge moedersterfte**. Interventies om moedersterfte terug te dringen richten zich vaak op het verbeteren van de bestaande gezondheidssystemen, terwijl socio-ecologische modellen aantonen dat de **gezondheidsstatus van individuen** niet enkel wordt bepaald door bio-medische factoren maar ook door **socio-culturele en structurele factoren** die de vraag naar gezondheidszorg beïnvloeden. Verschillen in welvaart, middelen en opportuniteiten op nationaal en regionaal niveau, in combinatie met de heersende cultuur en waardesystemen, bepalen de kwaliteit van gezondheidszorg voor moeders. Op lokaal niveau wordt de toegang en het gebruik van gezondheidszorg door moeders ook beïnvloed door individuele karakteristieken (zoals leeftijd, aantal geboortes, onderwijsniveau), de socio-economische status van het huishouden en de percepties in het huishouden en de gemeenschap over aanvaardbaar gedrag tijdens de zwangerschap en de bevalling. Vanuit dit perspectief is het belangrijk dat interventies op het vlak van gezondheidszorg voor moeders zich ook richten op bestaande structurele ongelijkheden in lokale gemeenschappen en huishoudens.

Sinds de jaren '90 is er groeiende aandacht voor **gendergevoelig budgetteren** als een instrument voor overheden om hun doelstellingen inzake gendergelijkheden en vrouwenrechten te realiseren. Gendergevoelig budgetteren richt zich op het analyseren van de effecten van het beleid, programma's en budgetten (uitgaven en inkomsten) op de gelijkheid tussen mannen en vrouwen, jongens en meisjes. Eenmaal resultaten van genderbudgetanalyse beschikbaar zijn, is het de bedoeling om in volgende fasen van beleid en budgettering rekening te houden met de verschillende noden en prioriteiten van verschillende groepen om verdere ongelijkheden te voorkomen en te corrigeren. Initiatieven van gendergevoelig budgetteren zijn zeer divers en verschillen op het vlak van locatie (binnen of buiten de overheid), sector (met een overwicht voor de sectoren van onderwijs en gezondheidszorg), fase in de beleidscyclus (ex-ante, tijdens of ex-post), en de focus kan zowel op uitgaven, inkomsten of budgettaire processen liggen. Initiatieven van **gendergevoelig budgetteren op het vlak van gezondheidszorg** voor moeders die zich buiten de overheid bevinden, gebruiken hoofdzakelijk participatieve benaderingen om noden en prioriteiten van moeders meer aandacht te geven (in besluitvormingsprocessen over) gezondheidszorg voor moeders. Ondanks het feit dat initiatieven van gendergevoelig budgetteren reeds een aantal decennia bestaan, is er tot op heden **relatief weinig empirische evidentie over de effectiviteit**

**en bijdrage van deze initiatieven aan een meer gendergevoelige gezondheidszorg en een betere gezondheidsstatus van moeders.**

Tegen deze achtergrond focust dit doctoraat op één specifiek initiatief van gendergevoelig budgetteren dat zich buiten de overheid bevindt en dat geïmplementeerd wordt door de Ugandese NGO FOWODE (Forum for Women in Development) onder meer in Kabale district. De **centrale onderzoeksvraag** is *“in welke mate en hoe beïnvloedt het initiatief van gendergevoelig budgetteren de gendergevoeligheid van de geleverde gezondheidszorg én het gebruik van gezondheidsdiensten door rurale vrouwen van reproductieve leeftijd”?*

De brede onderzoeksvraag is uitgesplitst in **drie specifieke onderzoeksvragen**:

- (i) Hoe kunnen initiatieven van gendergevoelig budgetteren potentieel de geleverde gezondheidszorg én het gebruik ervan door rurale vrouwen van reproductieve leeftijd beïnvloeden?
- (ii) Hoe heeft het initiatief van gendergevoelig budgetteren effectief bijgedragen tot gezondheidszorg én het gebruik ervan door rurale vrouwen van reproductieve leeftijd in Kabale district, Uganda?
- (iii) In welke mate heeft het initiatief van gendergevoelig budgetteren de vraag naar gezondheidsdiensten voor moeders beïnvloed bij rurale vrouwen van reproductieve leeftijd in Kabale district, Uganda?

Om deze onderzoeksvragen te beantwoorden werd gebruik gemaakt van een **sequentieel exploratieve onderzoeksdesign**, waarbij de kwantitatieve fase werd voorafgaan door een kwalitatieve fase. In de **kwalitatieve fase** werd gebruik gemaakt van een gevalstudie om de objectieven, activiteiten, actoren, processen en causale mechanismen te begrijpen die potentieel leiden tot effecten van gendergevoelig budgetteren op gezondheidszorg en het gebruik ervan door rurale vrouwen. **Process tracing (PT) methodologie** werd gebruikt om de werking van de veronderstelde causale mechanismen te testen. PT omvat het verzamelen en valideren van verschillende sporen van empirische evidentie en het uitvoeren van testen (gebruik makende van Bayesiaanse logica) om de verschillende stappen in de causale ketting te bevestigen of te verwerpen. Bevindingen van deze eerste onderzoeksfase tonen aan dat het initiatief van gendergevoelig budgetteren **een tweeledige strategie** gebruikt waarbij enerzijds wordt gepoogd om **technocraten en politici op district niveau** te bereiken (de **aanbodzijde** van de dienstverlening) terwijl anderzijds **lokale leiders van vrouwengroepen** op dorpsniveau worden georganiseerd in budgetclubs (de **vraagzijde**).

De **lokale vrouwengroepen, samen met de vrouwelijke leden van de districtsraad**, spelen over het algemeen een veel **actievere rol** in het bevorderen van gender accountability van gezondheidsbeleid en gezondheidszorg voor vrouwen dan de technocraten. De vrouwelijke districtsraadsleden slaagden erin om via lobby district fondsen te gebruiken voor de aanleg van putten (voor placenta's) bij een aantal gezondheidscentra en een brug te herstellen die een gezondheidscentrum voor moeders onbereikbaar maakte. Routine monitoring van de geleverde gezondheidsdiensten en interface meetings georganiseerd door de lokale

budgetclubs zorgen voor een aantal praktische verbeteringen in de dienstverlening zoals regelmatige openingsuren, volledig uitgeruste bevallingskits en een betere houding van gezondheidspersoneel tegenover vrouwen tijdens de bevalling.

De **rechtstreekse effecten** van het initiatief op lokaal vlak betreffen voornamelijk **het verhogen van bewustwording bij lokale vrouwen over het bestaan van de gezondheidsdiensten en rechten op het vlak van gezondheid**. De effecten op het **effectief gebruik van gezondheidsdiensten** zijn **beperkt** tot het moment van de bevalling zelf (geen effect voor en na de bevalling). De bevindingen van deze eerste fase zijn niet alleen interessant an sich maar ze werden ook gebruikt om de enquête (relevante variabelen, de vragen, sampling strategie) die gebruikt werd in de tweede onderzoeksfase verder te verfijnen.

Tijdens de kwantitatieve fase werd een **quasi-experimentele onderzoekopzet** gebruikt, waarbij de effecten van het initiatief van gendergevoelig budgetteren in één van de sub-counties vergeleken werd met de situatie in twee vergelijkbare controle sub-counties. Een van de controle sub-counties bevindt zich in hetzelfde district (Kabale) maar zonder de vertegenwoordiging van het lokaal initiatief van gendergevoelig budgetteren, de andere controle sub-county bevindt zich in een ander district (Kanungu). De enquête werd afgenomen bij 500 moeders met kinderen van drie jaar en jonger, verspreid over de drie locaties. **Propensity score matching** (PSM) werd gebruikt om de effecten te onderzoeken van het initiatief op toegenomen bewustwording bij lokale vrouwen van het bestaan van gezondheidsdiensten voor moeders en van rechten op het vlak van gezondheidszorg. PSM-resultaten geven aan dat **vrouwen in de GRB sub-county meer bewust zijn van gezondheidsdiensten en van hun rechten maar de verschillen zijn niet substantieel** (wel statistisch significant).

Vervolgens werd **binaire logistische regressie** gebruikt om de relatie te bestuderen tussen grotere kennis van gezondheidsdiensten en rechten enerzijds en het effectieve gebruik van gezondheidszorg tijdens de zwangerschap en na de bevalling anderzijds. Resultaten geven aan dat **toegenomen kennis gerelateerd is aan het gebruik van pre-natale consultaties maar niet aan het gebruik van getraind personeel tijdens de bevalling of postnatale gezondheidszorg**.

Tenslotte werd **exploratieve factoranalyse** gebruikt om de perceptie van rurale vrouwen inzake de kwaliteit en gendergevoeligheid van gezondheidszorg in Kabale district (waar het initiatief van gendergevoelig budgetteren werd geïmplementeerd) te bestuderen. Uit dit deelluk van het onderzoek blijkt dat **rurale vrouwen in de setting waar het initiatief werd geïmplementeerd tevreden zijn met de kwaliteit en gendergevoeligheid van de diensten**, voornamelijk wat betreft de **beschikbaarheid van de uitrusting voor verzorging** van zwangere vrouwen en jonge moeders (zowel qua infrastructuur als personeel) en de **houding van gezondheidspersoneel** tegenover jonge moeders.

**Niet-parametrische** (Kruskal-Wallis H and Mann-Whitney U) **testen** werd uitgevoerd om verschillen na te gaan in de ranking van de kwaliteit en de gendergevoeligheid van de

gezondheidsdiensten tussen de drie settings. Resultaten hiervan geven aan dat **de rankings significant hoger waren in de gezondheidscentra in Kabale district in vergelijking met Kanungu (controle) district.**

Op basis van de studie kunnen **drie globale aanbevelingen** gedistilleerd worden. Allereerst wordt aanbevolen om een **genderdimensie te institutionaliseren op het niveau van output budgettering** bij lokale overheden. Op deze manier wordt gendergevoelig budgetteren en het opvolgen van performantie inzake gendergevoeligheid een vereiste voor technocraten. Ten tweede is het aangewezen om **lokale budgetclubs te ondersteunen** en te versterken wat kan bijdragen tot een grotere duurzaamheid. Ten derde worden best inspanningen geleverd om initiatieven van gendergevoelig budgetteren specifiek te richten op **het effectieve gebruik van gezondheidszorg** (en niet alleen op een grotere bewustwording van de aanwezigheid van gezondheidsdiensten & rechten inzake gezondheidszorg).

Met betrekking tot **evaluatiemethodologie** heeft de studie aangetoond dat theorie-gebaseerde evaluatie met process tracing, in combinatie met quasi-experimenteel onderzoek een gedegen evaluatie-benadering is. Verder wordt aanbevolen dat **evaluaties** van GRB initiatieven en andere gender mainstreaming interventies zelf **gendergevoelig** zijn en specifieke aandacht hebben voor ongelijke posities bij aanvang van de interventie, tijdens de interventie en na de interventie.

Voor wat betreft **verder onderzoek** worden een drietal specifieke pistes geïdentificeerd : i) hoe het effectieve gebruik van gezondheidszorg voor moeders stimuleren in settings waar de gezondheidszorg reeds gendergevoelig is, ii) hoe initiatieven van gendergevoelig budgetteren die zich situeren buiten de overheid duurzaam maken, iii) in welke mate blijven de bevindingen van dit onderzoek overeind in een andere setting, met andere actoren en andere specifieke activiteiten.