



MINING HEALTH INITIATIVE: CASE STUDY GUIDELINES

FINAL

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ACKNOWLEDGEMENT AND DISCLAIMER

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Led by Health Partners International and Montrose International, in partnership with the Institute for Development Studies and the International Business Leaders Forum, the Mining Health Initiative aims to expand mining's contribution to good health by marshalling evidence of good practice and leveraging existing structures and programmes to create standards of good practice for expanding partnership.

Any perspective, opinion or analysis represented in this paper may reflect the views of its author and cannot be attributed to UKAID from the Department of International Development, the World Bank's International Financial Corporation, the Rockefeller Foundation or HANSHEP. Responsibility for any errors or omission rests solely with the author.

¹ HANSHEP (Harnessing Non-State Actors for Better Health for the Poor) is a group of development agencies comprising the Rockefeller and Gates Foundations along with AusAID, DFID, KfW, USAID and the World Bank. It was established in 2010 with the aim of seeking to work with the non-state sector in delivering better healthcare to the poor.

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1 INTRODUCTION

1.1 Background and purpose

The Mining Health Initiative has been commissioned by the HANSHEP group to build understanding of, and foster agreement on standards for, mining industry public-private partnerships (PPPs) which work to strengthen health services for underserved populations.

The Mining Health Initiative will lead to:

- enhanced understanding of on-going mining health PPPs;
- good practice documentation on mining health programmes for wide dissemination and application

As part of this process, the Mining Health Initiative plans to conduct a number of case studies of health programmes run by mining companies in sub-Saharan Africa (Box 1). The purpose of the case studies is to document the reach and impact that has been achieved through such projects and examine the best ways in which these programmes can overcome practical challenges and achieve maximum effectiveness both in terms of costs and efficacy.

Box 1. Mining companies as health providers

Mining companies support health programmes in a variety of locations in sub-Saharan Africa, often in remote areas where public health services are unavailable, scarce or of limited quality. Such companies provide preventative and curative health services within the fence, to their workforce (themselves often drawn from the surrounding communities) and contractors. As part of a social investment or cooperate social responsibility programming they often also work outside the fence, providing health services to surrounding communities or at district or national level.

On occasion they may be the only service providers in the area, in other contexts they may work by supporting public health facilities or through other non-governmental partners.

The range, scope and impact of such programmes is rarely documented for the purposes of the development community yet such approaches are important sources of high quality and potentially lasting health services in low income countries; building on these programmes as opportunities for health development requires a better understanding of how they operate and how best they can achieve a cost-effective impact.

1.2 Case studies: audiences and intended impacts

There are a number of key audiences for the case studies with varying intended impacts:

- **The Mining Health Initiative and HANSHEP.** *Intended impact:* improved understanding of the scope, potential and most effective approaches for mining health PPPs; to inform the Mining Health Initiative's Phase III.
- **The donor community.** *Intended impact:* increased awareness of the potential for mining health PPPs as approaches to improving the health of hard to reach populations.
- **The mining sector.** *Intended impact:* increased awareness of the range of potential approaches and the opportunities for increasing impact and cost-effectiveness.
- **Other health sector organisations.** *Intended impact:* increased awareness of the opportunities for mining PPPs and of how best such partnerships may work.

1.3 Case studies: objectives

The case studies will contribute to constructive learning in the theory and practice of public private health partnerships. To be useful they must have sufficient depth and detail on the context, programmes, costs, outputs and outcomes (both expected and unexpected) as well as the practical experiences faced and overcome by the mining companies. To achieve this, the case studies have core descriptive objectives, which feed into the analytical objectives (Figure 1).

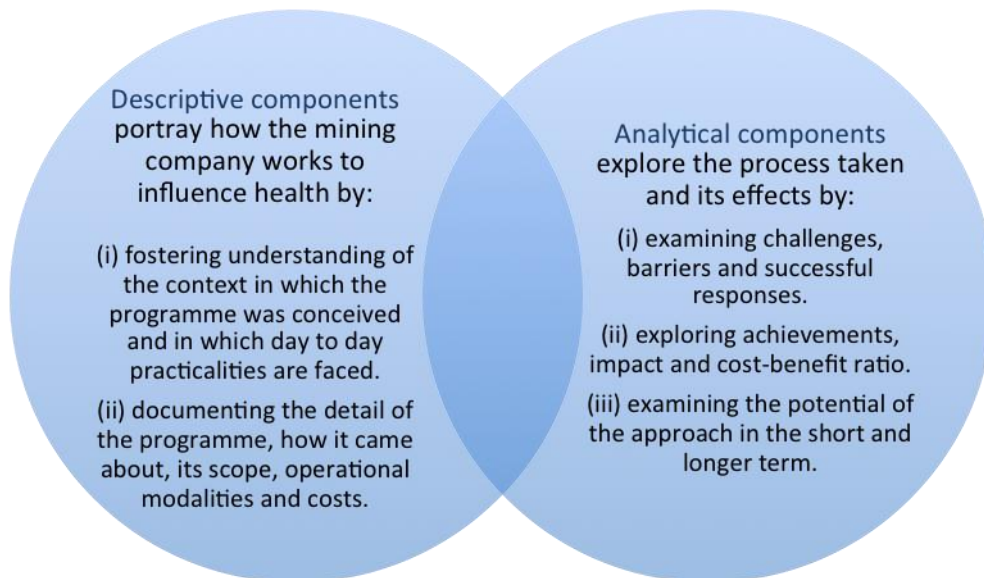


Figure 1. Objectives of the descriptive and analytical components of the case studies

Specific objectives of the case studies are to:

Describe:

1. The context of the area of operation in terms of:
 - relevant cultural and political aspects,
 - the demographic and epidemiological profile of the workforce and population,
 - the structure and functionality of the health system and other stakeholders involved in the health system,
 - the national health policy context.
2. Factors influencing the company's decision to initiate and continue health programming.
3. The objectives, scope, scale and quality of the health services provided by the company.
4. The plans, if any, for phase out and longer term impact.
5. The company's approach to interaction with the range of stakeholders: the public sector, civil society and potential beneficiary communities.
6. The partnership approach taken: who is involved, how do they work together.
7. Any changes in the delivery of public health services (planning, financing, management) that have resulted directly or indirectly from the company's intervention.

Analyze and document:

8. The costs of the intervention, as far as possible but potentially including financial and opportunity costs to the mining company, partners and communities.
9. The successes and achievements of the health intervention, including, as far as possible:
 - The immediate, mid-term and long-term health and social impacts including unforeseen positive and negative impacts and how they have affected the

relationship between the company and the public sector, civil society and communities.

10. The obstacles faced during the design, planning and implementation phases.
11. The barriers to expanding the package of health services or the geographical extent of health services currently provided.

1.4 Purpose of these guidelines

These guidelines are intended to ensure the different case studies undertaken are of similar depth, scope and format. Alongside this narrative guide are a number of separate tools that should be used to support both the collation of secondary data and the collection of primary data through qualitative methods (see Section 5). The 'Case Study Report Format' should also be referred to by the case study teams throughout.

2 CASE STUDY METHODOLOGY

A team of two consultants will conduct each case study, working closely with a technical task management team who will support consistency of depth and quality across the case studies.

2.1 Overall approach

Basic principles of good practice for case study development will be followed by the team to ensure the resulting information is as valid, reliable and richly detailed as possible (Box 2).

Box 2. General principles of the case study approach

- Use of as wide a range of data sources as possible.
- Multiple entry points: taking guidance on appropriate key informants from the range of people interviewed rather than just the initial contacts.
- An interactive approach: involving the company and other stakeholders in the process, drawing in their reflections at different stages.
- Not imposing coherence where it may not exist: attempting to reflecting multiple views to show the range of opinion, rather than trying to merge perceptions into one general view.
- Ensuring confidentiality and anonymity of the interviewees.
- Objectivity: the findings should be based as closely as possible on the primary and secondary data rather than on the researchers opinions or interpretations of these.
- Ensure clarity of purpose: not an evaluation, encourage discussion on challenges.

(including points modified from The Partnering Initiative's (2006) 'The Case Study Toolbook'²)

2.2 Activities

Whilst some basic activities will need to be undertaken it is important to be flexible in approach, responding to the context as well as preferences of stakeholders. For example semi-structured focus group discussions may be appropriate in some cases but one-on-one discussions more appropriate for the same group of stakeholders in other cases.

The case studies will involve data review and analysis, key informant interviews (semi-structured or free-ranging) and focus group discussions in order to complete the data collection requirements listed in Box 3.

The ideal key informants and participants in focus group discussions will depend on the scale of the health programme, Box 3 lists the most important respondents for programmes working in the local communities in the area of operation. However some health initiatives may operate at district or national level, especially on health promotion campaigns. In these cases additional key informants will need to be considered.

² Available from: http://thepartneringinitiative.org/publications/Toolbooks/The_Case_Study_Toolbook.jsp

Box 3. Data collection requirements.

Review of secondary data:

1. Cultural and political context, including national health policy context:
 - DHS reports, government policy documents and company documents will contribute though interviews will also be needed.
2. Demographic and epidemiological data:
 - Outside the fence: Including HMIS, DHS and other national surveys to identify key health indicators, relevant to the specific health intervention.
 - Within the fence: Analysis of company health data to identify main illnesses that have directly or indirectly contributed to decreased productivity among workers. Existing data from before and after introduction of the health intervention.
3. Description of existing health services in the mining company's area of operation – structure, functionality, type of provider, etc.
4. Information on the programme and partnership:
 - Programme reports, dissemination materials, partnering agreements etc.

Collection of primary data:

5. Key Informant Interviews with:
 - CSR or social investment (SI) representatives of the mining company
 - Rationale for intervention, design process and overall description
 - Sustainability plan
 - Partners and partnership modalities
 - Achievements, especially social impacts
 - Barriers or challenges faced in the design, planning, implementation
 - Financial costs, opportunity costs
 - Company Human Resources representative
 - Costs related to ill health and absenteeism
 - Company finance / accounts department
 - Costs related to ill health and absenteeism
 - Discussion of cost savings due to improved health
 - Costs related to health programme delivery
 - Information on commodities supply chain (may need operations department interview)
 - Partner organisations and local health authorities:
 - Partnership modality, role and involvement at all stages
 - Achievements, barriers and challenges
 - Perceptions of appropriateness, responsiveness to need and sustainability
 - Perceptions of or data on health and social impact of intervention on communities or on health system
 - Changes in perception of the mining company as a result of the programmes
 - Financial costs, opportunity costs
 - Company health clinic manager (and laboratory manager if relevant)
 - Review of records
 - Costs of treatment and care
 - Perspective on, and involvement with, community programme
6. Focus group discussions with:
 - Local workforce
 - Local community leaders
 - Local community representatives such as women's groups
 - Public health facility in-charges

To discuss:

 - Quality and accessibility of health services since implementation
 - Health status of community since introduction of the intervention
 - Equity of access and perspectives of different groups
 - Community perception of the intervention

2.3 Interview and focus group methodology

The discussion guides in section 4.3 should be used to guide the key informant interviews and focus group discussions. The following principles of good practice should be maintained:

- Not using leading questions
- Allowing silence and pauses, do not jump in too quickly
- Using non-committal verbal or visual encouragements that show you are listening but not leading them to think this is ‘what you want to hear’.

2.3.1 Key informant interviews

Written notes may be sufficient. If voice recording is planned this should be made clear during the informed consent process and notes will likely be needed as well. Notes should be reviewed soon after the interviews as possible.

2.3.2 Focus group discussions

A voice recorder should be used to record discussions, though it is likely a note taker will be useful to record visual cues and to allow immediate review.

If a translator is used for focus group discussions then the plans for the discussion and the questions should be discussed in detail prior to the group discussion. The translator should be briefed on good focus group discussion practice and asked to translate accurately without changing the meaning, abbreviating or expanding too much. If the translator has advice as to how abbreviations, expansions or changed meaning would be helpful then these should be discussed at the briefing prior to the group discussions.

The following good practice should be followed:

- Check on who has selected the participants and whether you are likely to get a good spread of opinions
- Check that the location for the meetings is likely to put the participants at ease
- To try and set the group at ease with talking in front of one another spend a few minutes at the start allowing everyone to introduce himself or herself and share some brief information.
- Notice if there are specific people who say little and try to draw them into the conversation, at first with visual cues (looking at them, nodding towards them) and then directly if necessary (e.g. “And what about you? Do you have any thoughts?”)

2.4 Record keeping and photos.

Voice recordings of group discussions and notes from interviews should be compiled and retained as the raw dataset that will be stored following the case studies. The excel data entry template should be completed (and expanded where necessary) to ensure all numeric data is available in a standardised format in one place. Ensure there is a digital camera within the team and take high-resolution photos of as much of the field work as possible particularly within the clinics and communities. All data remains the property of the Mining Health Initiative.

2.5 Ethical issues

A standard informed consent form should be signed by all interviewees, whether company, partner, stakeholder or community representatives. The purpose of the work should be explained and discussed as necessary to ensure true informed consent.

3 AREAS TO ADDRESS IN THE CASE STUDY

Table 1 (following pages) is taken from the excel data entry template. It gives an overview of the issues that must be considered during the case study, organised by component. This relates closely to the structure of the case study report format. Guidance on possible sources of information are shown.

Following Table 1 more guidance is provided on the rationale for different components and issues within them.

Table 1. Overview of issues to consider

Component	Issues to consider	Information sources
1. SITUATION ANALYSIS		
1.1 Company profile	<ul style="list-style-type: none"> a. Turnover for the site and country as appropriate b. Size of workforce for the site and country as appropriate c. Area of work (mining what) d. Location (within country and no. and type of sites etc.) (map) e. Time in country and phase out plans 	Company interview and documentation
1.2 Demographic profile	<ul style="list-style-type: none"> a. Population breakdown: national, area of operation (relevant administrative areas) b. Social characteristics: poverty levels, employment types, urbanisation, school enrolment rates, adult literacy, transport infrastructures 	DHS, Census
1.3 Epidemiological profile	<ul style="list-style-type: none"> a. Five main causes of: mortality; childhood mortality; inpatient attendance; outpatient attendance b. Specific measures of target diseases over time (to cover period before and after intervention for later analysis of impact; e.g. incidence, proportion of outpatient cases due to certain disease etc.) c. Any information on equity of health in this area (by gender or socio-economic status) 	DHS, HMIS
1.4 Health system	<ul style="list-style-type: none"> a. General structure (de/centralised; administrative levels; responsibilities at each level) b. Split of service provision between public, private-for-profit, private-not-for-profit c. Functionality as measured by: staffing levels; proportion of population living within 5km of health facility; proportion of health facilities reporting stock-out of essential medicines per month) with before and after information as far as possible d. Costs of services. i.e. What would be the cost of services similar to those provided by the company PPP if that company PPP were not in place? 	Local health authority interview, MoH documentation, HMIS data
1.5 Stakeholders and other local projects	<ul style="list-style-type: none"> a. Names and services offered by other stakeholders working in health provision in the area b. Relationships (good / bad; current / previous) between company and other stakeholders including different sections of society / communities. 	Company, partner, local health authority and stakeholder interviews
1.6 MOH strategic priorities	<ul style="list-style-type: none"> a. Priority areas within national health sector strategic plan b. Priorities within specific subject area of interest 	MoH documentation

Component	Issues to consider	Information sources
2. PROGRAMME CHARACTERISTICS		
2.1 Conception process	<ul style="list-style-type: none"> a. What was the specific prompt leading the company to decide to develop a health programme? Who was the initiator / driver who made it happen? (e.g. was an outside company / individual paid to take it forward?) b. When and what process was taken to select priorities for the health programme? (Health needs assessment / health and social impact assessment / health equity audit?) c. Involvement of partners / stakeholders in conception process d. Rationale for selection of priorities (esp. if in contrast with communities' perceived needs / stakeholders recommended priorities / government strategic priorities) 	Company, partner and community interview
2.2 Design of the programme (within and outside the fence)	<ul style="list-style-type: none"> a. Target beneficiaries b. Services offered c. Type of delivery model (e.g. vertical, integrated, PPP, private etc.) d. Who are the partners and what is the general partnership model? (see more detail in 2.4) e. Extent of integration with national health plan and national health priorities 	Company and partner interview
2.3 Plans for wider impact	<ul style="list-style-type: none"> a. Any plans for scale up or replication of the programme outside the area? b. Any plans for uptake within national policy? c. Any phases / timeframe considered for programme? d. Any consideration of sustained impact (e.g. handover to government/partners or wider systemic improvements)? 	Company and partner interview
2.4 Partnership (including government): structure and functionality	<ul style="list-style-type: none"> a. Partners' name and roles (e.g. involved in implementation, management, strategizing, monitoring?) b. Partners' involvement in different phases, e.g. conception, after phase out of company c. Who brokered the partnership and how was it done? Is there a formal partnership agreement? What is the mode and frequency of interaction? d. Is the partnership of benefit to the company? To the other partners? e. What are the partners' strengths? Are there any capacity weaknesses related to their specific roles? Did the partners' capacity need to be built in any way? (technical / management / accounting). f. Has the partnership proved efficient? What partnering knowledge/skills/capacity were necessary/would have been useful to make the partnership happen more easily/effectively? g. What are the trade-offs between inefficiency and benefits in capacity building or politics? h. What were the biggest challenges in developing or maintaining the partnership, how were these overcome? 	Company and partner interview
2.5 Governance, monitoring and oversight process	<ul style="list-style-type: none"> a. Breakdown of responsibilities: strategizing, management, oversight, delivery, monitoring, evaluation b. Methods used to monitor inputs, process and outputs and to evaluation of impact d. Responsibilities for monitoring and evaluation 	Company and partner interview

Component	Issues to consider	Information sources
3. PROGRAMME COSTS		
3.1 Within the fence services	a. Breakdown of costs involved in start up and running of health clinic (see programme costs worksheet of excel data entry template for detail)	Company interview and documentation
3.2 Outside of the fence services	a. Breakdown of costs involved in start up and running of community health programme (see programme costs worksheet of excel data entry template for detail) to include <ul style="list-style-type: none"> - Partner costs (total and breakdown if available) - Community costs (e.g. inputs for watsan activities etc., fees for health services) - Costs to government health facilities (e.g. additional staff time) 	Company interview and documentation
3.3 Financing modalities	a. Sub-grants? Performance-based? Co-financing?	Company interview and documentation
3.4 Cost effectiveness	a. How do the companies / partners themselves monitor cost and do cost benefit analyses? b. Costs per beneficiary (direct and indirect, within and outside the fence).	Cost data, beneficiary data. Excel template.
4. PROGRAMME BENEFITS AND IMPACT		
4.1 Employees and families	a. Beneficiary numbers (e.g. total workforce and families who benefit from any services, either company clinic or other). b. Impact on health of workforce assessed through health clinic data and HR records: incidence of target diseases over time, total consultations over time, proportion of potential working hours lost due to illness, mean hours per employee lost due to illness etc. as appropriate. c. Any other benefits / negative impacts?	Company clinic records, company HR records
4.2 Communities	a. Direct and indirect beneficiary numbers b. Impact on disease: incidence of specific diseases (See Guidance in Narrative Guide) c. Impact on access to services: availability of health services, availability of prevention tools d. Any other benefits / negative impacts?	a,c. Company, partner interview and documentation; b,c. HMIS
4.3 Mining company	a. Cost savings due to less money lost to ill-health. Calculation required of costs to company of ill-health in the workforce (see guidance in narrative guide) b. Improved reputation within communities / government which may improve social capital c. Any other benefits / negative impacts? (concrete or perceived)	Company, partner, local authorities and community interviews
4.4 Local government and health system	a. Specific support provided to the health system? E.g. vehicles, infrastructure, training etc. b. Indirect benefits to health system through improved reputation from better quality of service, potential for future partnerships / securing funding etc. Other benefits? (concrete or perceived) c. Any problems caused by the programmes (e.g. loss of staff to it?; competition for funding?) Any other negative impacts?	Company, partner and local health authority interviews

Component	Issues to consider	Information sources
5. STAKEHOLDER PERSPECTIVES		
5.1 Beneficiaries	<ul style="list-style-type: none"> a. Perceived benefits / negative impacts b. Perceived impact on equity (gender and SE status) (positive or negative) c. Recommendations (e.g. is the programme serving a real need, could it have been done better? Could it have addressed other issues more usefully? How can impact be sustained? How can scope be scaled up? How could negative impacts have been reduced?) 	Company, partner and community interviews
5.2 Partners (including government)	<ul style="list-style-type: none"> a. Perceived benefits e.g. to the communities, to themselves (e.g. improved capacity? To deliver, to secure funding in future etc.) Perceived negative impacts? b. Perceived impact on equity (gender and SE status) c. Recommendations (e.g. is the programme serving a real need, could it have been done better? Could it have addressed other issues more usefully? How can impact be sustained? How can scope be scaled up?) d. Any problems caused by the programmes (e.g. loss of staff to the company programme?; competition for funding?) 	Partner interviews
5.3 Other health stakeholders	<ul style="list-style-type: none"> a. Perceived benefits e.g. to the communities, to themselves (e.g. improved capacity? To deliver, to secure funding in future etc.). Perceived negative impacts? b. Recommendations (e.g. Could it have been done better? Could it have addressed other issues more usefully? How can impact be sustained? How can scope be scaled up? How could negative impacts have been reduced?) 	Company and local health authority interview
6. ANALYSIS OF PROGRAMME STRENGTHS (in addition to that covered above)		
6.1 Strategic issues	<ul style="list-style-type: none"> a. Do the costs outweigh the benefits of resource inputs into this programme b. How sustainable is the current programme. How sustainable is it intended to be? c. Is it cost-effective? Compared to other programmes? 	Company, partner, local health authority and community interviews. Document review, impact data, cost data.
6.2 Operational constraints	<ul style="list-style-type: none"> a. What issues have proved problematic in the following areas: funding, community and stakeholder acceptance, personnel, logistics, maintaining quality. b. What are the challenges for scaling up or replication? c. What are the challenges for sustaining impact? d. Which areas consume unnecessary resources? e. In which areas has the programme been particularly efficient? 	Company, partner, local health authority and community interview. Document review.

Below is further guidance on the rationale for different components and issues within them is given.

3.1 Situation analysis

Basic demographic and epidemiological information is needed to contextualise the work undertaken by the company, as well as to examine impact on disease (the latter is discussed further in Section 4).

An overview of the health system, other stakeholders, the company's relationships with them and the national policy context are also important to frame the programme.

3.2 Description of the programme

It is important to clarify early on the details of the programme itself, as this will guide decision-making on the appropriate approaches to measuring impact and cost. Considerable detail about the programme is needed, covering the phases from needs assessment to design, implementation and evaluation. In particular, it is important to understand the objectives of the company health programme (within and outside the fence), from the point of view of the company and relevant partners. Evaluation of impact will be in terms of these stated objectives.

3.3 Guidance on measuring impact

A case study is not designed to be a robust impact assessment. Nevertheless it will be possible to gather some indication of impact in a number of ways. It is first important to review the types of impact with which we may be concerned for certain of these case studies, such as impact on:

1. Health of the workforce
2. Health of the community
3. Health system functionality, where appropriate
4. Productivity of the workforce and sickness-related costs
5. The social capital of the company
6. Improved capacity of local partners

When considering impact using the case study approach the researchers will need to consider a wide range of other potential influences on the indicators in order to carefully discuss the likelihood of impact being due to the programme. Guidance on these is given in the sub-sections below.

3.3.1 Impact on health

In some cases the company will have undertaken evaluations that may provide robust data. In other cases, potential impact will have to be considered by a review of routine data, comparing the situation before and after the initiation of the programme and, where possible, to areas where the programme has not been supported.

Other possible influences on changes that should be considered include:

- Particular weather conditions that may impact on disease transmission or on other lifestyle determinants of health such as availability of safe water and nutrition

- Major changes in the age or gender profile of the workforce which may affect overall rates of ill-health or time off (e.g. if time off for pregnancy is recorded in the same way as sick days, as is the practice with some companies)
- Other disease specific or general health intervention programmes in the area undertaken by the government or other stakeholders
- Increased access to specific treatment or prevention tools through the private sector
- Dramatically improved road networks or employment opportunities than may change treatment seeking behaviour or generally improve opportunities for health.

3.3.2 Impact on health system functionality

This may be appropriate to include if the programme specifically aims at system strengthening, or if this is likely to be an associated benefit because of the approach taken.

Simple indicators of health system availability and functionality will be feasible to assess. Appropriate indicators will be linked to the specific problems that the programme was designed to address such as improved referral procedures, improved equipment, reduced stock outs or improved staffing levels. Possible indicators to be selected as appropriate are shown in Table 2.

Indications of improved alignment to national policies and procedures could be assessed through examination of availability of national guidance documents, links to the national referral system, and alignment with the national Health Management Information System etc.

Measuring quality of care will be difficult without thorough health facility assessments - unlikely to be feasible within the timeframe of the case study field work. Some indicative measures of quality could include: (i) are policies and protocols for infection control in place, are the equipment and supplies needed to implemented these in place; (ii) rational prescription for key diseases (e.g. does the register show patients diagnosed with malaria were prescribed anti-malarials) (iii) do staff have basic knowledge about the symptoms and appropriate treatment for key diseases.

Other potential influences on changes that should be considered include:

- Other health system strengthening programmes underway either by non-governmental/private partners or national governments.

3.3.3 Impact on productivity of the workforce and sickness related costs

Measuring this will rely heavily on data from the company and their understanding of their workforce and its performance. Some companies, such as AngloGold Ashanti, may have considered this in detail already, at the qualitative as well as quantitative level, and have data available for use. Other companies may not have done so and the case study will need to discuss with the company use of financial records to explore:

- Costs associated with employee ill health (direct and indirect costs to the company per absentee day, or per employee with HIV for example). These costs can then be linked to records of illness in the workforce to estimate impact in terms of cost savings resulting from reduced illness / absenteeism due to either treatment of preventative programming by the company.
- Employee productivity (outputs per employee in terms of company profit or commodity) which can be plotted over time to estimate impact of scaled up health services.

Other potential influences on changes that should be considered include:

- Other company initiatives that may change employee enthusiasm, work ethic (e.g. bonus schemes for productivity starting or ending).

3.3.4 Impact on the social capital of the company

Defining and measuring social capital is challenging given the range of understandings of the term. However the reputation of the company will directly impact on the social capital and is within the scope of the case studies to assess this. Qualitative assessment of the company's reputation should be conducted through the key informant interviews and focus group discussions which will specifically discuss relationship between the health services provided and the perceptions of the company.

Other potential influences on changes that should be considered include:

- Impact on reputation of the company due to the employment opportunities it brings or due to other activities it undertakes
- Changing reputation of the company relative to that of other companies / actors in the area

3.3.5 Impact on the capacity of local partners

This will be a qualitative assessment of impact through interviews with partners themselves, both private (for-profit or non-for-profit), NGO or government. Influences may include positive impact through intentional capacity building in terms of funding, equipment, infrastructure technical, management or fund raising skills. Negative impacts could include drawing down of personnel e.g. from government facilities to the company programme.

Other potential influences on changes that should be considered include:

- Other support provided to partners
- Partners access to funding

3.3.6 Challenge of assessing impact on equity

Ideally the case studies will give an indication of the programme impact not just on health overall but on the equity of health, by socio-economic status and gender.

A first step of the assessment will be to consider how far equity is included and addressed in the programme design and implementation; including:

- At what stage in the process this issue was considered
- What programme components are included to specifically address equity
- How the company monitors and evaluates impact on equity
- How particular sectors of the population are targeted for feedback

Determining impact on equity will be more problematic. For the health programming that benefits non-employees, the main source of health data will be the HMIS which does not breakdown disease reporting by gender or socio-economic status. It may be possible to examine proxies for socio-economic equity of impact by looking at relative impact in rural and urban areas (by comparing sub-sets of the HMIS data from health facilities with primarily urban or primarily rural catchment areas; preferably by comparing health facilities

of the same level to avoid the higher health facilities will be in urban areas and, as referral facilities, see a different cross section of health issues from the lower health facilities).

An important component will be perceived impact on equity (including issues around perceived appropriateness, access and quality) can be explored through focus group discussion with community and women's groups. This will be an important component.

For services offered to company employees (and families) through the health facility it will be possible to look at least at differences by gender and perhaps by pay-scale (if data are collected in this way). Possibly more detailed issues of equity can be discussed depending on the structure of the HR records or the details of the compensation and benefits schemes used by the company.

3.3.7 Indicators

Appropriate indicators will vary from case to case depending on the programme objectives, the way in which data is collected and organised by the company and health facilities, and on characteristics of the catchment population (i.e. how clear that is, both for the workforce and the targets of wider health programmes). Table 2 lists some indicators that may be appropriate for estimating impact in a range of areas.

For numeric indicators inference of impact will be by looking at changes over time, before company intervention, during and to the present, with, as discussed above, appropriate consideration of other potential influences on these indicators. Presentation of the changes over time should be by line graph by month / quarter / year indicating time of programme initiation, specific programme activities or scale up activities.

Table 2. Assessing impact: potential indicators

Area of impact	Possible indicators	Source of information	Additional information
1. Impact on health of the workforce	Percentage of work days / hours lost to illness per time period, potentially disaggregated by pay scales and gender (month, quarter, year etc)	Company clinic / HR records	<p><i>Numerator:</i> number of days / hours lost where personnel were recorded as absent due to illness.</p> <p><i>Denominator:</i> total potential working hours / days based on size of total workforce and normal working hours per day and days per time unit chosen.</p> <p>Avoid using whole numbers which will be highly sensitive to changes in the size of the workforce.</p> <p>Check that the denominator reflects the total pool of personnel on whom information would be recorded in your source of data on hours / days lost (e.g. check whether contractors are / are not included in one or other set of data).</p>
	Mean number of work hours / days per person per time period lost to illness	Company clinic / HR records	This indicator may be more flexible to situations where the length of the working day or the shift period differs for different subsets of the workforce.
	Percentage of clinic consultations due to a specific target disease	Company clinic records	<p><i>Numerator:</i> number of clinic consultations due to specific disease</p> <p><i>Denominator:</i> total number of clinic consultations</p> <p>Appropriate if the health programme targets specific diseases.</p>

Area of impact	Possible indicators	Source of information	Additional information
2. Impact on community health: including health status and access to key services.			<p>For this area of impact in particular the most appropriate indicators will depend on the objectives of the company's health programme.</p> <p>Most standard indicators relating to the Millennium Development Goals 4, 5 and 6 (child, maternal and disease specific health) are included as are some additional indicators for HIV, TB and malaria. These standard indicators are included for completeness only as they may be appropriate in some cases; in others it will not be appropriate to use these in relation to the company programming as data may only be available from DHS or similar national surveys. This (i) may not be disaggregated as sufficient detail to give indications specific to the catchment area of the programme and (ii) only take place every 5 years or so, so may not provide data on an appropriate time frame.</p> <p>Indicators below which fall into this category are indicated.</p>
	Percentage of outpatient consultations due to specific target disease	HMIS using records from health facilities within the catchment area of the programming.	<p><i>Numerator:</i> number outpatient consultations / admissions due to specific disease</p> <p><i>Denominator:</i> total number of outpatient consultations / admissions</p> <p>Less sensitive to overall changes in health facility utilisation but disease specific motivators should be considered, e.g. lack of specific medications or availability of specific medications in private facilities / drug shops.</p>
	Percentage of admissions due to specific target disease		Number of cases per 1,000 person years.
	Prevalence of specific target disease	DHS, with caveats above	<p>If cross sectional survey data (e.g. DHS) are not available then impact assessment should consider routine data on incidence, rather than prevalence.</p> <p>If prevalence is used it is normally appropriate within specific age groups (15 – 24y for HIV; under 5 of under 14y for malaria, depending on endemicity).</p>

Area of impact	Possible indicators	Source of information	Additional information
Continued: 2. Impact on community health: including health status and access to key services.	Under five mortality, expressed per 1,000 live births	DHS, with the caveats above	<i>Numerator:</i> Number of deaths in children under five in given year <i>Denominator:</i> Total number of live births in given year
	Infant mortality rate	HMIS or DHS with the caveats above	<i>Numerator:</i> Number of deaths in children before their first birthday in given year <i>Denominator:</i> Total number of live births in given year
	Proportion of 1 year old children immunised against measles		<i>Numerator:</i> Number of 1 year old children reported / recorded as having received at least one dose of measles vaccine <i>Denominator:</i> Total number of 1 year old children in survey / catchment population from which data above are drawn.
	Maternal mortality ratio, expressed per 100,000 live births		<i>Numerator:</i> Number of women who died from a cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, <i>Denominator:</i> Total number of live births
	Proportion of births attended by a skilled birth personnel		<i>Numerator:</i> Number of deliveries attended by a skilled birth attendant <i>Denominator:</i> Total number of deliveries Skilled health personnel include only those who are properly trained and who have appropriate equipment and drugs. Traditional birth attendants, even if they have received a short training course, are not to be included.
	Percentage of the population receiving an HIV test, the results and post-testing consultation		Specific programme registers, HMIS records if company provides services through / support to the public health
	Percentage of people with advanced HIV infection with access to antiretroviral combination therapy.	<i>Numerator:</i> Number of people with advanced HIV infection who have access to antiretroviral combination treatment according to the nationally approved treatment protocol (or WHO/UNAIDS standards) <i>Denominator:</i> Number of people with advanced HIV infection	
	Percentage of PLWHA, receiving	<i>Numerator:</i> Number of PLWHA seen at HIV testing and counseling or HIV treatment	

Area of impact	Possible indicators	Source of information	Additional information
Continued: 2. Impact on community health: including health status and access to key services.	HIV testing and counseling or HIV treatment and care services, who were screened for TB symptoms.	facilities, or programme records	and care services who were screened for TB symptoms, over a given time period <i>Denominator:</i> Total number of PLWHA seen at HIV testing and counseling or HIV treatment and care services, over the same given time period
	Percent of new smear-positive pulmonary TB cases that are successfully treated.	Specific programme registers, HMIS records if company provides services through / support to the public health facilities	<i>Numerator:</i> Number of new smear-positive pulmonary TB cases registered under DOTS in a specified period that subsequently were successfully treated (sum of WHO outcome categories 'cured' plus 'treatment completed') <i>Denominator:</i> Total number of new smear-positive pulmonary TB cases registered under DOTS in the same period
	Default rate for TB treatment completion	Specific programme registers	<i>Numerator:</i> Number of TB patients completing treatment <i>Denominator:</i> Total number of TB positive patients started on treatment
	Proportion of households in target area that have been sprayed in the past 3 months	Programme records	<i>Numerator:</i> Number of households completely sprayed in the past 3 months (or other depending on insecticide used) <i>Denominator:</i> Total number of households targeted
	(i) Proportion of under fives who slept under and LLIN the previous night (if survey data available) or, (ii) Number of LLINs distributed as a proportion of the households in the area.	Programme records	(i) <i>Numerator:</i> Number of children under five reported to have slept under an LLIN last night <i>Denominator:</i> Total number of children under five listed in the households surveyed This is a standard MDG indicator though it may also be appropriate to consider the proportion of households with sufficient LLINs or the proportion of households with 1 or more LLINs. OR (ii) <i>Numerator:</i> Number of LLINs distributed in previous 2 years <i>Denominator:</i> Total number of people in catchment area where LLINs distributed

Area of impact	Possible indicators	Source of information	Additional information
3. Impact on health system functionality	Proportion of health facilities offering specific services	Interview with local health authorities and partners.	May be appropriate if programme has aimed to scale up availability of services such as ITNs at ANC, HIV testing and counselling etc. Simple comparison before and after intervention with clear discussion of role of programme in improving availability compared to other stakeholder / government support.
	Number of inpatient beds per 10,000 population (10,000 is accepted standard, modified if necessary)	Interview with local health authorities.	Appropriate only if programme has been supporting expansion of health facility inpatient capacity or number of health facilities with in patient capability. Simple comparison before and after intervention with clear discussion of role of programme in improving availability compared to other stakeholder / government support.
	Number of health workers in place per 10,000 population (10,000 is accepted standard, modified if necessary) Number who have received training from a company supported programme.	Interview with local health authorities.	Appropriate if programme is involved in supporting training / retention rates etc. Simple comparison before and after intervention with clear discussion of role of programme in improving availability compared to other stakeholder / government support.
	Stock out rates of selected essential medicines	HMIS records	Detail of indicator will depend on what information is included in the HMIS reporting in case study country. Proportion of health facilities with selected indicator medicines stocked out for >7d each month for the previous 3 months.
	Proportion of patients diagnosed with specific target disease who received appropriate treatment	Health facility record review	If sufficient time available to allow on the spot review of written records. Considerations given the case study teams' right to enter and review health facility records from non-company clinics.

Area of impact	Possible indicators	Source of information	Additional information
4. Impact on health related costs to company (including productivity of the workforce and sickness related costs)	Mean cost to company due to ill health per employee per time unit.	Company financials, interview, clinic records	<p>The premise is to allow measurement of a reduction in costs to the company due to illness, over time, potentially showing changes in illness-related costs overtime.</p> <p>Mean hours or days lost to illness per employee will be known. If the mean cost associated with these hours / days lost is known then the mean sickness associated company costs per employee per time period can be calculated.</p> <p>Estimating the mean direct and indirect cost due to one hour or one day of sick time will (a) require detailed information and (b) can be calculated in a number of ways so clarity on assumptions and calculations is vital when reporting.</p> <p>Costs associated with each hour / day lost to illness will need to take the following into consideration:</p> <p>Direct costs:</p> <ul style="list-style-type: none"> - Treatment and care costs (may relate better to illness episode and then need to be averaged per day / hour) - Benefits payments (should be feasible to estimate per hour / day) - Payment of replacement personnel (possibly including recruitment and training) <p>Indirect costs:</p> <ul style="list-style-type: none"> - Additional supervisor time for replacement personnel - Vacancy until replacement in place - Possible poorer productivity of temporary replacement.
	Mean outputs per employee per hour / day	Company financials, interview,	HR or other company department may have data on productivity by output e.g. commodity. If so this can be used to estimate mean output per employee per hour / day and examine changes in this over time linked to clinic and community programme performance.

Area of impact	Possible indicators	Source of information	Additional information
5. Impact on reputation of the company	Perspective of community on company	Community focus groups	Qualitative assessment of community perspectives of the company
	Perspective of partners and other stakeholders on company	KII with partners and stakeholders	Qualitative assessment of partner and other stakeholders perspectives on the company
	Self-assessment of reputation of company	KII with company CSR rep or other	Qualitative assessment of companies own perspective on their reputation
6. Impact on capacity of local partners	Self-assessment of capacity to secure funding for and deliver health care to the communities	KII with partner representatives	Qualitative assessment of partner capacity to secure funding and deliver services.
	Perspective of company on their impact on partner capacity	KII with company CSR rep	Qualitative assessment of partner capacity to secure funding and deliver services.

3.4 Guidance on measuring costs

This section of the case study will examine the costs involved in providing health services. Note that financial information will also be considered when looking at the benefits of the health programme in reducing sickness-related costs, but this component is quite distinct.

Detailed costing information would be ideal but may not be accessible. As a minimum it should be possible to get the provider perspective information below:

- An overall figure of the financial costs involved in the start up and running of the company clinic; can be used to look at cost per employee treated or per sick day averted.
- An overall figure of the financial costs involved in the start up and running of the community health programme; can be used to look at cost per beneficiary (e.g. person treated, protected, accessing a service).

However efforts should be made to go further than this to include:

- Breakdown of financial costs by area including:
 - *Direct costs*
 - Recurrent costs
 - Delivery personnel (all associated costs including wages, benefits etc)
 - Commodities (including transport costs)
 - Supplies (including transport costs)
 - Running costs
 - Grants to partners
 - Capital costs
 - Infrastructure and equipment
 - *Indirect costs*
 - Management time and costs
 - Other overheads
- Estimation of economic costs if it is likely to be considerably different (e.g. if large donations of expensive drugs were received or if public health facility personnel or community volunteers worked on the programme with no associated financial outlay from the company). Consider:
 - In kind contributions by community (e.g. in latrine building)
 - Volunteer costs
 - Materials costs
 - Health facility personnel time
 - Partner personnel time

The excel data entry template includes guidance on, and a template for, information to be collected (Worksheet: "Programme Costs").

4 CASE STUDY TOOLKIT

4.1 Overview of tools

A number of tools are available to guide the case study data collection process (Table 3, following page). The purpose of the tools is to promote consistency across the case studies that will take place and ensure the information collected is at a similar level of depth for each programme studied.

4.2 Modification of tools

These tools are designed to be appropriate for a range of contexts and programmes with different health objectives. However, to be fit for purpose, considerable contextual modifications will be necessary. The tools are intended as a guide only; the onus is on the research teams conducting the case studies to ensure that sufficient and appropriate data are collected. In particular, the most appropriate indicators or approaches to assessing impact will be different from setting to setting. The following section discusses the issue of measuring impact within the case study approach.

Modifications to discussion guides will also be needed once documentary sources have been examined. Some overview information may already be available through such documents and the interviews can then focus rapidly in on the detail of the management experience.

Table 3. Overview of Case Study Toolkit

Tool	Description	Location
Overview checklist	Table of data needed, issues to consider, sources of information and associated tools, by component. Can be used as checklist to track collection of information on all key points.	Worksheet 1 of excel data entry template and Table 1 in this document
Preparation checklist	Includes list of documents to review and list of meetings needed, for advance requests to companies prior to case study team arrival.	Annex 3 of this document
Excel data entry template	Multipurpose file, primarily for collation of numeric data allows automatic creation of figures for some analyses. Additional section for record keeping of meetings.	Associated file “MHI - Case study data entry template.xlsx”
Key informant interview guides: <ul style="list-style-type: none"> • Company social investment / CSR representative • Company HR department • Company accounts department • Local health authorities • Company health clinic manager • Partner representatives 	Semi-structured discussion guides for use in key informant interviews. To be modified as appropriate to the context.	Section 4.3 of this document
Focus group discussion guides: <ul style="list-style-type: none"> • Community leaders • Community representatives (incl. women’s groups) • Workforce representatives 	Semi-structured discussion guides for use in focus group discussions. To be modified as appropriate to the context.	Section 4.3 of this document

4.3 Interview and discussion guides

The following pages include guides for key informant interviews and focus group discussions. The pages are marked for ease of reference during field work though it may be that photocopying each page as needed may be easier for field use.

The interview guides include questions that should be used flexibly as the discussion progresses, some may be too repetitive for example, if the previous question has already addressed the issues.

KEY INFORMANT INTERVIEW GUIDE 1

INTERVIEWEE: Company social investment / CSR representative

INTRODUCTION:

- Thank the interviewee for their time. Tell this this interview will take around 1.5 – 2h.
- Provide initial briefing using the informed consent form and get signature.
- Explain the purpose of this specific interview: *To gain more detailed insight into the health programme run by the company, how it was conceived, its design, challenges and achievements.*
- Ask if the interviewee has any questions.

INTERVIEW QUESTIONS:

1. Please give an overview of the health services provided to your workforce.

Probe: Who can access these? (Contractors? Families? Wider communities) Try to get an accurate as possible catchment population); Do clients bear any financial costs? What services are offered / not available? What support is provided for referral?

2. Please give an overview of the activities / programme where you work to improve health in the wider community.

Probe: What are the main objectives? Who are the intended beneficiaries? (Try to get as near as possible to an accurate catchment population, ask for or use a map or list of villages to discuss and gain clarity). What areas of health are covered? Are any associated services provided (in particular those where cost share may be an issue (e.g. some companies may have an education programme and a health programme with some costs shared). Which partners are involved? What is the delivery approach (private, PPP, NGO mix etc)? When did the programme begin?

3. How was the community programme conceived? Specifically, what problems was it designed to address and why?

Probe: Why was the decision to start a health programme taken? Who drove this process? Was there a needs assessment process? Who was involved (authorities? community? potential partners?)? What were the findings? What drove the decisions for the scope of services and scale of the project (catchment population)? How were partners selected? Was a link to the national health plan part of the consideration?

4. How is the programme managed?

Probe: Personnel (company and partners) involved in strategic management: roles, frequency of involvement. Personnel (company and partners) involved in strategic management: roles, frequency of involvement. Management time involved. Government involvement.

5. How are the services delivered?

Probe: Integrated into health services (through public / private / government / partner clinics?); vertically (e.g. stand alone indoor residual spraying programmes, stand alone HIV testing and counselling / TB treatment and support services in new locations etc). Routinely available services or intermittent (e.g. campaigns). Where are your personnel drawn from (probe for drawn down from government / partner personnel)?

6. How do you work with your partners (including government)? Does it work well? Could it work better?

Probe: Who brokered the partnership? Details on partners, who does what, interface mechanisms, shares of costs. Are there any skills (in partnering processes) that would have made the partnership easier to form and maintain? Were any conscious decisions made to sacrifice potential efficiency for other benefits (e.g. political; capacity building)? Probe for a good level of detail the benefits and challenges of the partnership.

7. Are you able to measure if the programme is performing cost-effectively, on target and achieving impact?

Probe: How is the programme monitored? Any data on impact in terms of reduction of specific disease, overall health improvements or benefits to the health system as a whole? Any baseline data?

8. Do you consider the programme to have had other impacts that the routine monitoring or programme evaluations do not capture?

Probe: e.g. acceptance of company by communities / authorities? Reputation of company. Consider positive and negative.

9. What are your thoughts on how well the community programme has worked? Do you have suggestions as to how it could have achieved more / been more efficient?

Probe: Partnership challenges. Management challenges. Community acceptance. Particularly probe for considerations of efficiency: personnel time, commodity needs, partnership approaches, potential for wider impact to improve cost benefit ratio.

10. We would like to build an understanding of the financing of such programmes:

- i. Where did the start-up investment come from?
- ii. What is the financing modality? Co-financing? Grants to sub-recipients / implementers? Results-based grants? Volunteer inputs / community time?
- iii. Were there any costs related to building partner capacity?
- iv. Has any external support been provided to the programme? E.g. Drug supplies, volunteer labour, use of public facilities, donor funding etc?

Probe: Costs for within the fence services versus outside the fence services. Detailed costing will be explored with the accounts department. If this interviewee is likely to have good detail then refer to accounts KII guide now for questions.

11. Do you think the community health programme could be successfully broadened in scope of target population? What challenges or benefits would this bring?

Probe: Potential increase in efficiency and benefit: cost ratio. Barriers to scale-up or replication.

12. What are your plans for the future?

Probe: Any specific phases/ timeframes planned? Any expansion planned? Probe for issues around how this would be possible, what the challenges and barriers would be. Is there an intention to have a wider impact either beyond the programme area or an impact that is sustained after the programme ends? Has any such replication or wider impact taken place already

13. What are the top three pieces of advice you'd give to any company / health authority considering setting up a health PPP?

CLOSE:

- Thank the interviewee and ask if they have any questions.
- Review list of documents / materials you have discussed and check when you can get them.
- Ask if it is OK if you contact them again for further information or to check any points.
- Give them your contact details in case they have any further questions for you.

KEY INFORMANT INTERVIEW GUIDE 2

INTERVIEWEE: Company Human Resource department

INTRODUCTION:

- Thank the interviewee for their time. Tell them this interview will take about 1h.
- Provide initial briefing using the informed consent form and get signature.
- Explain the purpose of this specific interview: *Our main task is to understand how the company health programmes (both within and outside the fence) are run and achieve impact. Part of this is to look in some detail into the cost implications ill-health has on the company, the costs that the company bears to run the health programmes and the benefits to the company in terms of improved productivity or lower illness related costs resulting from the health programming.*
- Ask if the interviewee has any questions.

INTERVIEW QUESTIONS:

1. Do you keep track of the number of days or hours that your employees do not work due to ill-health?
Probe: What format is this data in? Are we able to review it? We would be interested at some level of detail for example, looking at differences in days / hours lost to ill-health by gender and by pay scale. If we are not able to review the raw data could we give you some headings which you / your staff would be able to give us summary data for?
2. Does the company routinely calculate losses due to workforce ill-health? Are there summary or detailed data we could use?
3. What costs does the company bear when an employee is sick? We would like to get as specific information as possible in order to try and estimate the value of the improvements due to improved health.
Probe: Replacement personnel? Increased supervisor time? Sick pay? Benefits? Treatment / referral costs? Is it easier to consider costs per day lost to ill-health or per employee with a certain condition (e.g. HIV) for example?
4. Do any of the workforce come to you to discuss the company health services (within the fence), are they valued? DO they have complaints / concerns?

CLOSE:

- Thank the interviewee and ask if they have any questions.
- Review list of documents / materials you have discussed and check when you can get them.
- Ask if it is OK if you contact them again for further information or to check any points.
- Give them your contact details in case they have any further questions for you.

KEY INFORMANT INTERVIEW GUIDE 3

INTERVIEWEE: Company accounts department

INTRODUCTION:

- Thank the interviewee for their time. Tell them this interview will take about 1h.
- Provide initial briefing using the informed consent form and get signature.
- Explain the purpose of this specific interview: *Our main task is to understand how the company health programmes (both within and outside the fence) are run and achieve impact. Part of this is to look in some detail into the cost implications ill-health has on the company, the costs that the company bears to run the health programmes and the benefits to the company in terms of improved productivity or lower illness related costs resulting from the health programming.*
- Ask if the interviewee has any questions.

INTERVIEW QUESTIONS:

1. Could you breakdown for us what costs are involved in the health services provided within the fence?

Probe (and refer to "Programme costs" worksheet of excel data entry template)

- *Start up costs (infrastructure, equipment)*
- *Likely life-span of capital goods*
- *Commodities, in particular drugs*
- *Supplies*
- *Transport costs related to commodities and supplies*
- *Personnel (management, supervision, laboratory, clinic, administrative, finance etc)*
- *Utilities*
- *Other costs?*

2. Could you breakdown of the costs related to health programme(s) undertaken outside the fence for the communities?

Probe (and refer to "Programme costs" worksheet of excel data entry template)

- *Start up costs (infrastructure, equipment, expected life-span of capital goods)*
- *Commodities, in particular drugs and Supplies (including procurement and transport costs)*
- *Personnel (management, supervision, laboratory, clinic, administrative, finance etc)*
- *Utilities*
- *Activity costs*
- *Other costs?*
- *If such detail is not possible are you able to give us a summary figure of cost per person served? We would need to know what cost categories have fed into that figure.*

3. Where did the start-up investment for the community health programmes come from?

4. What is the financing modality?

Probe: Co-financing? Grants to sub-recipients / implementers? Results-based grants? Volunteer inputs/ community time?

5. Has any external support been provided to the programme?

Probe: E.g. Drug supplies, volunteer labour, use of public facilities, donor funding etc?

CLOSE:

- Thank the interviewee and ask if they have any questions.
- Review list of documents / materials you have discussed and check when you can get them.
- Ask if it is OK if you contact them again for further information or to check any points.
- Give them your contact details in case they have any further questions for you.

KEY INFORMANT INTERVIEW GUIDE 4

INTERVIEWEE: Local health authority representative

INTRODUCTION:

- Thank the interviewee. Tell them this interview will take about 1.5h.
- Provide initial briefing using the informed consent form and get signature.
- Explain the purpose of this specific interview: *To explore their perspective on the company's health programme including how they engage with it, its objectives, challenges, achievements and recommendations for the future.*
- Ask if the interviewee has any questions.

INTERVIEW QUESTIONS:

1. Could you give us a brief overview of the structure of health system in the country and this area in particular?

Probe: levels of service delivery, referral system, functionality of public sector (positions filled, HMIS reporting, stock outs, proportion functional facilities), accessibility to public sector, fee arrangements for patients, proportion of delivery by different sectors (private for profit, private not for profit, NGO, CSO, mission etc), accessibility and particular challenges in achieving equity.

2. Could you briefly describe for us the community health programme which *the company* support?

Probe: Target beneficiaries, catchment area, services supported.

3. Were the local / national health or government authorities involved in the planning of the programme?

Probe: Level of involvement (None? Tokenistic? True Partnership?), interviewees perspectives on sufficiency of involvement. Mode of involvement.

4. Do you think the programme responds to the needs in this area?

Probe: Any additional sources for information on the epidemiological profile of the area if documentary sources need supplementing.

5. Are the local / national health authorities involved in the management and implementation of the programme?

Probe: Level of involvement (None? Tokenistic? True Partnership?), roles, involvement of personnel (consider economic cost implications).

6. Are the local / national health authorities involved in the monitoring of the programme?

Probe: In what way? Do you think the monitoring approach is sound or could be improved?

7. How well do you think the partnership works? What are the challenges? Could it work better?

Probe: Was it well put together? Are the right partners involved? Frequency of interaction of partners? Level of satisfaction? Suggestions? What skills (from within the partners) might have helped it work more easily?

8. Do you feel the programme has been useful / valuable? In what ways?

Probe: Impact on specific disease, overall health, health system capacity, CSO capacity, community acceptance / perspectives, company's reputation. Probe for any hard data available. Has the programme created any problems for you?

9. Has the programme causes any problems for you?

Probe: disapproval from communities, problems with superiors / national level, leakage of government personnel into the company programme?

10. What are your thoughts on how the community programme has been designed and organised? Do you have suggestions as to how it could have achieved more / been more efficient or more equitable?
Probe: Partnership challenges. Management challenges. Community acceptance. Particularly probe for considerations of efficiency: personnel time, commodity needs, partnership approaches, potential for wider impact to improve cost benefit ratio. Consider missed opportunities.
11. Does the local health authority receive any support from the company (financial or otherwise)?
Probe: e.g. grants, in kind contributions of commodities, supplies or personnel, training, technical assistance, other? Clarify whether specific facilities are supported, details on these, and whether other more general support to the system (district? region? national?) is provided.
12. We would like to understand more about the financing of this and similar programmes.
- Are you financially supported for your role in the programme? *Probe for details.*
 - What inputs are required from you? *Probe for management time, service delivery personnel time, commodities, supplies, financial cost-share. Probe for details of costs if possible.*
13. Do you think the community health programme could be successfully replicated and / or expanded? What challenges or benefits would this bring?
Probe: Potential increase in efficiency and benefit: cost ratio. Barriers to scale-up or replication.
14. Are you aware of any plans for sustaining the programme or its impacts beyond the period of direct support by the company? What are your thoughts on whether this will be possible?
Probe: Improvements to the health system that will be lasting? (e.g. TA, changes to delivery approaches, planning or other systems). New partnerships fostered which can outlast the programme? Will any specific components become routine for this area and/or elsewhere in the country? Does the programme comply with national or local health objectives?
15. Do you think the health programme has affected the reputation of the company in any way?
Probe: In the eyes of the communities? The local government? The national government?
16. What are the top three pieces of advice you'd give to any company / health authority considering setting up a health PPP?

CLOSE:

- Thank the interviewee and ask if they have any questions.
- Review list of documents / materials you have discussed and check when you can get them.
- Ask if it is OK if you contact them again for further information or to check any points.
- Give them your contact details in case they have any further questions for you.

KEY INFORMANT INTERVIEW GUIDE 5

INTERVIEWEE: Company health clinic manager

INTRODUCTION:

- Thank the interviewee for agreeing to the meeting.
- Provide initial briefing using the informed consent form, invite questions and discussion, get signature or close interview if not willing.
- Explain the purpose of this specific interview: *To gather data and perspectives on the health of the workforce and the challenges, costs and impacts of the provision of services to the workforce.*
- Ask if the interviewee has any questions.

INTERVIEW QUESTIONS

1. Who is allowed to access the company health clinics?

Probe: Workforce only or also families? Workforce whilst on site only or also on leave / off days? All able to access for free or some client groups pay? Information on payment types/ levels.

2. What services do you offer at the clinic/s?

Probe: Diagnostic facilities? Inpatient facilities? Treatment for what disease? Surgical options? When, and where to, are referrals made?

3. What is the best source of data for us to review to look at the scale of the service provision (e.g. numbers seen / treated) and look at for possible impact?

Probe: Where and when can the data be accessed by the team? Can we make copies?

4. What is your opinion of the impact of the health services on the health of the workforce?

Probe: What do you base this on? Do you think other services should be offered? What?

5. What challenges would be faced in widening the catchment area/groups?

Probe: Financial; personnel; wishes / perspectives of company / workforce / community.

6. Are you able to provide us with information on the costs of the services provided through the clinics e.g. personnel costs, commodity costs etc?

Probe: Who is the best person for us to ask to get some idea of costs? Refer to excel cost worksheet.

7. Are you involved in the wider community health programme?

Probe: If no, perspectives on whether you should have been involved? Possible added value?

8. Do you relate to the government health facilities and health authorities in the area? How?

Probe: Supply chain for drugs, reporting within the HMIS system, referrals.

CLOSE:

- Thank the interviewee and ask if they have any questions.
- Review list of documents / materials you have discussed and check when you can get them.
- Ask if it is OK if you contact them again for further information or to check any points.
- Give them your contact details in case they have any further questions for you.

KEY INFORMANT INTERVIEW GUIDE 6

INTERVIEWEE: Partner representative

INTRODUCTION:

- Provide initial briefing using the informed consent form and get signature
- Thank the interviewee
- Explain the purpose of this specific interview: *To gain more detailed insight into the health programme and their role on it, particularly around the partnership modality and the challenges and achievements of the programme.*
- Ask if the interviewee has any questions.

INTERVIEW QUESTIONS:

1. Could you briefly describe for us the community health programme which you are involved in with *the company*?
Probe: Target beneficiaries, catchment population, services offered.
2. How did you get involved in the programme?
Probe: Who approached who? Were you initially keen or reluctant? Why? How did the partnership form? Who drove this? Was it an easy process? Was a formal agreement signed?
3. Were you involved in the needs assessment and design phase?
Probe: What was your role? Was your involvement sufficient? Were others also involved (ask particularly about local health authorities)? What was your perspective on how well this phase was done? Do you have any suggestions?
4. Do you think the programme responds to the main needs in this area of the country?
Probe: Any additional sources for information on the epidemiological profile of the area if documentary sources need supplementing.
5. What is your involvement in the programme?
Probe: Roles – Implementation? Strategizing? Monitoring? Evaluation?
6. Do you feel the programme has been useful and beneficial? In what ways?
Probe: Impact on specific disease, overall health, health system capacity, own and other CSO / NGO capacity, community acceptance / perspectives, company's reputation. Probe for any hard data available.
7. What are your thoughts on how well the community programme has functioned? Do you have suggestions as to how it could have achieved more / been more efficient?
Probe: Partnership challenges. Management challenges. Community acceptance. Particularly probe for considerations of efficiency: personnel time, commodity needs, partnership approaches, potential for wider impact to improve cost benefit ratio. Consider missed opportunities.
8. What are the main challenges for the programme? How were these overcome? Do you have suggestions as to how these could / should have been overcome?
Probe: Programme functionality, quality, personnel, logistics, scale-up, acceptance, cost-effectiveness.

9. How well do you think the partnership works? What have been the main challenges and how have these been overcome?

Probe: Could the partnership work better, how? Frequency of interaction? Level of satisfaction? Are there any skills that you feel your organisation or others in the partnership lack that could have made the process of the partnering easier (i.e. partnership skills rather than technical skills)?

10. Does your organisation receive any support from the company (financial or otherwise)?

Probe: e.g. grants, in kind contributions of commodities, supplies or personnel, training, technical assistance, other? Clarify whether specific facilities are supported, details on these, and whether other more general support to the system (district? region? national?) is provided.

11. We would like to understand more about the financing of this and similar programmes.

- What inputs are required from you? *Probe for management time, service delivery personnel time, commodities, supplies, financial cost-share. Probe for details of costs if possible.*

12. How do you monitor your own progress, cost-effectiveness or impact?

13. Do you think the community health programme could be successfully replicated and / or expanded? What challenges or benefits would this bring?

Probe: Potential increase in efficiency and benefit: cost ratio. Barriers to scale-up or replication.

14. Are you aware of any plans for sustaining the programme or its impacts beyond the period of direct support by the company? What are your thoughts on whether this will be possible?

Probe: Improvements to the health system or to partners capacities that will be lasting? (e.g. TA, changes to delivery approaches, planning or other systems). New partnerships fostered which can outlast the programme? Will any specific components become routine for this area and/or elsewhere in the country?

15. What are the top three pieces of advice you'd give to any company / health authority considering setting up a health PPP?

CLOSE:

- Thank the interviewee and ask if they have any questions.
- Review list of documents / materials you have discussed and check when you can get them.
- Ask if it is OK if you contact them again for further information or to check any points.
- Give them your contact details in case they have any further questions for you.

FOCUS GROUP DISCUSSION GUIDE 1

PARTICIPANTS: 6 – 8 Community leaders

INTRODUCTION:

- Each participant should already have been given brief information on the plans for the focus group discussion and asked verbally if they agree to come and take part.
- Now explain the specific issues you would like to discuss during this session: *the company and the community health programmes supported by the company*. You may need to give a brief explanation as to what activities the company supports to be clear what you are discussing.
- On arrival the group should be given further briefing from the standard consent form and asked to sign a sign-in sheet (which will record basic details of the participants) to signify their consent to taking part. Check if they have any questions.
- Thank the interviewees and ask them all to introduce themselves and share brief information about the community they are from and their role in the community.

DISCUSSION PROMPTS:

1. Is the community run health programme beneficial for your communities?
 - Why, why not?
 - Does it address your needs? How?
 - Have you or your family members used the services?
2. Has the programme led to health improvements?
 - Who has benefitted most? Employees? Their families? People who do not have a family member working for the company?
 - Do you think the poorer groups or less served groups have been considered? Benefitted?
 - Do you think there has been a balance in impact for men and women?
3. Do you appreciate the fact that the company provides these services? Has it altered the way you think about the company at all, or the way the company is seen by others in the community?
4. How have you and your communities been involved in (i.e. worked with) the programme?
 - Assessment and design phase?
 - Implementation, community inputs?
 - Monitoring and evaluating
5. What challenges has the health programme faced?
6. What could have been done differently to improve the running of the programme or the benefits?
7. Do you think the benefits and improvements will continue in any way once the programme finishes?

CLOSE:

- Thank the participants.
- Ask if they have any questions.

FOCUS GROUP DISCUSSION GUIDE 2

PARTICIPANTS: 10 - 12 Community representatives (over 18 years).

These should be people who do not work for the company, nor have family members working for the company (company employees will be met separately). They should have been resident (as adults) long enough to remember the arrival of the company. It is proposed that a number of these are held with different groupings, the choices may be different based on the health programme under consideration.

Groups should at minimum include:

- (i) men and women unknown to each other, drawn from at least 3 different communities
- (ii) women representing local women's groups

Other appropriate groups may include:

- (iii) men representing local occupational groups or other organisation
- (iv) youth or youth group representatives (e.g. where the targets of the health programme are youths (e.g. HIV prevention programmes or other health promotion programmes)
- (v) additional female groups e.g. mothers of young children

INTRODUCTION:

- Each participant should already have been given brief information on the plans for the focus group discussion and asked verbally if they agree to come and take part.
- Now explain the specific issues you would like to discuss during this session: *the company and the health programme that it runs to benefit the surrounding communities*. You may need to give a brief explanation as to what activities the company supports to be clear what you are discussing.
- On arrival the group should be given further briefing from the standard consent form and asked to sign a sign-in sheet (which will record basic details of the participants) to signify their consent to taking part. Check if they have any questions.
- Thank the interviewees and ask them all to introduce themselves and share brief information about the community they are from and their role in the community.

DISCUSSION PROMPTS:

1. Before we called this meeting, were you aware of the community health programme run by the company?
 - Separate from the health clinic that they run for their employees? (*Note: in some settings this health clinic may be open to wider communities (even non-family of employees), perhaps for a fee. Be clear on what is being discussed*).
 - Have you or your family members used / come into contact with the services of the community health programme?
2. Is the community health programme beneficial for your communities?
 - Why, why not?
 - Does it address your needs? How?
 - Have you or your family members directly benefited from the services?
3. Has the programme led to health improvements?
 - Do you think the poorer groups or less served groups have been considered? Benefitted?
 - Do you think there has been a balance in impact for men and women?
2. Do you appreciate the fact that the company provides these services? Has it altered the way you think about the company at all, or the way the company is seen by others in the community?

4. How have you and your communities been involved in the programme?
 - Assessment and design?
 - Implementation, community inputs?
5. Has / does the programme cost the communities anything?
 - Fees for services
 - Time involved in supporting it
 - Contributions in kind for certain activities (e.g. latrine building etc).
 - Time lost when accessing services that could be used for work etc?
 - Travel costs?
6. What could have been done differently to improve the running of the programme or the benefits?

CLOSE:

- Thank the participants.
- Ask if they have any questions.

FOCUS GROUP DISCUSSION GUIDE 3

PARTICIPANTS: 10 - 12 representatives of the national workforce

INTRODUCTION:

- Each participant should already have been given brief information on the plans for the focus group discussion and asked verbally if they agree to come and take part.
- Now explain the specific issues you would like to discuss during this session: *the health clinic and other health services that the company provides for its employees.*
- On arrival the group should be given further briefing from the standard consent form and asked to sign a sign-in sheet (which will record basic details of the participants) to signify their consent to taking part. Check if they have any questions.
- Thank the interviewees and ask them all to introduce themselves and share brief information about the community they are from and their role in the community.

DISCUSSION PROMPTS:

1. Have you used the company health clinic? What do you think about it?
2. Do you prefer the company health clinic or alternative available services (why?)
3. Could the health clinic offer other services that would be useful?
4. Has the programme led to health improvements? Are there fewer people taking days off for sickness?
5. What does it cost you to make use of the services?
 - Fees
 - Time
 - What would it cost you if you took time off for illness?
6. What could have been done differently to improve the running of the health clinic or the other health services offered to you?

CLOSE:

- Thank the participants.
- Ask if they have any questions.

ANNEX 1. STANDARD CONSENT FORM

INFORMATION

We are independent researchers who are looking at a number of mining companies around Africa to understand how they provide health services to the nearby communities. The hope is to learn lessons about the best way of running programmes most efficiently and usefully, to achieve the most benefit.

We value your opinions and would like to discuss your experiences of and perspectives on the community health programmes supported by X company.

We would like to record what is said here by taking notes (*modify if voice recorders are planned*). However, everything you say will be confidential and your names will not be mentioned when the findings are discussed. We do not work for *the company*. Nothing you say here will impact on your employment with the company, your benefits or rights.

If you have any questions please ask us. You may ask questions throughout or withdraw from the interview at any time.

If you understand this information and agree to take part please sign below. This indicates to us your consent to be part of this discussion.

I understand the purpose of this interview. I understand that my comments will be confidential and reported anonymously. I understand that I can choose to withdraw from the interview at any time.

Name:

Position:

Age:

Gender:

Signature:

ANNEX 2. CONSENT AND SIGN IN SHEET FOR FOCUS GROUP DISCUSSIONS

INFORMATION

We are independent researchers who are looking at a number of mining companies around Africa to understand how they provide health services to the nearby communities. The hope is to learn lessons about the best way of running programmes most efficiently and usefully, to achieve the most benefit.

We value your opinions and would like to discuss your experiences of and perspectives on the community health programmes supported by X company.

We would like to record what is said here by taking notes (*modify if voice recorders are planned*). However, everything you say will be confidential and your names will not be mentioned when the findings are discussed. We do not work for *the company*. Nothing you say here will impact on the services you receive from the company or your rights.

If you have any questions please ask us. You may withdraw from the discussion at any time.

If you understand this information and agree to take part, please sign the list on the next page. This indicates to us your consent to be part of this discussion.

ANNEX 3. PREPARATION CHECKLIST

The following documents should be requested / sought from partners or internet in advance of field work.

- National Health Policy / Strategy
- Disease specific policy / strategy
- Most recent DHS and other relevant surveys
- Report of needs assessment for programme or other situational analysis documents
- Programme reports
- Company overview document (general e.g. workforce, operations etc)
- Company reports / overview of health programming

The following meetings should be requested in advance to allow time for them to be set up:

One to one meetings with:

- Company social investment / corporate social responsibility representative
- Representative from the HR department who will have knowledge of, access to and authority to discuss data on workforce health and related costs
- Representative from the accounts department who will have knowledge of, access to, and authority to discuss data on the costs related to the health services provided within and outside the fence
- Senior representative of the local health authority who has been involved in health programming outside the fence
- Senior representatives of any partners closely involved in the outside the fence health programming
- Manager of the company health clinic (and possibly head of the laboratory services)

Focus groups with:

- 6-8 Community leaders from different communities, who are aware of the health programme or have been involved with it
- Community representatives: people who do not work for the company, nor have family members working for the company (company employees will be met separately). They should have been resident (as adults) long enough to remember the arrival of the company. It is proposed that a number of these are held with different groupings, the choices may be different based on the health programme under consideration. Groups should at minimum include:
 - (i) men and women unknown to each other, drawn from at least 3 different communities
 - (ii) women representing local women's groups
 Other appropriate groups may include:
 - (iii) men representing local occupational groups or other organisation
 - (iv) youth or youth group representatives (e.g. where the targets of the health programme are youths (e.g. HIV prevention programmes or other health promotion programmes)
 - (v) additional female groups e.g. mothers of young children).