

**Technical Report 19:
Dominican Republic
Performance Improvement
Project Evaluation**

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PRIME is a project for training and supporting primary providers of reproductive health services around the world. PRIME is implemented by INTRAH in collaboration with American College of Nurse Midwives, Ipas, Program for Appropriate Technology in Health, and Training Resources Group, Inc.

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Highlights from Interviews with PRIME Dominican Republic PI Project Participants

PRIME's assistance has been immeasurable.

- General Director, IDSS Health Sector

The assistance from PRIME has been invaluable and stays with the institution. In all our services, in developing the PI methodology, it has allowed us to incorporate the methodology and continue to replicate it in other areas of the IDSS.

-IDSS RH Coordinator

[The PRIME PI Project] has built capacity. It has changed the culture [of the IDSS] in analyzing problems, taking clients into account. It has helped to decentralize [decision-making] without relying on the central level. It has left us with a team capable of doing training. It has helped the whole institution (IDSS).

- IDSS RH Director

The [RH] technical team is sustainable. It no longer depends on PRIME. It continues working, gaining experience and using the [PI] methodology.

- UNFPA Medical Coordinator/IDSS RH team member

We will continue to use the PI methodology in this and other projects. The PI Approach was very important, and essential in thinking about what are our needs, and in defining gaps, in defining what we have and what we want in the future.

-IDSS RH Coordinator

We feel like we have contributed to the process. We feel like we are a key part of it. It isn't just a PRIME methodology. We feel like it is ours.

- IDSS RH Director

After just a short time, we have noted the benefits of our new focus on integrated reproductive health services. It has gotten the providers very interested in the criteria for service delivery, in user satisfaction and in humanized care, and in expanding RH services. Before the doctor would arrive and not discuss - they would assume. They are talking with clients now. The providers are treating clients more nicely, and the providers are feeling good about it.

-IDSS RH Coordinator

The providers take it seriously [improving their performance]. They understand the job. In treating the patient, they are friendlier, and more thorough from a sociological point of view. The provider sees the patient as a human being, not just a medical problem.

- Hospital Director.

We have all the methods [of family planning] thanks to PRIME. And from that, we have improved office visits and hospital services. People are demanding more services because they see the improved quality of our [IDSS] services.

-IDSS RH Coordinator

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FIGURE 1: MAP OF THE DOMINICAN REPUBLIC



Source: National Geographic website, 1999.

Abbreviations

AID	United States Agency for International Development
APSISA	Project for USAID-funding of the IDSS
CMT	Communication, Management and Training Division of AID, Washington, DC
CPI	Client-Provider Interaction
CPR	Contraceptive Prevalence Rate
DA	Development Associates, Inc.
DHS	Demographic Health Surveys
DR	Dominican Republic
EDD	Evaluation, Documentation, and Dissemination Initiative
FP	Family Planning
FPLM	Family Planning Logistics Management Project
IPPF	International Planned Parenthood Federation
JSI	John Snow, Inc.
LAC	Latin America and the Caribbean
IRH	Integrated Reproductive Health
IDSS	Dominican Social Security Institute (<i>Instituto Dominicana de Seguros Sociales</i>)
IDSS	Ministry of Health
NGO	Non-governmental Organization
OCP	Oral Contraceptives
PHNC	Population, Health and Nutrition Center of USAID in Washington, DC
PI	Performance Improvement
PIA	Performance Improvement Approach
PRB	Population Reference Bureau
PRIME	Project for Training Primary Providers of Reproductive Health Services
RH	Reproductive Health
SESPAS	Dominican Ministry of Health (<i>Secretaria de Salud Publica y Asistencia Social</i>)
STI	Sexually-Transmitted Infection
TA	Technical Assistance
PNA	Performance Needs Assessment
TFR	Total Fertility Rate
TOT	Training of Trainers Workshops
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

In June of 1998 the Dominican Republic was selected as one of the sites in which PRIME would test its Performance Improvement Approach (PIA). PRIME'S PIA is a methodology newly adapted from successful use in business, which can be used to identify gaps in primary care provider performance, the root causes of those gaps, and the interventions that can be applied to fix those problem causes. At the suggestion of the USAID mission in Santo Domingo, PRIME opened preliminary discussions with the Dominican Social Security Institute (IDSS). IDSS agreed to become a pilot test site, focusing on the performance of family planning/reproductive health (FP/RH) providers at hospitals, clinics, and *consultorios* (physician offices).

With technical assistance from PRIME, IDSS PIA team members defined and identified indicators for the desired performance of FP/RH providers. Baseline data were gathered to determine the actual level of performance, using these same indicators. Root causes were uncovered for performance problems, and the team designed an array of interventions to address the causes. After prioritizing interventions, a controlled operations research (OR) design was chosen to determine the effects of alternate intervention combinations on quality of care (QOC) and provider performance, and whether lower cost interventions could have adequate effects without higher cost interventions. Three provinces were selected for testing the array of interventions. San Cristóbal received the full set of interventions, which included RH training for providers, expectation setting by IDSS headquarters, client feedback, and dissemination of educational materials. La Romana received only expectation setting, client feedback, and educational materials. La Vega served as a control area and did not receive any intervention.

Early results indicate that provider performance has improved significantly over baseline levels where the full package of interventions was applied. In areas where simple interventions were applied, performance has not increased significantly. The nature of these interventions (e.g., feedback systems) may require more time to note performance changes. The short intervention time allowed between baseline and follow-up make the results informative, but inconclusive. Longer-term follow-up should provide more compelling results. During follow-up interviews, local project participants found the PIA useful, and praised the participatory and systematic nature of the approach. The IDSS management plans to expand the interventions used during this pilot to a nation-wide application.

I. INTRODUCTION

Background

In the Dominican Republic (DR), the Social Security Administration (*Instituto de Seguros Sociales*, IDSS) provides healthcare services for employed individuals, many of whom are free-trade zone employees. Currently the IDSS provides healthcare for 8% of the total population. Until recently, the main service population was male, when the country's main industry was agriculture. For this and other reasons, Family Planning (FP) and Reproductive Health (RH) services were not given priority in the IDSS. In recent years, however, because of high female employment in light industry in the free trade zones (*zonas francas*), the client population has become increasingly female. At present, the majority of IDSS clients are female. Still, the priority given to FP/RH services remained quite low; the Reproductive Health program was placed in a lower level in the organization, reporting to the director of Special Projects, sharing an organizational level with the anti-malaria project. Usage of IDSS facilities was low, with individuals who were able to use IDSS services choosing other service providers, even if the other sites represented an increase in cost. Informal surveys indicated a high degree of client dissatisfaction with the FP and RH services and treatment received from providers.

In 1998, PRIME was in the process of adapting a performance improvement model and making changes that would adapt it to the FP/RH community in developing countries. In order to field-test the model, PRIME sought to test it in 3 pilot sites. PRIME's Latin American and Caribbean (LAC) regional office agreed to test the methodology. After exploring possible sites in Nicaragua and the Dominican Republic, the IDSS RH program was approached. Introductory meetings proved successful, and the IDSS became the LAC PI Pilot test site, with the goal of improving provider performance at IDSS healthcare sites.

In July 1998, a team was formed consisting of IDSS RH program management and staff, PRIME LAC regional office staff, and PRIME PI specialists.

Project Purpose

The purpose of the project was to improve the performance of the primary reproductive health care providers at IDSS health centers, which consist of hospitals, clinics, and *consultorios*. IDSS management perceived that providers were not performing as they should, and this poor performance was leading to low attendance at the service sites and low utilization of IDSS services. PRIME's Performance Improvement Approach would be used as the framework for the project.

PRIME's PI Approach

Performance Improvement is **the systematic approach used to find the root cause** of a performance issue, and then apply interventions ("fixes") that apply only to the real problems. The performance improvement approach (PIA) is a how-to set of tools to reach performance goals.

Factors that Affect Performance

People need the following factors to perform well:

- **Information**, in the form of clear job expectations, and clear and immediate performance feedback.
- **Environment**, including adequate and proper tools and workspace
- **Motivation** and incentives
- **Organizational support** in terms of well-aligned organizational goals and mission, and supportive supervision that assures all the other performance factors are in place.
- **Skills and knowledge**: knowing **how to** do the job

For each factor, when a problem is identified, a solution, or intervention usually becomes clear. For example, if workers lack **information** about what is expected of them, providing written policies or job descriptions or even verbal directions are obvious interventions.

The PI practitioner sees a human performance **system** rather than focusing on the provider alone. The PI practitioner focuses on desired performance and improved organizational results, and is not committed to any particular type of intervention. Often, the PI practitioner will not have expertise in a needed intervention, but will call on other professionals with that expertise, for example, logistical management expertise if there are supply problems.

The 5-Step Process

A typical PI application usually covers the following 5 stages, but rarely in a linear fashion:

1. **Getting Project Agreement**: Gaining agreement among all stakeholders about the goals of the project and the conditions that will represent project success.
2. **Performance Needs Assessment (PNA)**: Defining the desired performance, the actual performance, the indicators used to measure that performance, and the gaps between desired and actual performance. During the PNA, the PI team also determines the root cause(s) of the performance gaps.
3. **Design of Interventions**: Designing interventions that fix the root causes of the performance gaps.
4. **Implementation**: Implementing the interventions designed in the previous phase.
5. **Evaluation**: Determining the extent to which the interventions that were applied closed the performance gaps.

II. METHODS-HOW PRIME APPLIED THE PIA

Getting Project Agreement (GPA)

In July 1998 a series of meetings were conducted between the coordinators of the RH Program, the IDSS Health Director and PRIME to determine the suitability of a project for testing the Performance Improvement Approach. Through these conversations and visits to various IDSS health centers, the team identified several areas of RH service delivery that could be improved by the implementation of a pilot PI Project. The initial areas identified as needing improvement were quality of care, service coverage, and program management. Later, in the GPA stage and in Stage 2 (Performance Needs Assessment), specific problems related to these points were uncovered. These include: a) lack of skills and knowledge in reproductive health; b) lack of contraceptive methods; c) a weak organizational structure of the RH Program; d) weak supervision; e) lack of guidelines and service protocols; f) weak information systems and g) lack of systematic monitoring and evaluation at the operational level.

As a result, a memorandum of understanding was signed between the coordinators of the RH program and PRIME to work together on the pilot project. The memorandum also stated that the Project would begin with the implementation of a Performance Needs Assessment (PNA) in order to better understand what was happening in the field with regard to RH provider performance. The province of San Cristóbal was selected as the project site because it has the highest IDSS population density, easy access, high number of potential RH service clients, great demand and need for services, and represents all three levels of IDSS health centers (hospital, clinics, and *consultorios*). The northern region of San Cristóbal, known as Villa Altagracia, is often mentioned separately because it comprises a large IDSS insured population and a major hospital. The memorandum also discussed the PNA methodology to be utilized, the need for close participation with the RH Program team, and the PNA timeline.

After project agreement was reached at the middle management level, the IDSS RH Program/PRIME team presented the Project to the IDSS General Director, Dr. Pablo Yermenos for his approval. He supported the project idea, but asked that higher level approval be sought since it was the first time that IDSS was collaborating with an international organization. As such, the project was presented to the IDSS Executive Board, which officially approved the agreement between IDSS and PRIME in November 1998 (see Appendix 1).

It is important to note that Getting Project Agreement is not a finite stage but an on-going process, depending on necessity, changing circumstances and a better understanding of performance issues. For example, during the life of the project, the General Director changed twice: Dr. Yermenos was replaced by Dr. Juan Octavio Ceballos in August 1998, who was then replaced by Dr. Sabino Baez in September 1999, when Dr. Ceballos was appointed the Minister of Health. With each new director the IDSS RH/PRIME team presented the project to date and received project agreement in an effort to maintain the political goodwill and support the PI project enjoyed with IDSS upper management. Also, as the IDSS RH/PRIME team worked together and collected more data, a deeper understanding of problems and solutions led to new “mini-agreements”.

Performance Needs Assessment (PNA)

A performance needs assessment was conducted in San Cristóbal by a team of PRIME staff and consultants in September and October 1998. The objective was to understand actual RH provider performance at the different levels of the IDSS health system. The assessment instruments were developed with close collaboration between Dr. James McCaffery of PRIME/TRG, the IDSS RH Program coordinators, and local PRIME staff and consultants. These consisted of an in-depth interview guide directed at health center directors, RH providers, and IDSS higher level management, and a focus group guide to gather client perceptions of RH services. The PNA instruments were validated by PRIME staff and consultants in the province of San Pedro de Macoris, and changes were made accordingly. The province of San Pedro was chosen as the validation site because of its similarity to San Cristóbal with its free trade zones, similar demographics of the IDSS insured population, and multi-level health system.

The objectives of the PNA were to:

- Define desired performance of primary care providers
- Define actual performance

- Define the gap between desired and actual performance
- Identify key causes of RH performance gaps
- Identify and agree on actions/interventions to address these causes

The PNA was conducted in the province of San Cristóbal where 26 IDSS personnel were interviewed, including doctors and nurses from hospitals and clinics, and supervisors and directors from upper level management. Four focus groups were conducted with clients who use RH services.

The PNA data were analyzed with the technical assistance of Dr. McCaffery, the technical team of the RH Program, and local PRIME staff. Data analysis consisted of identifying ideal RH performance as defined by the RH Program coordinators and determining actual RH performance as identified in the PNA data collection in order to determine the RH performance gaps and their key causes. The key causes were determined through root cause analysis (fishbone diagram) relating cause for the performance gaps to the five performance factors. Data analysis was a very intensive process where the IDSS local counterparts generously contributed five full workdays of their time.

Analysis of the PNA data revealed the following gaps between desired and actual RH performance and their respective primary causes: (for more detail on desired and actual performance, see Appendix 3)

Gap 1: Providers offer only some RH services in an incomplete and non-integrated manner. For example, some clinics offer condoms and pills (OCPs), but do not refer for sterilization.

Cause: Lack of knowledge of integrated RH.

Gap 2: Providers at the program level are not empowered nor make RH decisions at the local level about the way in which RH services are offered.

Cause: Lack of knowledge about integrated RH, lack of decision-making skills to make daily decisions that would result in IRH care to clients, and lack of skills and experience in working in teams (which they must do in order to provide integrated RH care.)

Gap 3 : Providers express interest in RH and define it in individual ways but do not have a common or shared concept of integrated RH, and thus are unable to focus on the same goal.

Cause: Integrated RH is not priority at the political level there is no high-level organizational support regarding RH importance and as such the RH program is not allotted money or resources so RH staff cannot develop a “common concept”.

Gap 4: The lack of contraceptive methods and insufficient medical supplies limits providers’ capacity to provide RH services, especially at the clinic and *consultorio* levels.

Cause: No budget line item at the central level for the purchase of contraceptive methods and other RH materials, and inability to obtain or negotiate methods from donors.

Gap 5: Providers do not work according to published integrated RH guidelines.

Cause: Out of date norms that have neither been communicated nor disseminated. IDSS does not have the authority to develop guidelines, but they can disseminate.

Gap 6: Most providers are perceived as not treating clients in a humanistic ¹manner.

Cause: Local supervisors do not evaluate providers based on how well they treat clients. Lack of knowledge/skills in how to treat clients in a humanistic manner. Incentive issues.

Design and Development of Interventions

According to the gaps and causes identified in the PNA, possible areas of interventions were identified in order to correct the problems. In January 1999, at a meeting in Boca Chica, the results of the PNA and possible strategies were presented to a group of 26 multidisciplinary technical personnel and directors of IDSS. This group prioritized the areas of intervention and helped define each strategy. These intervention areas in order of priority are:

1. Improvement of client provider interaction (CPI) (gap 6)
2. Provider knowledge of integrated RH (gaps 2 and 1)
3. RH service protocols (gap 5)
4. Increase in availability of RH supplies (gap 4)
5. Information systems (gap 2)

In addition, the group recommended that the organizational structure of the IDSS Division of Health be revised in order to position the RH Program at a more visible level. A proposal was submitted to the Health Director to change the program from a special project to a *department* of reproductive health. The proposal is currently being reviewed. At the end of the meeting, a 10 member follow-up committee was formed in order to provide technical support when needed.

With additional PRIME technical assistance provided by Dr. McCaffery and Mr. Marc Luoma, Performance Improvement Director, to the PI team in-country, detailed strategies were developed to address the priority areas mentioned above. A cost-benefit analysis also was conducted for the suggested interventions in order to determine the priority of each intervention.

In addition, because the project was a pilot test of the PIA and given the number of interventions, the team decided to use a three-group operations research design to better determine the return on investment for the intervention activities. The three provinces used in the project were chosen for their proximity to the project staff and their similarities to one another. The province of San Cristóbal would receive all the proposed interventions, while La Romana would receive only the educational materials portion, and La Vega would act as the control for the project and receive no interventions.

¹ The English “Humanistic treatment” is an approximate translation of the Spanish *trato humano* which was identified in focus groups and interviews as a component of good client-provider interaction (CPI) that was missing in many provider sites.

Implementation of Interventions

Improvement of Client Provider Interaction (CPI)

To assure that health providers were treating clients in a humanized manner, it was essential that the interaction between the client and the provider be improved. Humanized treatment has strong links to quality of care, the creation of client-friendly services, and addresses barriers to access issues, by creating a demand for services that meet community needs and expectations. Four key interventions were identified for inclusion under the Phase 1 project timeline, and data were gathered to identify possible interventions in a fifth area (incentives for improved CPI) that would be carried out under a future project.

Interventions:

- **Development and dissemination of CPI norms:** The follow-up committee met in March 1999 with the technical team of the IDSS RH Program, 10 members representing the central office, hospitals, and clinics, and PRIME to participate in the development of the CPI norms. As a result of this meeting, the norms were designed based on 4 components: friendliness, privacy and confidentiality, adequate information, and problem solving. Information gathered from client focus groups was used as a base for the norms. The norms were sent to approximately 50 RH providers in San Cristóbal and La Romana for their review and validation. To disseminate the information to clients and providers, a poster was designed describing the CPI norms governing the treatment each client is entitled to receive at IDSS health centers. (See Appendix 2 for a complete list).
- **Client feedback:** In addition to improving the services provided, it was important to consider the opinions of the population for whom the services are directed. A practical method was designed to evaluate client satisfaction on a weekly basis as a way to know if the goals of humanization were being achieved in each location. The process consisted of a suggestion box with feedback cards that client could complete to provide suggestions on how services may be improved and comment about the treatment they had received. The cards were analyzed weekly, and the results were presented to the director of the health center who then discussed them with his staff in a group meeting or individually depending on the circumstances. These discussions allowed for health providers to become aware of how clients perceived their services, make adjustments to these services, and if necessary, motivate personnel to improve their work.
- **Training:** A training of trainers (TOT) workshop was conducted for a selected group of 12 IDSS technical personnel, who would later train health providers. The topics of the TOT workshop consisted of CPI skills, an integrated RH model, effective communication, and participatory adult training skills. The TOT trained the participants to conduct effective, active and participatory workshops. The group of formed trainers then conducted 7 three-day workshops on humanization of services for 125 health center personnel from San Cristóbal and Villa Altigracia, with an average of 15 participants in each workshop. These workshops covered effective communication, CPI, humanized care, and the integrated RH model.
- **System of incentives for improved CPI:** Six focus groups with a sample of providers and 4 interviews with hospital directors from San Cristóbal and Villa Altigracia were conducted asking the following question: “What would motivate you to treat clients in a humanized manner?” It was clearly stated from the beginning that this study dealt with

non-financial incentives, i.e., not including salary increases. The analysis of the results identified a list of incentives that included public recognition, adequate physical space, benefits and support systems. This data was intended to serve as the basis for a longer term incentives intervention that was beyond the timeline of this component of the project.

Provider Knowledge of Integrated Reproductive Health

An integrated RH program in the IDSS system was defined by the team as the following services:

- Family Planning
- Maternal and Child Health Care
- Sexually Transmitted Infections and AIDS Services
- Breastfeeding Promotion
- Prevention of Breast and Cervical Cancer

Many of the IDSS health centers did not offer the complete range of RH services as defined above, nor were providers always clear that this was the IDSS definition of integrated RH. Therefore, the Project tried to raise the awareness of health providers and their managers of the importance of offering and promoting all types of RH services. With this objective, the team implemented the following interventions:

Interventions:

– **Communicate to the health personnel and clients about the services that comprise an Integrated Reproductive Health Program:**

An attractive and informative poster was designed that highlighted IDSS RH services so clients would be aware of their RH options. Each IDSS health center in San Cristóbal and La Romana received a poster to be placed in a visible location.

A client brochure was designed for the RH program to describe the mission, objectives and strategies of the program.

A letter was written and signed by the General Director of the IDSS, Dr. Juan Octavio Ceballos, that informed clients and providers of efforts being made to improve the quality of services offered by the IDSS. The letter also asked for client opinions concerning the treatment they receive during their visits, by completing a feedback card and placing it in the suggestion box.

The CPI norms poster, described above, also helped communicate to clients the treatment they should expect at each IDSS health center.

– **RH mandate letter:** A letter from the IDSS central level was sent to health centers in San Cristóbal and La Romana noting the expectation that each center would offer each of the integrated RH services.

– **RH provider folder:** A folder with posters and pamphlets (designed by Development Associates, Inc. (DA)) of information about the different RH components was developed and distributed as reference material to each RH provider in San Cristóbal and La Romana. The intent was to use the folders in ongoing client education.

- **Client RH materials:** RH educational materials previously developed by Development Associates were distributed to each IDSS health center in San Cristóbal and La Romana to provide clients with more information on IDSS RH services. (The adaptation of the DA materials is a good example of inter-CA cooperation that can be stimulated by an effective PI approach).

RH Service Protocols

After defining the range of RH services, it was important to assure that these services would be high quality. Developing service protocols is one way to assure that health care providers are clear about what is expected of them, and that they work in an environment that allows them to deliver services of the highest quality.

Interventions:

- **Development of service protocols:** Because of the limited time of the pilot project, the IDSS RH/PRIME team decided to develop service protocols only for family planning and uterine/cervical cancer. (These cancers were deemed most important for initial emphasis by the IDSS clinical team.) A team of technical leaders from the local and central IDSS levels was selected to develop the protocols with technical assistance from the PRIME LAC Medical Director. A draft of the protocols is now available and will be completed during the second phase of the project.

Increase in availability of RH supplies

Without contraceptive methods or RH supplies, the RH Program could only educate and counsel clients and then make referrals to centers with FP methods. Until 1999, IDSS clients desiring FP had to go to Ministry of Health health centers, which offered a minimal amount of contraceptive methods at some cost. In order to improve IDSS FP/RH services, IDSS had to provide contraceptives to their own client population.

Interventions:

- **Technical assistance from the Family Planning Logistic Program (FPLM) of John Snow, Inc.:** As a result of the PRIME PI Project, the USAID-funded FPLM Project is providing technical assistance to IDSS in contraceptive logistics. The technical assistance has focused on learning to accurately project contraceptive needs, improving logistic systems, storage of contraceptives, and obtaining supplies.

Through negotiations by the FPLM Consultant, Ms. Nora Quesada, in March 1999, the IDSS RH Program received donations of contraceptives from USAID and CONAPOFA (the Dominican National Family Planning Council). The RH technical team distributed these contraceptives to several health centers at the national level, giving priority to the centers that provide the majority of services. During the second visit of the FPLM consultant in August 1999, Ms. Quesada assisted in estimating the need and cost of contraceptives for IDSS. The IDSS directorate level agreed to purchase contraceptives from the United Nations Population Fund (UNFPA) using IDSS funds. In addition, the contraceptive information forms were modified, and IDSS personnel began training in the use and completion of the forms, calculations of orders and correct storage in October 1999.

Information Systems

As was identified in the PNA, client demographic and visit-specific information was collected and sent to the central IDSS level but was not used at the local level for help in the decision-making process. An important component for improving performance is to have adequate data to make changes in the policies and practices of a health center and the performance of health providers.

Interventions:

- **Measure client satisfaction:** As previously described, a system to measure client satisfaction was developed through the use of a client feedback card. This process gives clients the opportunity to share their opinions about the treatment received and to suggest changes, if necessary. This information is useful for making decisions at the local level because it provides the health centers with the necessary data to make changes to improve performance.

Evaluation

During the final PNA refinement, the IDSS/PRIME team developed indicators to measure actual performance. In order to measure the changes the project may have had on provider performance, a baseline study using these indicators was undertaken in May 1999 in the provinces of San Cristóbal, La Romana, and La Vega prior to the implementation of interventions. The baseline study measured 5 components: client perception of provider performance, CPI observations, provider knowledge of RH, existence of RH educational materials at the health centers, and existence of RH services at each center. Ms. Leda Herasme, PRIME PI Assistant, conducted the baseline study at 14 selected IDSS health centers (a convenience sample of hospitals, clinics, and *consultorios*) in the 3 provinces. Ms. Herasme conducted a follow-up evaluation at the same health centers in August 1999. The evaluation measured the immediate effects the interventions may have had on the levels of performance using the same indicators used in the PNA and baseline data gathering. A cost-effectiveness study also will be conducted among the 3 provinces to determine what level of intervention is necessary to achieve a substantial change in services and quality of care.

Because the project was a pilot test of the PIA, qualitative information also was collected to assess project participant's perceptions of the suitability of the approach in this setting. In September 1999 an evaluation team of Mr. Luoma, Ms. Diane Catotti, PRIME/INTRAH Management and Training Specialist, and Ms. Wanda Jaskiewicz, PRIME LAC Program Officer, conducted 18 interviews with 23 central and local level staff of the IDSS. Hospital directors and staff, clients, USAID, and PRIME local consultants were interviewed in order to obtain their impressions, their sense of lessons learned, and suggestions to improve the PI process. Ms. Catotti also applied the PRIME evaluation, documentation, and dissemination (EDD) methodology to assess the project's impact on IDSS institutional capacity (see Section VI).

III. QUANTITATIVE RESULTS: CHANGES IN PERFORMANCE GAPS

Purpose

This section highlights pre and post-intervention results for the Dominican Republic Performance Improvement pilot project. Baseline data were collected from March to April 1999, and follow-up data were gathered in August 1999 to determine if there were any differences across the three geographic regions of the project.

Project Design

Because the project was a pilot initiative, three regions of the country were selected to test the interventions identified in the PNA stage of the PI model. One region of the country (San Cristóbal) received the full set of interventions, which included reproductive health training for providers, expectation setting by IDSS headquarters, and dissemination of educational materials. A second region (La Romana) received expectation setting and educational materials. A third region (La Vega) served as a control area and did not receive any programmatic intervention. In each of these regions, client satisfaction surveys were conducted pre and post-intervention.

The client satisfaction surveys contained 12 questions addressing the following key areas of quality of care:

1. Courtesy
2. Privacy
3. Information Given, and
4. Continuity of Services

Analysis

An overall quality score was established for baseline and follow-up survey results. In addition, scores (means) were established for each of the key areas of the questionnaire. Means were calculated based on the total number of completed and applicable questions, which were then multiplied by the maximum possible score to “weight” responses. Data were entered in SPSS 9.0, and ANOVA tables were run to compare means across the three regions. The threshold for statistical significance was set at $p=.05$.

For a more in-depth discussion of the results presented here, please see the *Discussion* section.

TABLE 1
Performance gaps, indicators, and interventions

Performance Gap	Indicator(s)	Intervention Package 1 (La Romana)	Intervention Package 2 (San Cristóbal)
CPI: Humanistic Treatment	Adherence to CPI norms, measured by: <ul style="list-style-type: none"> - Client evaluation of provider adherence to CPI norms - Direct CPI observations 	<ul style="list-style-type: none"> - Incentives for improved performance - Disseminate CPI norms - Client satisfaction surveys as feedback to providers 	<ul style="list-style-type: none"> - Incentives for improved performance - Disseminate CPI norms - Client satisfaction surveys as feedback to providers - Training - TOT - Provider workshops - Supervisor workshops - Follow-up materials
Existence and awareness of 5 integrated RH services	The extent to which providers were aware (could state) the 5 services that make up integrated RH, as measured by <ul style="list-style-type: none"> - Interview of site directors - Interview of providers 	<ul style="list-style-type: none"> - Letter from the IDSS director about what services should be offered. - RH services poster on site walls. - Provider reference folder of more in-depth descriptions of minimum services offered. - Client RH materials distributed to clients at service sites. 	<ul style="list-style-type: none"> - Letter from the IDSS director about what services should be offered. - RH services poster on site walls. - Provider reference folder of more in-depth descriptions of minimum services offered. - Client RH materials distributed to clients at service sites. - Training - TOT - Provider workshops - Supervisor workshops - Follow-up materials

La Vega served as the control area, and received no interventions.

Results indicate that there was a clear and statistically significant change in both performance gaps in settings where the full package of interventions was implemented, as compared to partial-package, and control areas.²

Gap 1. Humanistic Treatment: Adherence to CPI norms

Humanistic Treatment of clients was measured by client evaluation of providers' adherence to CPI norms, and by direct observation of provider behavior. Observers used the same CPI norm criteria to judge provider behavior. (See Appendix 2) Client assessment results indicate that in San Cristóbal, where the full intervention package was implemented, provider adherence to the CPI norms improved significantly over time (see Graph 1). In total, 163 clients from hospitals, *poli-clínicas* and *consultorios* from the 3 provinces completed the baseline evaluation and 166 follow-up evaluations. The number of clients by facility and province is presented below, in Table 2.

² Special thanks go to PRIME Latin American & Caribbean (LAC) Region Evaluation Specialist Sandra Echeverria and Wanda Jaskiewicz who conducted data analysis and presentation.

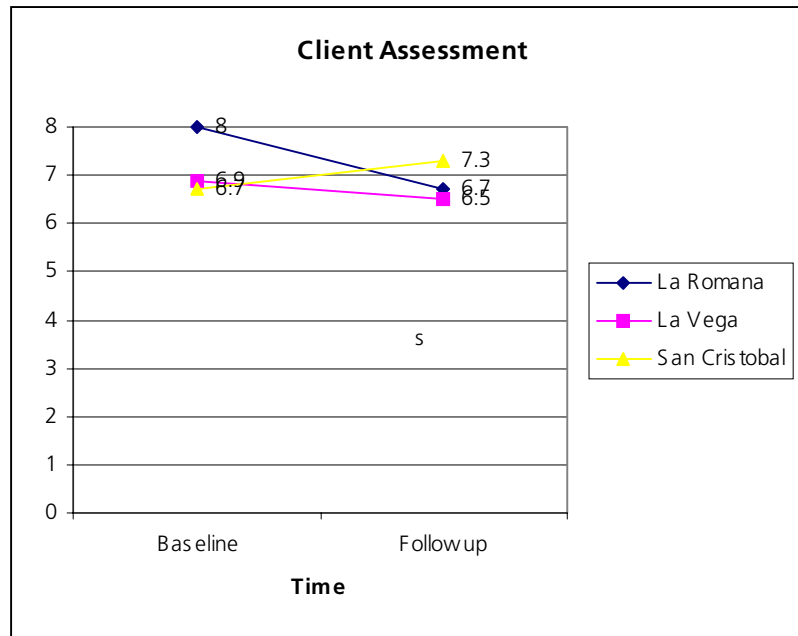
TABLE 2

Distribution of Number of Clients Evaluating Providers' Adherence to CPI Norms, by Province And Facility

PROVINCE AND FACILITY	HOSPITAL		POLICLINICAS		CONSULTORIOS		TOTAL	
	BAS	FU	BAS	FU	BAS	FU	BAS	FU
LA ROMANA	20	23	37	34	0	5	57	62
LA VEGA	20	19	0	0	23	23	43	42
S. CRISTOBAL	18	20	21	19	24	23	63	62
TOTAL	58	62	58	53	47	51	163	166

BAS: Baseline; FU: Follow up

Graph 1
Provider adherence to CPI norms, by region, as assessed by clients



The two other regions show mixed results. In La Vega, where no activities were implemented, there was a slight decrease in provider adherence to CPI norms, but this decrease was not statistically significant. In La Romana, where the partial intervention package was implemented, there was a statistically significant decrease in client assessment of adherence to CPI norms, dropping from 8.0 at baseline to 6.7 at follow-up ($p < .005$).

The direct observation data support the client assessment of increased adherence to CPI norms in San Cristóbal.

Direct observation of client-provider interaction (CPI) was made from a sample of facilities. In total, 51 interactions were observed before and 64 after the intervention in all 3 provinces.

The number of CPI observations by facility and province are presented below in Table 3 and results for the 3 regions in Graph 2.

TABLE 3

Number of CPI Observations, by Province And Facility

PROVINCE AND FACILITY	HOSPITAL		POLICLINICAS		CONSULTORIOS		TOTAL	
	BAS	FU	BAS	FU	BAS	FU	BAS	FU
LA ROMANA	5	9	10	12	0*	3	15	24
LA VEGA	6	8	NA	NA	6	12	12	20
S. CRISTOBAL	6	6	6	5	12	9	24	20
TOTAL	17	23	16	17	18	24	51	64

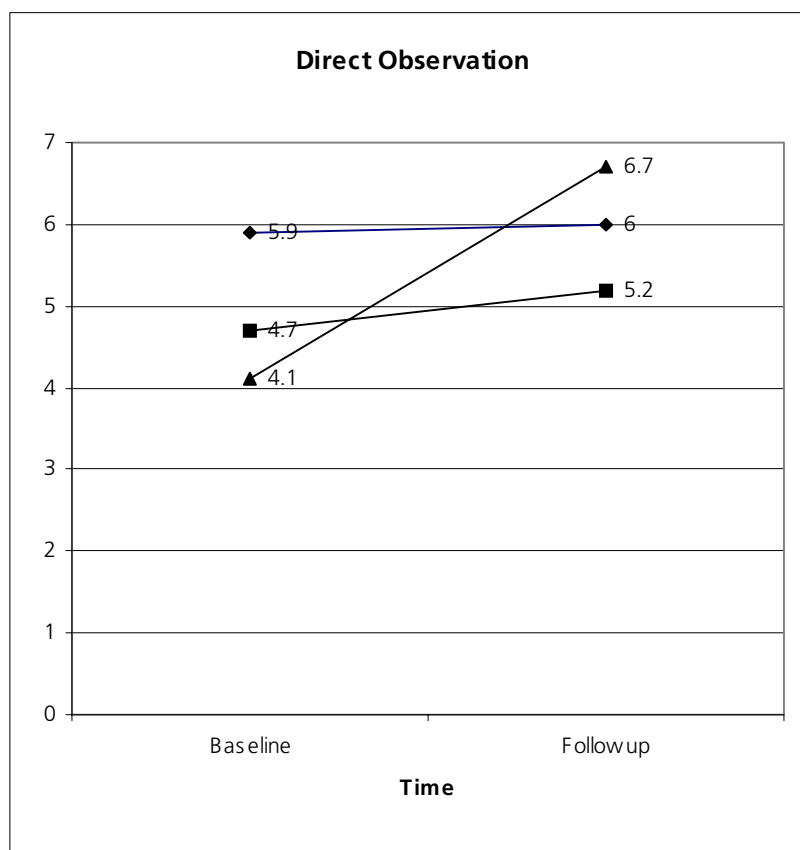
BAS: Baseline; FU: Follow up

* : No female clients of reproductive age encountered

NA: no policlinicas available in that province

Graph 2

Provider adherence to CPI norms, by region, as assessed by direct observation

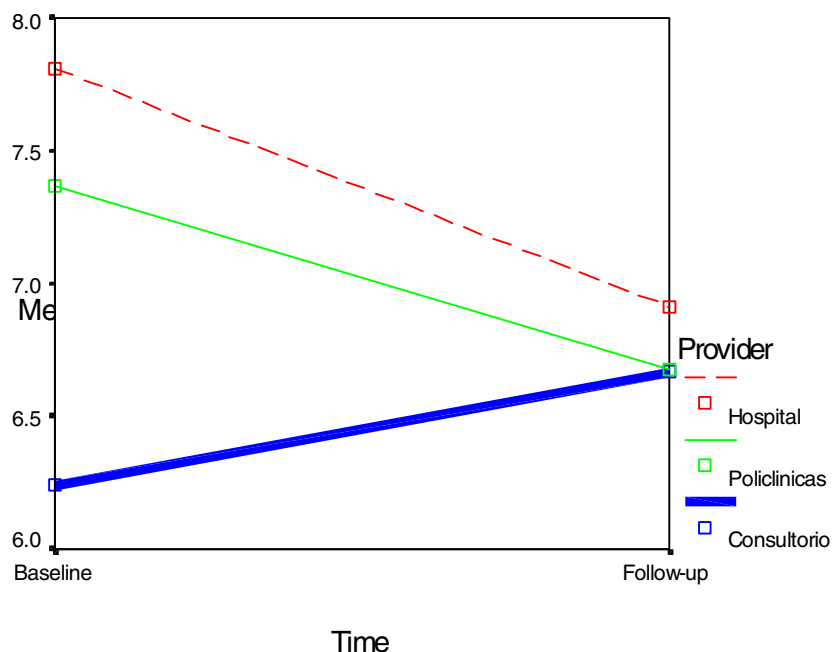


Direct observation data from the partial-intervention area (La Romana) and from the control area (La Vega) did not, however, correlate with client assessment, in that no drops in provider adherence were seen. Instead, minor increases were seen.

The graph below (Graph 3) highlights changes in CPI adherence for the three provider settings in which interventions were implemented. Hospitals and clinics experienced a drop in client satisfaction scores, while smaller private physician offices (consultorios) showed an increase.

Graph 3
Provider adherence to CPI norms, by site

Overall Client Satisfaction, By Provider



For more detailed CPI Adherence results, see Appendix 4, which contains data about CPI adherence by site size (hospital, clinic, *consultorio*) and by CPI factor, including :

1. Provider courtesy
2. Privacy and confidentiality
3. Completeness of information provided to clients, and
4. Problem solving

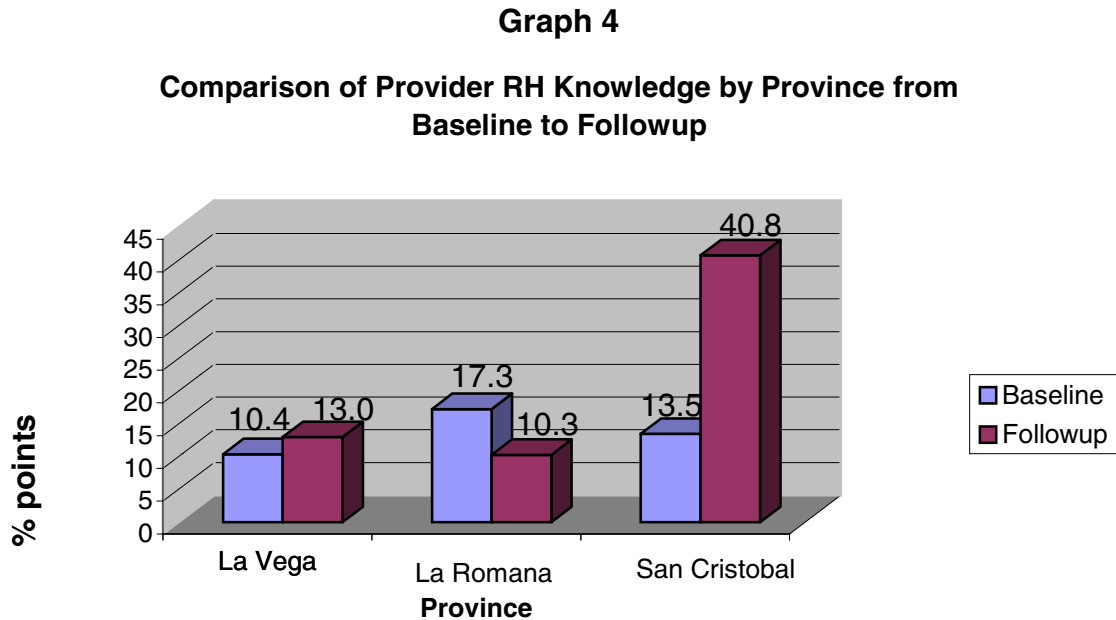
Gap 2. Existence and Awareness of integrated RH Services

The extent to which the five minimum RH services were offered at each site, **and** the extent to which providers were aware of which five services comprised the minimum package of RH services was assessed.

For the purposes of the baseline, reproductive health is defined by the IDSS as:

1. Family Planning
2. Maternal and child health care
3. Sexually transmitted diseases and AIDS services
4. Breastfeeding promotion
5. Prevention of breast and cervical cancer

To determine the level of RH knowledge, evaluators interviewed 79 (baseline) and 78 (post-intervention) providers to determine their level of awareness. It should be noted that groups were randomly chosen at baseline and at follow-up. (See Graph 4 for results.)



As the graph shows, the level of awareness of the 5 services that constitute the basic integrated RH service package rose significantly in San Cristóbal, which received the full package of interventions. In La Vega, the level of awareness rose only slightly, and in La Romana, the level of awareness decreased markedly between baseline and follow-up.

For more information, see Appendix 5, which illustrates RH knowledge of the providers interviewed by region and by specific service delivery site.

IV. QUALITATIVE RESULTS: CLIENT FEEDBACK SAMPLES

This section describes the general results of the client feedback intervention developed to improve client provider interaction so providers treat clients in a humanized manner.

Intervention Description

The client feedback intervention consists of a process in which client opinions regarding services received are collected systematically and analyzed in an effort to make improvements in clinic practices and provider behavior. With the assistance of Ms. Lucy Harber, PRIME/INTRAH Instructional Designer, a feedback card was developed that asked clients to rate provider adherence to the newly developed CPI norms. The card contained four general questions, which relate to the four components of the CPI norms: friendliness, privacy and confidentiality, information, and problem solving (See Appendix 7: Client Feedback/Suggestion Card). There also is space at the bottom of the card for additional comments or suggestions. When completed, the client places it in the wooden suggestion box specifically designed for the intervention.

The feedback cards were distributed to clients in all project health centers in two ways. Twice a week the coordinator of the feedback intervention at each site (selected by the center director) distributed cards to clients seeking RH services when they registered for their visit, in an effort to motivate clients to provide feedback. The cards also were located alongside the suggestion box in a visible place in the health center such as the waiting room or outside the office of the social worker with whom most clients meet before their consultation. This allowed clients to provide feedback on their own initiative.

The goal of the intervention was to empower health center staff to use client feedback data to make decisions and changes at the local level that would improve the quality of services. So local staff would not feel threatened by possible negative comments, the results of the feedback cards were never sent to the central IDSS level or to PRIME.

Analysis

At the end of each week the feedback cards were collected from the suggestion box by the feedback coordinator. The coordinator then tabulated all the cards, and using a simple data presentation instrument, recorded the results. The results were then shared with the director of the health center who during weekly staff meetings would present the data to center personnel and, if necessary, discuss ways to improve service and quality. If a client mentioned a particular provider as having treated him/her poorly, the director would address the provider in private to correct the problem.

As mentioned above, a systematic collection of feedback cards and results by central staff was never conducted. However, samples of the cards and analysis sheets were collected, which provide anecdotal evidence of how the cards were being utilized. In addition, interviews with hospital directors in San Cristóbal confirmed the use and impact of the comment feedback cards.

Results Summary

Although the feedback cards were originally targeted at clients seeking RH services, they have been used by clients seeking various services who had a comment to share or a suggestion to make. For example, some clients complained about the treatment received by the X-ray technician in one hospital, the aggressiveness of the security guard at another center, and the disorganization of the dentistry clinic, all of which are unrelated to RH services. Others though did point out issues related to RH services such as the need for a sonogram machine at one clinic.

Some clients, not satisfied with the space allotted on the card for additional comments, attach full pages of narrative regarding their experiences and suggestions they have for change. In some instances, clients began the letters by thanking the director for listening to them via this communication route. This project is the first time that the IDSS health system has sought client opinions of the quality of service delivery, and as a result, clients felt valued and hopeful that changes could be made.

Also, because the cards were associated with the newly disseminated CPI norms, clients were aware (some for the first time) of their right to receive a certain level of treatment. One client noted that two medical specialists “depress them with their inhuman attitude, instead of finding solutions to a patient’s problems.” Another client commented, “I am discontent because they [providers] work very fast and do not take enough time to tell the patient what is really happening with him/her.”

The most recurrent trend in the feedback cards related to the issue of punctuality and respecting clients' time. Many of the clients who attend IDSS health centers work in the factories of the industrial free trade zones and must seek permission to go to the health center. The client then has a limited time to take care of his/her health needs and must return to work. If they return late to their job, then they are not paid for that portion of time. According to many clients, "doctors from all health areas arrive late. They should be more efficient." Various hospital clients agreed that the gynecologist tended to arrive late. Another asked that staff meetings be shorter so providers can attend to the clients within a reasonable time period. As a result of this particular feedback, one hospital now provides breakfast for providers since many explained they were late because they had to eat breakfast at home. This change has resulted in more providers arriving on time.

Not all cards have negative comments. Many clients wrote about the quality of the service they received, mentioned the names of providers who treated them especially well, and praised the facilities in some of the health centers. One client noted, "I would like to congratulate all the personnel for the care given to me during my hospital stay, and the great consideration [given to] my family members." Another client wrote, "Congratulations for the good service, and improvement of the physical structure and administration of the hospital." Another hospital client stated, "the change is better because [the hospital] has improved in all aspects."

V. QUALITATIVE EVALUATION OF THE PI APPROACH: INTERVIEWS AND IMPRESSIONS

The second major question to be answered by the project evaluation was the extent to which the Performance Improvement Approach (PIA) was accepted and found useful by the personnel involved. To assess this important factor, the researchers conducted in-depth interviews with those who had participated in the various stages of the project.

Methodology

Sample

The researchers conducted 18 interviews with personnel from the following groups that had been involved in the project at some point in time:

- IDSS RH Department management and staff (3)
- An IDSS executive (1)
- A Dominican Ministry of Health executive (former Director General of IDSS) (1)
- PRIME project staff and consultants (6)
- The USAID program manager responsible for project funding (1)
- Hospital Directors and staff (4)
- Hospital clients (1 group interview)

See Appendix 9 for a list of persons interviewed. The evaluation team conducted interviews with project staff and a convenience sampling of hospital directors and staff. The interviews to assess the PIA methodology were conducted at the same time as those for the PRIME EDD methodology (See Section VI below). The interviewees can be categorized into 3 groups:

- Those who were aware of the PIA and that the project was a pilot test of that approach, and who were involved in applying the steps of the PIA. This group was comprised of IDSS RH management and staff, and PRIME staff.

- Those who were aware of the PI pilot and some awareness of the PI methodology, but did not apply the steps of the approach. IDSS executives and USAID management comprised this group.
- Those who were unaware that this project represented a test of a new approach, and were unaware of the methodology used. This group was comprised of hospital directors and staff, and 2 PRIME staff members involved only in training workshops.

Interviews

Interviews lasted between 30 minutes and 3 hours. Interviewers utilized the interview guide instruments presented in Appendix 6. The interviews were recorded by hand or on a laptop computer, supplemented with audio and video tape recordings. Interviews sought to determine general impressions about the PIA, likes and dislikes, differences between the PIA and other approaches, what worked best and least, and suggestions for changing the PIA to make it work better in a similar setting.

Results

As might be expected, there was a marked difference in interview responses between those who were aware of the PIA methodology and those who were unaware. Those who were aware spoke about their experiences using the new (to them) approach. Those unaware of the PIA spoke about the innovative interventions generated by the project.

In general, those who were aware of the PIA praised it for its participatory nature, systematic, step-by-step methodology, and flexibility in application.

Participatory Nature of the PIA

Use of participatory methods is a goal of all PRIME technical assistance, regardless of the methodology used. The nature of the PIA reinforces this goal. For example, the PIA requires that all stakeholders are involved at the outset, during Getting Project Agreement. Again, during the PNA phase, all stakeholders are called together to agree on the definition of desired performance. Without fail, each respondent, when asked about general impressions, responded with comments about the participatory nature of the PIA project, and how all stakeholders were repeatedly involved in setting project goals and agreeing on desired performance. When asked about the time it often took to reach consensus with larger groups, no respondents felt that the time was not justified by the benefits received. Some were perplexed by the question. An IDSS management member responded “well of course; there would be no other way to proceed.” The consensus-reaching methods were praised as democratic and giving everyone a chance to contribute. An IDSS member compared the process to “a construction project - we contributed as much to the building as anyone else.” Another team member stated that “this is a method of ‘us’, not of ‘you’ doing it.” Another IDSS team member supported this feeling, saying “PRIME and IDSS formed one team.” While the impression of a participatory and democratic process is plain, assigning causality is not. Participatory project implementation is a regular practice of PRIME’s Latin American & Caribbean office, hence, it is difficult to *demonstrate* that the PIA caused this impression on the part of participants.

Systematic Nature of the PIA

The systematic methodology was well-received as something that was easily learned, and could be applied in other settings. Interviewees called it the framework or bones on which other content could be built, in other projects. A local consultant working for PRIME said of the process, one can use this in many places, in any language. One of the main benefits claimed by several subjects was the learning that took place within the team. An IDSS

project member stated that we learned a lot. We now know it [the PIA] well enough to try it in our other projects. Many team members felt that they could now apply the framework with little or no technical assistance. In addition, there are currently plans to use the interventions developed by this project in all parts of the IDSS to improve the treatment of clients. While the systematic nature of the PIA was praised, this particular project's short time for interventions was mentioned more than once. Interviewees pointed out that having to fit within the constraints of the current PRIME project duration shortened the intervention period beyond what was ideal or perhaps even acceptable.

Comments on Specific PIA phases

Team members involved in the various phases of the PIA had specific thoughts about each phase:

- **Getting Project Agreement:** *“This happened over many meetings. I feel like some of the time was spent for the benefit of [upper management], but that was important later on, to keep their support. Another team member who also served as a workshop facilitator echoed the importance of including executives as key stakeholders in GPA meetings: “It was good because it got [the IDSS health director] very motivated for our project.”*
- **Performance Needs Assessment:** *“It was good to take the time to see what the real problems were. Many of our impressions were validated, and it was good to have the proof. In terms of difficulty, this was a 7 or 8 on a scale of 10, but it was really worth the effort. This lets us focus on what we really mean by quality of service delivery.”* A project member and facilitator stated that *“this is the first time we’ve considered other things (other than training) like incentives.”* The USAID Project Manager spoke about the cost/benefit analysis stating *“It’s very appealing for comparing different options, what level of effort produces what results.”* He also praised the approach’s focus on results, saying *“PI looks at the actual performance, not just numbers trained. It permits us to measure outputs.”* A PRIME consultant intimately involved in all PNA meetings and information gathering stated that *“during the process of defining desired and actual performance, the managers of IDSS really opened their eyes and saw the reality of what was happening at the service sites.”* It should be noted that the PNA phase was carried out under the duress of Hurricane George. Noting the IDSS team members willingness to work through these conditions, the PRIME LAC Regional Director called *“their dedication to the process truly amazing.”*
- **Design and Development of Interventions:** *“We discovered many things that were necessary that we might have missed. So using a big workshop was a good idea.”* Praising the collaboration engendered during this phase, the USAID representative spoke about the involvement of FPLM in securing contraceptive supplies and strengthening the supply chain: *“Without [PI] it wouldn’t have happened.”* Another team member stated that the process of prioritizing interventions was of particular use in low-resource settings: *“This is a great method to prioritize. We learned to pick the things [interventions] that they have the resources to do.”*

Differences between PIA and other approaches

When asked, participants noticed several differences between PIA and other methodologies they had used in past projects. Echoing sentiments expressed above, a physician and IDSS staff members who participated in the project from start to finish stated, the process allowed for lots of participation, and that was different from other methods that are more *“sit and*

listen to me.” A field coordinator agreed, stating, “*we actually had the involvement of the people doing the work, not just the bosses.*” The USAID representative also noted that compared to other projects, the PIA was more subtle and participatory and generated fewer political problems. Since many respondents had experience working on training-only projects, several mentioned that this was the first project they had worked on that examined several causes for performance problems, not just a lack of training. A facilitator said that “*rather than giving a long training course, you could tell someone the expectations or the norms or just tell them on a poster.*”

Importance of the client feedback intervention

Some project participants were involved in implementing interventions and were not aware of a new methodology. This was particularly true of hospital staff, consisting of doctors, nurses, primary-care providers, and administrative workers, e.g., a personnel director or an administrative assistant. When asked about differences between this and other projects, as well as important impacts of the project, all interviewees talked at length about the use of the feedback intervention, about how it was never tried by other (training) projects, and about the enormous impact it is having on the hospital management and providers. An administrator described the procedures they are applying to use the feedback cards: “*I give one to each client or they take them from the boxes provided. Once a week I collect them and review them with the director. Every Friday the Director reviews them with the providers and goes over needed changes.*” Speaking about the introduction of the feedback system, the same administrator said “*they are very well accepted by clients. We learn things that the people never would say [in person]. This is responsible for many improvements.*”

A hospital Director stated that “*the feedback cards have allowed them to understand the satisfaction of our clients. We now see that it is critical to get real data about the satisfaction level of clients.*” He spoke at length about the changes made in the hospital because of the feedback cards. “*The quality of service from providers has gone up. The treatment they [clients] get has improved. No longer do doctors see patients as a set of problems. They really see them as a person. The providers are happier with their work, too, because the clients are happier.*” A hospital personnel director spoke about the impact of gaining client feedback: “*The change here is so evident, the change in attitude of the providers towards their clients. We now have attention to quality.*” When asked about the cost in work of using the feedback card system, the administrator stated that “*the benefit was definitely worth the trouble.*”

Another hospital director described the methods he designed to use the client feedback: “*Every Friday my secretary collects the 30 or 40 cards we get and prepares a report. She reviews the report with me, and when there are problems I contact the person responsible so we can make changes.*” He calculated that based on improvements made due to the feedback system, patient load had increased 375%.

The effects of the changes made based on client feedback will undoubtedly take far longer to see than the 6-week intervention period studied here. Only longer-term data will properly evaluate the effects of the client feedback system.

Summary

In summary, the interviews show that the PIA was well-accepted at IDSS. Participants made many positive remarks about the PIAs’ participatory nature, its systematic framework that could be adapted to any setting, the results focus, and the chance to look at performance problem causes and interventions that have been ignored or have not received the same

priority in other projects. Of particular interest to hospital staff was the feedback system generated by PIA stages 2 and 3. Hospital staff are excited about being in direct touch with their clients' expectations for quality treatment.

VI. Institutional Capacity Building in the IDSS: Evaluation, Documentation, and Dissemination (EDD) Methodology

As part of the qualitative analysis conducted in September 1999, Ms. Catotti applied the PRIME Evaluation, Documentation and Dissemination (EDD) methodology to assess the impact of the PRIME PI Project on IDSS institutional capacity in improving provider performance and RH service delivery. In collaboration with Mr. Luoma and Ms. Jaskiewicz, Ms. Catotti conducted 18 semi-structured interviews with 23 central and local level staff of the IDSS, the project director, facilitators, workshop participants (providers), and hospital staff. Ms. Catotti also interviewed a representative of USAID/Dominican Republic. Local and regional PRIME staff were interviewed for background on the project.

A Spanish-language INTRAH/PRIME EDD Interview Instrument was used to structure the EDD interviews (Appendix 10). This Guide reflects questions from the English Interview Guide (Appendix 11) and English EDD Questionnaire (Appendix 12.) Ms. Catotti used interview responses from IDSS personnel to complete an EDD questionnaire, representing an "aggregate" IDSS response. Ms. Catotti also shared the EDD questionnaire and conducted interviews with representatives of the FPLM and USAID, but because of an incomplete knowledge of the project, their assessments were incomplete and are not included here.

The EDD questionnaire was designed to assess institutional capacity building in improved provider performance and RH service delivery. The questionnaire allowed for a comparison of indicators in 1998, prior to the initiation of the PRIME DR Pilot project, and in 1999, after 12 or more months of PRIME Project activity. Indicators include the status of FP/RH service norms/guidelines, IDSS RH and/or training policy, budget, facilities, materials and equipment. Other indicators include the use of needs assessment (NA); IDSS ability to replicate the PI approach and/or training courses; the use of incentives, feedback and supervision as part of performance improvement; and PI links to quality of care and improved service access. Additional indicators assessed the presence of decentralized RH services; evidence of public-private collaboration in RH service delivery and/or training; community involvement; and public IDSS statements in support of RH services and/or training, among others. The interviews also assessed IDSS reproductive health services and training, and the content and impact of the PRIME Project. For training participants, the purpose of the interviews was to get a first-hand impression of their experiences and their perceptions of the impact of the project.

While the focus of the PRIME Dominican Republic project was not to strengthen the IDSS training system per se, the EDD methodology was useful in helping to assess and describe the impact of PRIME's involvement in strengthening IDSS provider performance and training. As noted above, the training intervention was implemented in just one province, San Cristóbal. Hence, indicator scores regarding training refer to IDSS efforts particularly in San Cristóbal.

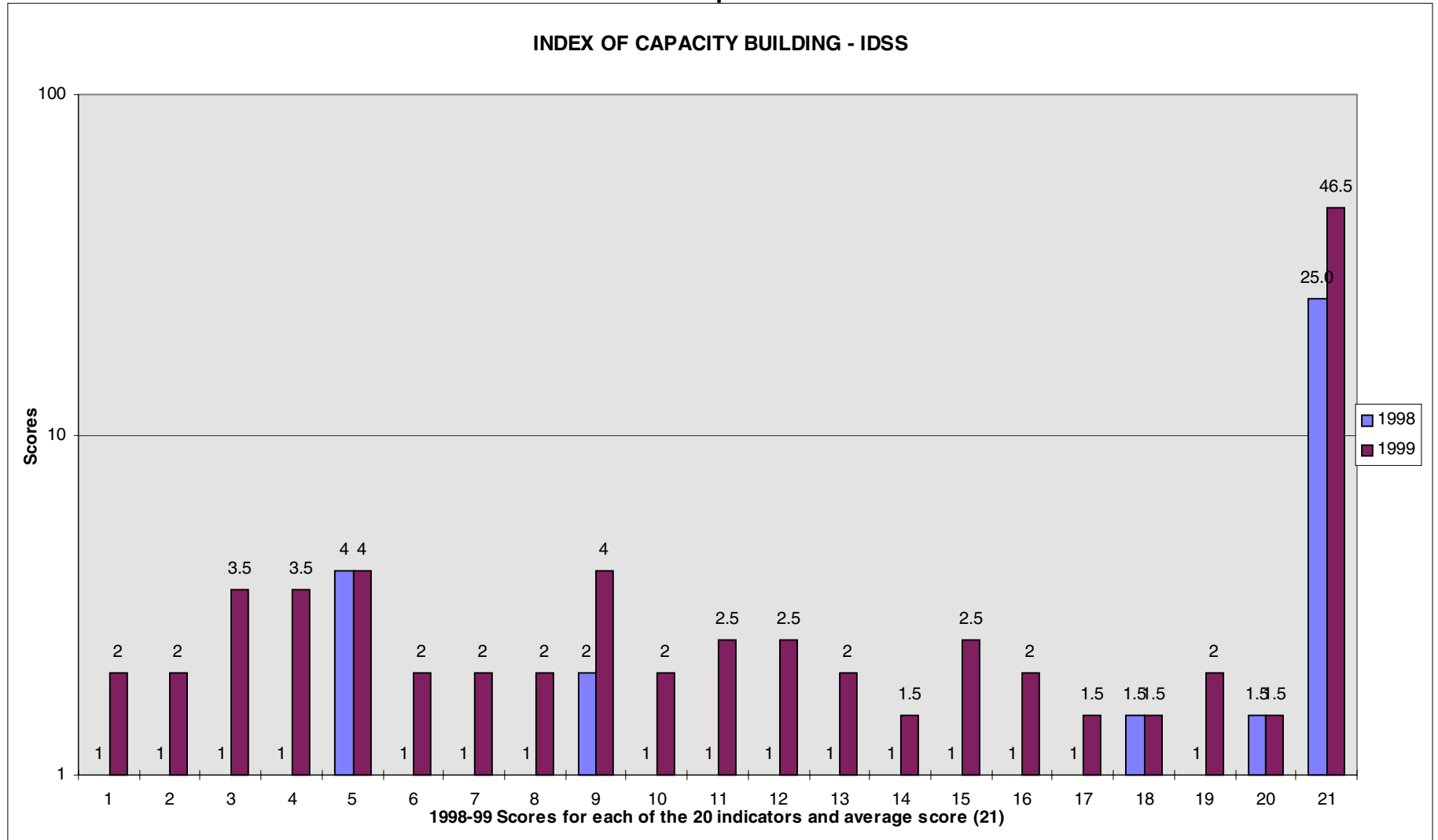
A comparison of the EDD questionnaire responses is presented in Table 4 and Graph 5, below.

TABLE 4**COMPARISON of EDD CAPACITY BUILDING IN TRAINING QUESTIONNAIRE RESPONSES**

Dominican Republic (IDSS) <u>INDICATOR</u>	IDSS Aggregate Score	
	1998	1999
1 Updated RH/FP Service +/- Training Guidelines	1	2
2 Official RH Service +/- Training Policy*	1	2
3 Positive Public Statements on RH/FP Service +/- Training	1	3.5
4 Internal RH Service Budget	1	3.5
5 Adequate RH Training Venues	4	4
6 RH Materials, Equipment & Supplies (MES)	1	2
7 Capability for Updating RH MES	1	2
8 Updated Trainer Knowledge & Skills (TOT)	1	2
9 RH Workplan and/or Training Plan Exists	2	4
10 Standard RH/FP Curriculum	1	2
11 PI linked to QOC and Improved Service Access	1	2.5
12 PI Is Part of Strategic Plan	1	2.5
13 Interagency Collaboration	1	2
14 Decentralized RH Services	1	1.5
15 Human Resource Development as Part of PI	1	2.5
16 Needs Assessment	1	2
17 MIS for RH Services and/or Provider Performance	1	1.5
18 E&R Feeds Improved training +/- RH service provider performance	1.5	1.5
19 Replicate PI approach and/or Training Independently#	1	2
20 Community Involvement in Provider training +/- performance	1.5	1.5
	25.0	46.5
	1.3	2.3

Scores are translated from the EDD Questionnaire on a 4 point scale: a=1; b=2; c=3; d=4.

Graph 5



(Source: Catotti, 1999)

EDD questionnaire responses (on a scale of a to d) were converted to numeric scores (of 1 to 4) and an average of responses was calculated. The resulting assessment score showed a significant improvement in IDSS institutional capacity as a result of PRIME Project activities. Specifically, a score of 46.5 (of a total possible score of 80.0) was generated for the status of IDSS RH service and/or training capacity in 1999 after 12 months of PRIME Project activities, as compared to a score of 25.0 prior to PRIME Project intervention. This represents a 77% increase in IDSS capacity in the pilot regions from 1998 to 1999. While there is room for additional improvement, significant improvement in RH service and/or training capacity resulted from PRIME Project activities.

A summary of the status of the IDSS service and training environment is presented here, and follows the order of indicators in Table 4.

(1) Updated RH/FP Service and/or Training Guidelines: Official RH/FP Service and Training Norms do not exist for the Dominican Republic. However, they would be generated by the Ministry of Health (SESPAS), and are not the responsibility of the IDSS. SESPAS has produced national norms on infectious diseases (*Normas Nacionales para la Vigilancia EpidemiolÚgica de Enfermedades Transmisibles, 1998*). However, the IDSS, through the RH Unit, with technical assistance from PRIME, has drafted 2 service protocols on family planning and cervical cancer prevention. These should be finalized and distributed within the IDSS late in 1999.

(2) Official RH Service and/or Training Policy: There is no official RH service and/or training policy within the IDSS. However, RH services have been defined by the RH Unit and a letter from the Director General of the IDSS noting such has been distributed to service providers in the pilot areas.

(3) Positive Public Statements: Political support for FP/RH prior to PRIME was minimal or non-existent, and improved markedly under the PRIME Project with the full support of the Director General of IDSS (Dr. Ceballos) and the IDSS Director of the Health Sector (Dr. David Díaz Guzmán). Dr. Ceballos was appointed as the Minister of Health in September 1999, and has spoken publicly about the need for humanized care, a key intervention goal of the PRIME project. (Reference: Listín Diario (daily newspaper), Sunday, September 12, 1999.) The new Director of IDSS also has publicly urged all IDSS physicians to treat clients more humanely, and thus make their work more successful.

(4) Internal RH Service Budget: The IDSS RH service budget is part of the overall IDSS budget. The RH program did not exist in 1997. The IDSS budget supports all staff and service costs. The PRIME Project is the first USAID support of the IDSS. USAID field support and core money funded all technical assistance. TA included the pilot test of the PIA approach and project interventions, including training, purchase of client education materials, and provider materials development, production and distribution. In addition, USAID facilitated the donation of contraceptive method supplies to the IDSS, and has funded technical assistance from FPLM/JSI for contraceptive logistics management.

(5) Adequate RH Training Venues: Training venues in the Dominican Republic are adequate. For the PRIME training workshops, hospital training rooms, municipal buildings, and private (hotel) facilities were used. This did not change during PRIME nor was it a

component of the PRIME Project.

(6) RH Materials, Equipment and Supplies (MES): PRIME technical assistance was key to updating training and educational materials and curricula. Client education materials, being used by the Ministry of Health, and other Dominican RH/FP service institutions, were obtained from Development Associates.

(7) Capability for Updating MES: The IDSS has the capability for updating materials. They routinely print posters, pamphlets, and other materials, but had not previously done so for the RH Unit. The IDSS has plans to reproduce the CPI norms poster and distribute it nationwide with their own funds.

(8) Updated Trainer Knowledge and Skills (TOT): Under the PRIME Project, IDSS providers were trained in TOT and replicated training in San Cristóbal with hospital, policlinic, and physician office (*consultorio*) personnel.

(9) RH Workplan and/or Training Plan Exists: An RH workplan is produced annually by the IDSS RH Unit. The first RH workplan was generated in 1997, but had not been implemented prior to the PRIME Project. No RH training plan exists for the IDSS.

(10) Standard RH/FP Curricula: Curricula are developed by the Ministry of Health, rather than by the IDSS. Only one curricula had been available previously on lactation. More recently one was developed by SESPAS on HIV/AIDs. Under the PRIME Project, a new curricula was developed for hospital, policlinic and *consultorio* staff on reproductive health, humanized care, communication skills and principles of participatory adult education.

(11) PI is linked to Quality of Care and Improved Service Access: Under the PRIME DR Pilot Performance Improvement Project, all interventions with the IDSS reflected improved quality of care (more humanized care) and improved service delivery and access in the pilot regions.

(12) PI is Part of the Strategic Plan: PI is not part of the IDSS institutional strategic plan, however, it is part of the RH Unit's planning and general philosophy. And, pilot PI activities were implemented through the PRIME Project. There is a desire on the part of IDSS officials to incorporate PI into the institution's strategic plan. (There also is an indication that PI may be incorporated into the strategic plan for the Ministry of Health, since the former IDSS Director, a key supporter of PRIME's PI approach, has recently become the Minister of Health.)

(13) Interagency Collaboration: There was little public-private collaboration regarding FP/RH issues prior to PRIME. There was some improvement during the PRIME Project, most notably in the sharing of educational materials that were developed by Development Associates, Inc. These materials are used nationwide by the Ministry of Health, PROFAMILIA, and other NGOs, which are the leading FP/RH service providers in the Dominican Republic, hence increasing the consistency of family planning messages provided. In addition, the IDSS has plans to replicate the PI approach and the PRIME training in a Ministry of Health hospital, utilizing PRIME-trained IDSS personnel. In coordination with UNICEF, the IDSS also plans to develop a model baby-friendly hospital,

and hopes to share their PI experience and the methodology. Other areas of collaboration between the IDSS and the MOH include the participation of the IDSS RH Director on the National Breastfeeding Commission. IDSS RH Unit staff also interact with the United Nations Fund for Population Activities (UNFPA).

(14) Decentralized RH Services: Efforts to expand and integrate RH services were undertaken in the pilot areas, but true integration of services is limited and weak. There are no clear indications of decentralization elsewhere in the country, although there is desire on the part of central IDSS RH Unit staff.

(15) Performance Improvement as Part of Human Resource Development: Some incentives and follow-up supervision have been demonstrated in the pilot intervention areas. These have been implemented as a result of PRIME project interventions, including training and the development of client comment cards and suggestions boxes (buzones). For example, in one hospital in San Cristóbal, breakfast is now provided for physicians as an incentive for them to arrive early. In both hospitals visited by the PRIME PI/evaluation team, the suggestion boxes have become a key component of improved provider performance. The Hospital Directors receive weekly reports of the suggestions, comments or complaints made by clients; they meet regularly to discuss the findings with provider teams and often follow-up with individual providers to discuss concerns, e.g., address a client complaint. Both Hospital Directors noted that they had specifically met with an individual physician to discuss expectations for improved performance (and sometimes to reprimand them for poor service delivery.)

(16) Needs Assessment (NA): NA is, at best, done on an ad hoc basis by the IDSS. A performance needs assessment was a key step in the PRIME DR PI Project development.

(17) Management Information Systems (MIS) for RH Services and/or Provider Performance: No MIS for RH services exists within the IDSS. However, at the hospital level, information was collected and reports have been generated on the training workshops, including the name and position of trainees, dates and duration of training, and a notation of the training topic. In addition, as noted previously, reports are generated at the local level summarizing findings from the suggestion boxes.

(18) Evaluation and Research (E&R) Feeds Improved Training and/or RH service provider performance: The IDSS does not routinely incorporate evaluation or research findings into RH service provider performance or training improvement. But, they have received reports and publications from the UNFPA and from PROFAMILIA, the local IPPF affiliate, on mortality and the status of reproductive health in the DR. And, as noted previously they are incorporating feedback from the client suggestion boxes to improve service provision at the local level.

(19) Replicate the PI Approach and/or Training Independently: The IDSS RH Unit has plans to replicate the training workshops using the PRIME curricula in the IDSS Maternidad Hospital in Santo Domingo. The San Cristóbal Hospital also is planning to replicate the PRIME training for additional hospital employees. At present, there are no plans to replicate the PI approach, specifically, although RH Unit employees did express interest, and noted feeling capable in their ability to do so.

(20) Community Involvement: There is minimal community involvement in RH service provider performance or training. In the past, the IDSS has worked with the unions (*sindicatos*) in the free trade zones, regarding service awareness and prior to implementation of new services. This did not change during the PRIME Project. The IDSS RH Director summarized PRIME's impact, noting, "*The PRIME Project has built institutional capacity. It has changed the culture of the IDSS in analyzing problems and taking clients into account. It has helped to decentralize decision-making, without relying on the central level. It has left us with a team capable of doing training. It has helped the whole institution.*"

VII. CONCLUSIONS

Discussion of Results

The researchers collected data to determine the extent to which the 2 performance gaps closed. The gaps were 1) lack of adherence to CPI norms, and 2) lack of awareness of integrated RH. The data clearly demonstrate that the full package of interventions increased providers' adherence to CPI norms especially for humanistic treatment. Likewise, the full package of interventions caused clear and significant increases in providers' knowledge of what constitutes integrated reproductive healthcare.

CPI Adherence

Regarding closing the CPI adherence performance gap, a central question for the researchers is which performance factor might have been causing the lack of CPI adherence: was it lack of information about what was expected, or was it a lack of skills and knowledge about how to treat clients? In other words, did providers lack information about **what they should do**, or lack skills and knowledge about **how to do so**? The results at least partially answer the question. It is clear that in the partial intervention region (La Romana), expectation setting without training was insufficient to generate CPI norm adherence. In the full intervention region (San Cristóbal), the addition of training resulted in CPI norm adherence. (During training providers learned and practiced effective communication skills, and became familiar with the newly-developed CPI norms.) It would appear then, that even when providers in La Romana knew what was expected of them, they didn't know how to treat clients in a way that adhered to the CPI norms. Training filled in the skills and knowledge gaps and gave the providers a basis for adhering to CPI norms. Since expectation setting is a part of all training, we might conclude that setting expectations is a necessary, but insufficient condition when not accompanied by examples of how to meet the expectations.

An interesting question remains about the lack of correlation between follow-up client assessments and follow-up direct observation of CPI norm adherence. The client assessment data show a clear and marked decrease in adherence in La Romana, a surprising outcome. The observation data show almost no change in adherence, which might be expected. Part of the intervention package applied in both intervention locations was the posting of CPI norms in client waiting rooms and other public sites. A possible explanation is that prior to interventions, clients had low expectations, and rated any hint of CPI adherence as a yes on baseline instruments, while after learning of their rights to good treatment, demanded more adherence before rating providers with a yes on rating sheets. This change in expectations and judgement might explain the surprising drop in CPI adherence in La Romana.

The effect of the **client feedback cards** is, as yet, unknown. The cards were part of the intervention package in both intervention regions. Due to the short duration of data collection, the effect of an intervention such as client feedback would not be seen. While the other interventions (i.e., expectation setting and training) are expected to have an immediate effect, reaction to client feedback takes far longer to integrate into policies, practices, procedures, and provider behavior. The cards must be filled out, collected, collated, and reported to the responsible parties, who then take action. Once action is taken, clients may take some time to notice the changes. The researchers recommend strongly that further follow-ups be completed in the longer term, to better assess feedback effects.

RH Existence and Knowledge

The change in RH knowledge indicators is clear in that the full package of interventions was necessary to increase RH awareness. Upon further examination of the indicators used, however, it becomes less clear as to *why* training was necessary. The indicator was whether providers could state what services constituted integrated reproductive health. Providers were required to simply list the services, not to explain how they were performed or when they should be performed, or in fact give any information about the services other than their names (e.g., family planning). Typically, expectation-setting lets workers know **what** is required, and training is useful in letting them know **how to** perform a work task. But, in the present situation, the expectation setting that was part of both intervention packages was insufficient to raise awareness of what constituted integrated reproductive health care in La Romana. We surmise that the expectation setting done in this project was insufficient and the extra reinforcement during training let providers know what services were expected in an integrated reproductive health environment.

Lessons Learned

- **The model is replicable to FP/RH work.** As the PRIME PIA borrowed significantly from models developed in US industry, a large unknown factor was the model's applicability to FP/RH in developing countries. Our results in the Dominican Republic suggest that the model does work well in these situations. Our experience there has also allowed us to modify the model to fit even better.
- **A Win-Win arrangement is necessary.** The success of the project represented a clear win for IDSS, for PRIME, and for USAID. This alignment of goals is critical for the kind of positive outcomes seen in this project.
- **A flexible approach works best.** The experience of the PIA project in the DR proved to be a learning experience for both the IDSS as well as the PRIME TA team. Tools, methods, and processes were adapted on the fly during the project. This willingness to adapt to local customs and realities allowed the project to proceed. A rigid, dogmatic adherence to pre-conceived methodology would not serve well with host-country counterparts.
- **Early successes are important.** Because the PIA is front-loaded with careful analysis, to better assure the appropriateness of interventions, newcomers to the process can become impatient with the amount of analysis. This impatience can be overcome by building in early activities that are intrinsically rewarding for those involved. For example, in the IDSS PIA project, early GPA workshops gave project members access to executive-level managers and to their counterparts from other areas of the organization. These networking opportunities were rewarding.
- **Involve stakeholders early and at every stage.** By having all stakeholders, including executive-level management, involved at each step, the IDSS PIA project enjoyed unprecedented levels of management support. While constantly checking with stakeholders about direction changes or project findings may seem like a time-

- consuming task, the project efficiencies gained through high levels of management support more than justify the time spent. The ongoing Getting Project Agreement also assures a high level of teamwork and team spirit, as evidenced by the interviews conducted at the end of the project. Early successes and high levels of stakeholder involvement allowed stakeholders to become advocates for the ongoing PIA.
- **Old problem-solving habits are hard to replace.** It is our experience that when a team is engaged in a process of trying to improve conditions, they will naturally gravitate towards brainstorming solutions rather than following a problem-solving process of identifying performance gaps, causes, and only the solutions suggested by them. Even in this relatively experienced team, favorite interventions kept cropping up in the mix, even when not supported directly by the data or analyses, hence the PI leader will need to practice good facilitation skills and keep the team on-track. It seems that approaching problems from the solution side, before doing careful analysis, is a frequent and almost-natural pitfall that bears close care.
 - **The role of a PI leader or facilitator is important.** Often the group would approach problems with solutions already in mind (usually a training workshop). When reminded of the problem-solving approach, all were enthusiastically back on course in short order.

Recommendations for Continuation of the DR PI Project (Phase II)

As mentioned previously, the end of Phase I of the DR PI project was designed to coincide with the termination of the PRIME project in late 1999. During Phase II of the project, with technical assistance from a project like PRIME, IDSS will consider the following next steps.

Introduce RH norms and protocols

One of the problems uncovered during the performance needs assessment is that providers do not have any norms or protocols for delivering FP/RH services. Development of service protocols in Family Planning and cancer prevention is already underway, and during the end of 1999 and early 2000, the norms and protocols will be developed and disseminated to providers nationwide.

Introduce local-site data systems for use throughout IDSS

A key intervention the need for which was uncovered during the PNA was the use of local data for local decision-making. While the time needed to implement this intervention precluded its use during PRIME I, it should be implemented as soon as possible to gain the identified benefits.

Check results over time

While the initial results of the project are very promising, such a short duration from inception of interventions to follow-up data collection shows only initial effects. What remains to be seen is how well the results develop fully over the next six months or so, and how well the results are sustained over a longer term.

Use-of-feedback data

The interview data suggest that the use of client feedback has had an enormous impact on quality of care. The data, however, show only where the feedback system tools (comment cards, suggestion boxes) were implemented. Data about the actual *use* of the feedback system need to be gathered. If the feedback system is being used universally, then the difference in improved provider performance in San Cristóbal, as compared to La Romana, could not be explained by the feedback system. If, on the other hand, use data showed that the feedback system was being used at higher rates in San Cristóbal, as compared to La Romana, then we might conclude the feedback system played some part in San Cristóbal's

higher CPI performance. In addition, IDSS management intends to scale up this intervention to a national application.

Recommended changes for future PI projects

During interviews, the researcher queried participants as to their suggestions for improving the PIA for future use here in the DR, or in any other FP/RH setting. Their suggestions are summarized below (and all are consistent with plans we would propose for scaling up the use of PI in the future).

- **Reduce costs by using host-country experts.** As soon as possible, PRIME should develop in-country PI expertise, to reduce the need for international travel and assistance, as travel costs and consulting fees result in larger project costs, thus thinning the cost/benefit ratio of a project.
- **Spend more time on implementing interventions.** The time spent on analysis is appropriate, but the time spent on implementing interventions should be expanded, to better see the effects of the interventions.
- **Explain the PI concept to consultants or other team members using the process.** Some members were only given smaller, fragmentary tasks to perform, and didn't understand how they fit into the whole project. In the future, all participants should understand the PIA process and the function of each piece.
- **Allow more time before follow-up assessment.** As mentioned previously, the timing of the project to fit within the constraints of the current PRIME project resulted in an only-6-week period after intervention implementation, and before collecting follow-up data. This was not enough time to see the true effects of the interventions.
- **Make the process less formal.** Now that the process is known here, there will be less need to be so lock-step in the approach, and less formality can reign during meetings and workshops.
- **Construct the instruments and tools in the setting they will be used.** Because every setting is different, imported tools and instruments do not work well. It is well worth the time required to develop tools and instruments locally (e.g., the information-gathering tools used during the PNA).
- **Minimize language difficulties.** To the extent possible, involve participants who can speak the local language and be understood by the larger group.
- **Widen the focus.** This pilot-project only focused on two regions. Aim for a much wider scope on future projects, to maximize the effects of the effort (better cost/benefit).

VIII. APPENDICES

APPENDIX 1
PROJECT APPROVAL LETTER

(THIS LETTER IS ONLY AVAILABLE IN HARDCOPY VERSIONS OF THIS REPORT)

APPENDIX 2

CLIENT/PROVIDER INTERACTION NORMS

BASIC CRITERIA FOR THE HUMANIZATION OF SERVICES

“Be Nice”

- Greet the person using their name
- Introduce yourself, say your name
- When interacting, maintain eye contact
- Ask about the reason for the person's visit and their needs/concerns.
- Listen positively by maintaining eye contact, using open body language, smiling appropriately, asking follow-up questions, and summarizing.
- Allow client to speak without interrupting
- Respect the person's opinion, do not judge

Guarantee Privacy/Confidentiality

- Assure to the extent possible a pleasant and private physical environment for the person
- Ask the person's permission if other professionals to participate in the visit and explain the reason why they are there
- Conduct sensitive conversations without allowing others to listen
- Assure client verbally that all information will be kept confidential
- Make client as comfortable as possible during physical exam (eg, avoid nakedness on rough wooden tables (!)).

Provide Information

- Provide information which responds to client questions/needs.
- Be clear, precise and complete in your explanations to the person
- Use simple non-technical language
- Encourage questions
- Encourage client to express their opinions and disagreements
- Make sure that you are being understood (eg, ask client to restate important instructions).
- Use educational materials where appropriate to reinforce your messages.

Solve Problems

- Help client make a decision or solve a problem (assure client you will get to the bottom of their problem).
- Help client plan next steps (eg, like referral, next appointment)

APPENDIX 3
PNA DATA GATHERING INSTRUMENTS

CPI NORMS FEEDBACK FORM

We are doing a survey to find out how clients perceive they are treated at clinics. Please give your honest response to the following questions. Your answers will be confidential. Please circle the answer that best describes your response to this visit. Please add any comments.

"Be Nice"

Did the medical personnel:

- | | | | |
|---|-----|----|---------------|
| 1. Greet you using your name? | YES | NO | Comments_____ |
| 2. Ask about the reason for your visit, needs and concerns? | YES | NO | Comments_____ |
| 3. Pay attention while you spokeask questions, look at you? YES | NO | | Comments_____ |
| 4. Allow you to speak without interrupting? | YES | NO | Comments_____ |

GUARANTEE PRIVACY/CONFIDENTIALITY

Did the medical personnel:

- | | | | |
|--|-----|----|---------------|
| 5. Assure you to the extent possible a pleasant and private physical environment? | YES | NO | Comments_____ |
| 6. Help you maintain your dignity and modesty during physical exam? | YES | NO | Comments_____ |
| 7. Ask your permission if other people could be present during your consultation and explain the reason why? | YES | NO | Comments_____ |
| 8. Discuss issues with you in a discrete manner? | YES | NO | Comments_____ |
| 9. Assure you that what you said would not be told to another person? | YES | NO | Comments_____ |

PLEASE TURN THE PAGE →

PROVIDE INFORMATION

Did the medical personnel:

- 10. Give you information that responded to your questions/needs? YES NO Comments_____
- 11. Provide clear and complete explanations using simple language? YES NO Comments_____
- 12. Invite you to ask questions and express opinions and disagreements? YES NO Comments_____
- 13. Check to see you understood (e.g., by asking you to restate important instructions)? YES NO Comments_____
- 14. Use educational materials where appropriate to reinforce his/her messages? YES NO Comments_____

SEEKING SOLUTIONS

Did the medical personnel:

- 15. Help you make a decision in order to solve a problem? YES NO Comments_____
- 16. Help you plan your next appointment (i.e. next steps)? YES NO Comments_____

Reason for the visit_____

Type of medical personnel who attended to you _____

Establishment_____ Date_____

Entrevista con Proveedor sobre Salud Reproductiva

Hoy en día se habla mucho acerca de salud reproductiva. Para usted, qué significa salud reproductiva?

En este centro de salud, cuáles son los servicios de salud reproductiva que se ofrecen?

Se hacen referimientos de servicios de salud reproductiva? Cuáles?

FOCUS GROUP GUIDE

1. Access:

Is it easy or difficult to receive RH Services in this policlinic/consultorio?

Why?

Why not?

Tell me more

What day and time is most convenient for you to visit the policlinic/consultorio?

2. Environment

When you are in the policlinic or consultorio, do you feel comfortable, at ease, receive privacy?

Why?

Why not?

Tell me more.

3. How you were treated

When you arrive at the consultorio or clinic, how do you feel you are treated?

Do you feel that that you are important to the staff that attends to you?

Why?

Why not?

Tell me more

If you have a health problem, do you hesitate in going to the consultorio/policlinic for the treatment/welcome that the staff gives?

Why?

Why not?

Tell me more

Do you feel confident in asking any question of the attending staff because you feel sure that they will respond confidently?

Why?

Why not?

Tell me more

4. Technical capacity

Do you feel that the attending staff in the consultorio/policlinic are well trained and prepared and can resolve whatever health problems you may have?

Why?

Why not?

Tell me more

5. Type and quality of service

When you go to a policlinic or consultorio, what service do you usually seek?

Why?

Why not?

Tell me more

6. Recommendations

What recommendations would you give the staff in the consultorio/policlinic to improve the different RH services you receive?

IN-DEPTH INTERVIEW QUESTIONNAIRE

Introduction:

Welcome and introduction of project:

The purpose of this interview is to collect information about the performance of reproductive health services.

The RH components are:

- _ Family Planning
- _ Maternal health
- _ Child health
- _ Prevention of STDs and reproductive organ dysfunction (male and female)
- _ Women's focus on gender

STATEMENT OF PNA OBJECTIVES

Using San Cristóbal as a pilot site and in collaboration between IDSS and PRIME:

- 1) Compile information for the elaboration of the model of desired RH performance at the primary care level (i.e. polyclinic and consultorios)
- 2) Compare current performance against the perception of desired RH performance to identify performance gaps
- 3) Identify key causes of RH performance gaps
- 4) Identify user's perception of the RH services about the type and quality of service and human treatment
- 5) Identify and agree on actions/interventions to address these causes

Site name _____ Date _____
 Type of site _____ Place _____
 Time _____ Title _____
 Profession _____

(For the interviewer)

The following questions should be asked using language that is appropriate to the cultural context and person you are interviewing.

The following is a list of typical follow-up questions that may be used to get more detailed information:

- _ Can you summarize that for me?
- _ Could you be more specific about ...?
- _ Can you give me an example of how (X) influences the quality of work, diminishes it, etc.? How typical/common/frequent is what you just described? Does it occur only sometimes? More frequently?
- _ Can you estimate the percentage of time that you spend doing (X) or not doing (X)?
- _ Allow me to summarize what you are saying (is the greatest obstacle).
- _ Anything else you would like to add?

I. Management Level

- I.1 What is the importance of the reproductive health program for the IDSS Health Directorate?
- I.2 How is the RH program presently organized?
- I.3 What goals and results are you looking to reach through the RH program?
- I.4 Explain what resources are available to implement the RH program?
- I.5 Explain how you imagine the ideal RH program in terms of:

Availability of

SERVICE MIX

RESOURCES

GOALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- I.6 What percentage of the IDSS RH service providers perform their functions ideally?

II. Administrative Level (Regional Supervisor and/or Director of Establishment)

- II.1 Describe what for you is the typical performance for service providers in the area of RH. Please give examples.
- II.2 Which goals or results are you and your health center trying to reach in the area of Reproductive Health?
- II.3 Which activities do you carry out to help achieve these results?
- II.4 What resources does this health center depend on to help you provide reproductive health services in the best manner?
- II.5 What are the reasons you are prevented from doing your reproductive health work in the best way?
- II.6 Are there other administrative aspects, which help or hinder your work?

Help

Hinder

- II.7 Are there other health sector issues which affect performance (i.e. lack of norms, lack of coordination with other public and private health institutions, etc)?
- II.8 Explain what you consider to be ideal performance of RH providers in this establishment.
- II.9 In this ideal vision which you have imagined, what results would be produced?
- II.10 How would these new results give greater value or satisfaction to the services that are provided?
- II.11 What other activities should be performed by the RH provider to perform the ideal RH service? Why?
- II.12 What impedes you from performing ideal work?
- II.13 Which of the obstacles/barriers that you have mentioned are the most important?
- II.14 How do you think these barriers could be addressed? (Repeat the sequence of questions as many times as necessary for each answer in question II.13)
- II.15 What is the result of unsatisfactory performance?

III. Operational Level (Technicians from Hospitals, Policlinicas, Consultorios)

III.1 Do you consider yourself a RH service provider? Why?

III.2 Describe what are your activities during a typical work day?

III.3 Which goals or results are you and your health center trying to reach in Reproductive Health?

III.4 Which activities do you carry out to achieve these results?

III.5 What resources do you rely on to perform your job in the best manner?

III.6 Please list some reasons which hinder you from performing your work in the best manner?

III.7 Are there other administrative aspects, which help or hinder your work?

Help

Hinder

III.8 Name other issues which can help or hinder your work?

III.9 Is there a lack of coordination between the IDSS with other public and private health institutions?

III.10 Describe what you would characterize as your typical performance in the area of Reproductive Health. Please give examples.

III.11 What is the ideal work you would wish to perform in the area of RH in this establishment?

III.12 What impedes you from performing ideal work?

III.13 Which of the obstacles/barriers that you have mentioned are the most important??

III.14 How do you think these barriers could be addressed? (Repeat the sequence of questions as many times as necessary for each answer in question III.13)

Interviewer name _____

Time interview completed _____

BASELINE AND FOLLOW-UP DATA GATHERING INSTRUMENTS

- _ Client Survey Form**
- _ CPI Observation Form**
- _ RH Knowledge Form**

SAMPLE CLIENT SURVEY FORM

We are doing a survey to find out how clients perceive they are treated at clinics. Please give your honest response to the following questions. Your answers will be confidential. Please circle the number that best describes your response to this visit with 1 = not well at all, 10 = very well. Please add any comments.

How well did the person who treated you (your provider) do at the following:

1. Being nice?

Did the provider greet you using your name and introduce him/herself; ask about the reason for your visit, needs and concerns; listen positively by maintaining eye contact, using open body language, smiling appropriately, asking follow-up questions, and summarizing; allow you to speak without interrupting; respect your opinions (e.g., by not making judgmental statements)?

Not well Very well
1 2 3 4 5 6 7 8 9 10

Comments _____

2. Guarantee privacy/confidentiality?

Did the provider assure you to the extent possible a pleasant and private physical environment; help you maintain your dignity and modesty during physical exam; ask your permission if other professionals may participate in the visit and explain the reason why; conduct sensitive conversations without allowing others to listen; assure you verbally that all information will be kept confidential

Not well Very well
1 2 3 4 5 6 7 8 9 10

Comments _____

3. Providing information?

Did the provider give you information that responded to your questions/needs; provide clear and complete explanations using non-technical language; encourage you to ask questions and express opinions and disagreements; check to see you understood (e.g., by asking you to restate important instructions); use educational materials where appropriate to reinforce his/her messages

Not well Very well
1 2 3 4 5 6 7 8 9 10

Comments _____

4. Solving problems

Did the provider help you make a decision or solve a problem; help you plan your next steps (e.g., make a referral, or set up your next appointment)

Not well										Very well
1	2	3	4	5	6	7	8	9	10	

Comments _____

GUIA DE OBSERVACION DE INTERACCION ENTRE PROVEEDOR Y USUARIA

SER AMABLE

El personal médico:

- | | | | |
|--|----|----|-------------------|
| 1. Le saludó y llamó por su nombre? | SI | NO | Comentarios _____ |
| 2. Le preguntó sobre el motivo de su visita, sus necesidades y preocupaciones? | SI | NO | Comentarios _____ |
| 3. Puso atención mientras hablaba: le hizo preguntas, la miraba? | SI | NO | Comentarios _____ |
| 4. Permitió que se expresara sin interrupciones? | SI | NO | Comentarios _____ |

Garantizar la privacidad y confidencialidad

El personal médico:

- | | | | |
|---|----|----|-------------------|
| 5. Le aseguró un consultorio cómodo y privado en lo posible? | SI | NO | Comentarios _____ |
| 6. Respetó su pudor durante el examen físico? | SI | NO | Comentarios _____ |
| 7. Solicitó su permiso para que otras personas estuvieran con ella durante la consulta y explicó por qué? | SI | NO | Comentarios _____ |
| 8. Le habló sobre sus asuntos en una manera discreta? | SI | NO | Comentarios _____ |
| 9. Le aseguró que lo que ella le dijo no se lo diría a otra persona? | SI | NO | Comentarios _____ |

Brindar información*El personal médico:*

- | | | | |
|--|----|----|-------------------|
| 10. Le brindó información correspondiendo a sus preguntas o necesidades? | SI | NO | Comentarios _____ |
| 11. Era clara y completa en sus explicaciones usando un lenguaje sencillo? | SI | NO | Comentarios _____ |
| 12. La invitó a que hiciera preguntas y expresara sus opiniones y desacuerdos? | SI | NO | Comentarios _____ |
| 13. Se preocupó por saber si ella entendió lo que le explicó? | SI | NO | Comentarios _____ |
| 14. Usó materiales educativos para reforzar sus mensajes? | SI | NO | Comentarios _____ |

Buscar soluciones*El personal médico:*

- | | | | |
|--|----|----|-------------------|
| 15. La ayudó a tomar una decisión para resolver un problema? | SI | NO | Comentarios _____ |
| 16. La ayudó a planear su próxima cita? | SI | NO | Comentarios _____ |

Razón por su visita _____

GUIDE TO INTERVIEW PROVIDER ABOUT REPRODUCTIVE HEALTH

There has been much discussion lately about reproductive health. What does reproductive health mean to you?

Which reproductive health services are offered in this health establishment?

Do you make referrals for reproductive health services? If so, which ones?

Type of medical personnel interviewed _____

Establishment _____ Date _____

APPENDIX 4

PROVIDER ADHERENCE TO CPI NORMS DETAILED DATA PRESENTATION

UNIVARIATE ANALYSIS OF VARIANCE

Between-Subjects Factors

		Value Label	N
Province	1.00	La Romana	119
	2.00	La Vega	85
	3.00	San Cristobal	125
Provider	1.00	Hospital	120
	2.00	Policlinicas	111
	3.00	Consultorio	98
Time	1	Baseline	163
	2	Follow-up	166

Tests of Between-Subjects Effects

Dependent Variable: OVERALL

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	255.246	14	18.232	5.551	.000
Intercept	12181.524	1	12181.524	3708.879	.000
PROVINCE	4.566	2	2.283	.695	.500
PROVIDER	26.914	2	13.457	4.097	.018
TIME	13.125	1	13.125	3.996	.046
PROVINCE * PROVIDER	89.267	3	29.756	9.060	.000
PROVINCE * TIME	26.837	2	13.418	4.085	.018
PROVIDER * TIME	21.620	2	10.810	3.291	.038
PROVINCE * PROVIDER * TIME	44.565	2	22.283	6.784	.001
Error	1031.309	314	3.284		
Total	17749.163	329			
Corrected Total	1286.554	328			

a. R Squared = .198 (Adjusted R Squared = .163)

Dependent Variable: COURTESY

Province	Provider	Time	Mean	Std. Deviation	N	
La Romana	Hospital	Baseline	3.7500	.4443	20	
		Follow-up	2.7246	1.1355	23	
		Total	3.2016	1.0161	43	
	Policlinicas	Baseline	3.5676	.6472	37	
		Follow-up	3.4314	.7132	34	
		Total	3.5023	.6782	71	
	Consultorio	Follow-up	3.0000	.7071	5	
		Total	3.0000	.7071	5	
		Total	Baseline	3.6316	.5865	57
			Follow-up	3.1344	.9418	62
			Total	3.3725	.8270	119
	La Vega	Hospital	Baseline	3.5500	.8256	20
Follow-up			2.9474	1.4327	19	
Total			3.2564	1.1858	39	
Consultorio		Baseline	2.8986	.5983	23	
		Follow-up	3.1739	.9367	23	
		Total	3.0362	.7895	46	
Total		Baseline	3.2016	.7771	43	
		Follow-up	3.0714	1.1769	42	
		Total	3.1373	.9911	85	
San Cristobal		Hospital	Baseline	3.5556	.6157	18
			Follow-up	3.7000	.5712	20
			Total	3.6316	.5891	38
	Policlinicas	Baseline	3.3968	.8207	21	
		Follow-up	2.8947	1.4101	19	
		Total	3.1583	1.1522	40	
	Consultorio	Baseline	2.9583	.9546	24	
		Follow-up	3.6957	.4705	23	
		Total	3.3191	.8368	47	
	Total	Baseline	3.2751	.8520	63	
		Follow-up	3.4516	.9526	62	
		Total	3.3627	.9040	125	
Total	Hospital	Baseline	3.6207	.6442	58	
		Follow-up	3.1075	1.1622	62	
		Total	3.3556	.9785	120	
	Policlinicas	Baseline	3.5057	.7126	58	
		Follow-up	3.2390	1.0385	53	
		Total	3.3784	.8893	111	
	Consultorio	Baseline	2.9291	.7923	47	
		Follow-up	3.3922	.7766	51	
		Total	3.1701	.8140	98	
	Total	Baseline	3.3804	.7670	163	
		Follow-up	3.2369	1.0177	166	
		Total	3.3080	.9038	329	

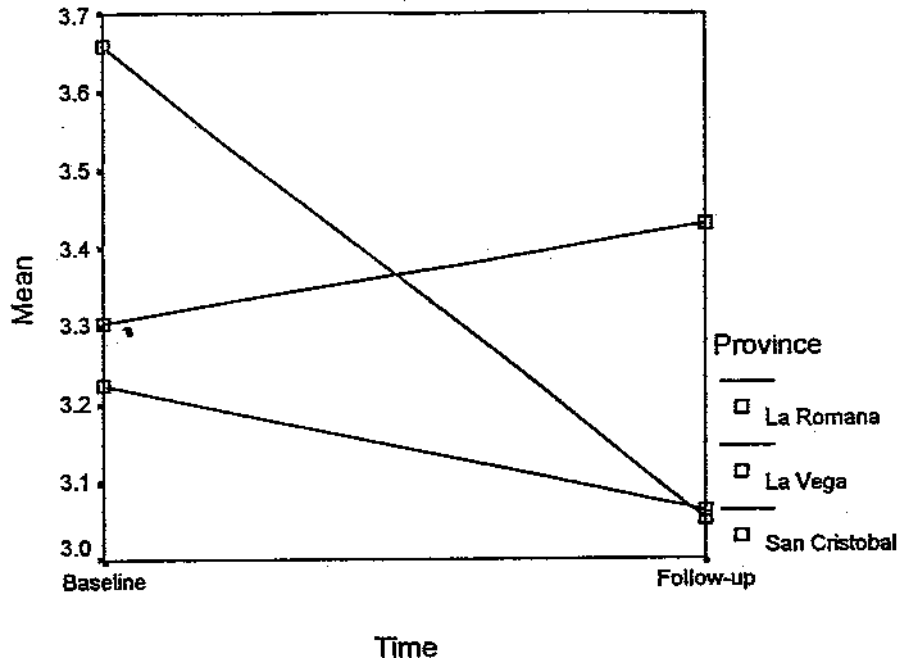
Tests of Between-Subjects Effects
Dependent Variable: COURTESY

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	37.109	14	2.651	3.606	.000
Intercept	2685.758	1	2685.758	3654.070	.000
PROVINCE	2.393	2	1.197	1.628	.198
PROVIDER	2.015	2	1.007	1.371	.255
TIME	1.806	1	1.806	2.457	.118
PROVINCE * PROVIDER	7.146	3	2.382	3.241	.022
PROVINCE * TIME	3.133	2	1.567	2.132	.120
PROVIDER * TIME	10.303	2	5.152	7.009	.001
PROVINCE * PROVIDER * TIME	6.713	2	3.357	4.567	.011
Error	230.791	314	.735		
Total	3868.111	329			
Corrected Total	267.900	328			

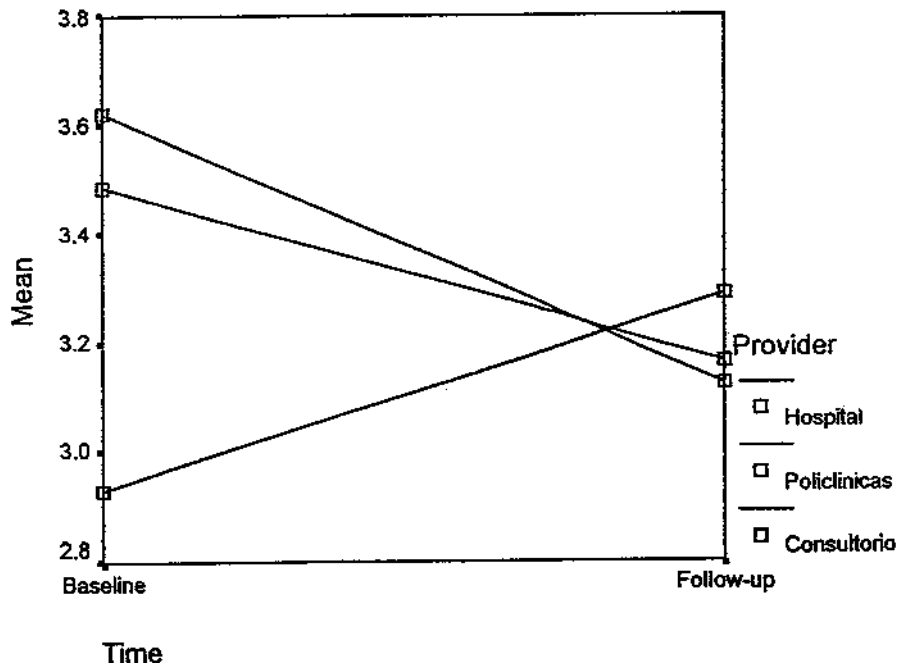
a R Squared = .139 (Adjusted R Squared = .100)

Profile Plots

Provider Courtesy, By Region



Provider Courtesy, By Provider Setting



Descriptive Statistics
Dependent Variable: PRIVACY

Province	Provider	Time	Mean	Std. Deviation	N	
La Romana	Hospital	Baseline	1.5750	.9216	20	
		Follow-up	1.1522	.4631	23	
		Total	1.3488	.7363	43	
	Policlinicas	Baseline	1.7838	.6619	37	
		Follow-up	1.9118	.5704	34	
		Total	1.8451	.6187	71	
	Consultorio	Follow-up	1.2000	.4472	5	
		Total	1.2000	.4472	5	
		Total	Baseline	1.7105	.7615	57
			Follow-up	1.5726	.6392	62
			Total	1.6387	.7009	119
La Vega	Hospital	Baseline	1.6250	.5821	20	
		Follow-up	1.2632	.7335	19	
		Total	1.4487	.6766	39	
	Consultorio	Baseline	1.3696	.7719	23	
		Follow-up	1.2609	.5194	23	
		Total	1.3152	.6528	46	
	Total	Baseline	1.4884	.6943	43	
		Follow-up	1.2619	.6172	42	
		Total	1.3765	.6633	85	
	San Cristobal	Hospital	Baseline	1.5556	.7048	18
			Follow-up	2.0000	.4588	20
Total			1.7895	.6220	38	
Policlinicas		Baseline	1.2143	.7512	21	
		Follow-up	1.0526	.7799	19	
		Total	1.1375	.7594	40	
Consultorio		Baseline	1.5625	.5770	24	
		Follow-up	1.7391	.6192	23	
		Total	1.6489	.5981	47	
Total		Baseline	1.4444	.6846	63	
		Follow-up	1.6129	.7323	62	
		Total	1.5280	.7108	125	
Total		Hospital	Baseline	1.5862	.7383	58
			Follow-up	1.4597	.6671	62
			Total	1.5208	.7023	120
	Policlinicas	Baseline	1.5776	.7422	58	
		Follow-up	1.6038	.7681	53	
		Total	1.5901	.7514	111	
	Consultorio	Baseline	1.4681	.6789	47	
		Follow-up	1.4706	.6034	51	
		Total	1.4694	.6374	98	
	Total	Baseline	1.5491	.7205	163	
		Follow-up	1.5090	.6820	166	
		Total	1.5289	.7006	329	

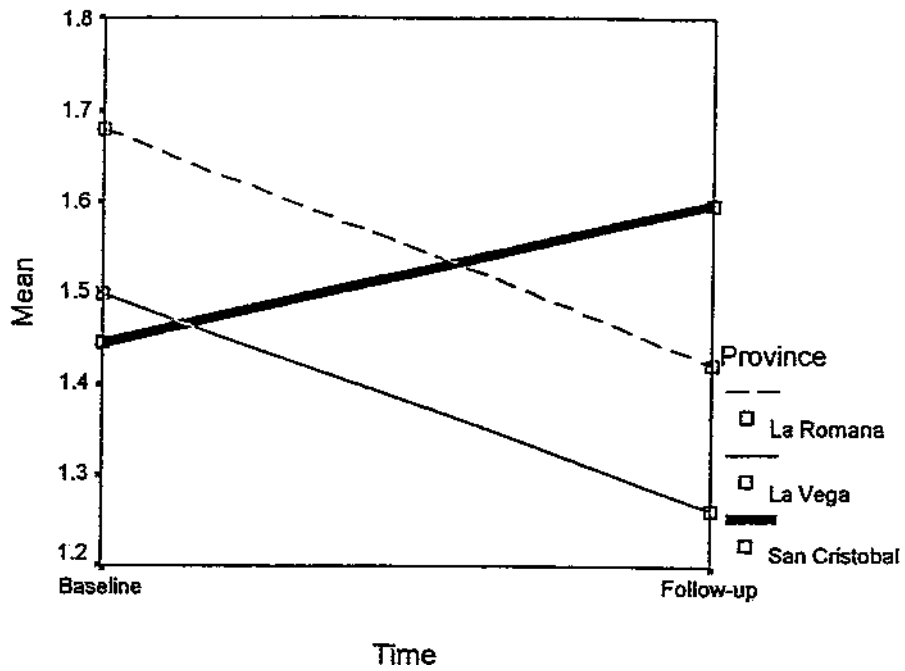
Tests of Between-Subjects Effects
Dependent Variable: PRIVACY

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	26.881	14	1.920	4.496	.000
Intercept	546.741	1	546.741	1280.268	.000
PROVINCE	1.057	2	.529	1.238	.292
PROVIDER	.575	2	.287	.673	.511
TIME	.293	1	.293	.687	.408
PROVINCE * PROVIDER	16.594	3	5.531	12.952	.000
PROVINCE * TIME	2.192	2	1.096	2.566	.078
PROVIDER * TIME	.208	2	.104	.244	.784
PROVINCE * PROVIDER * TIME	3.853	2	1.927	4.511	.012
Error	134.094	314	.427		
Total	930.000	329			
Corrected Total	160.976	328			

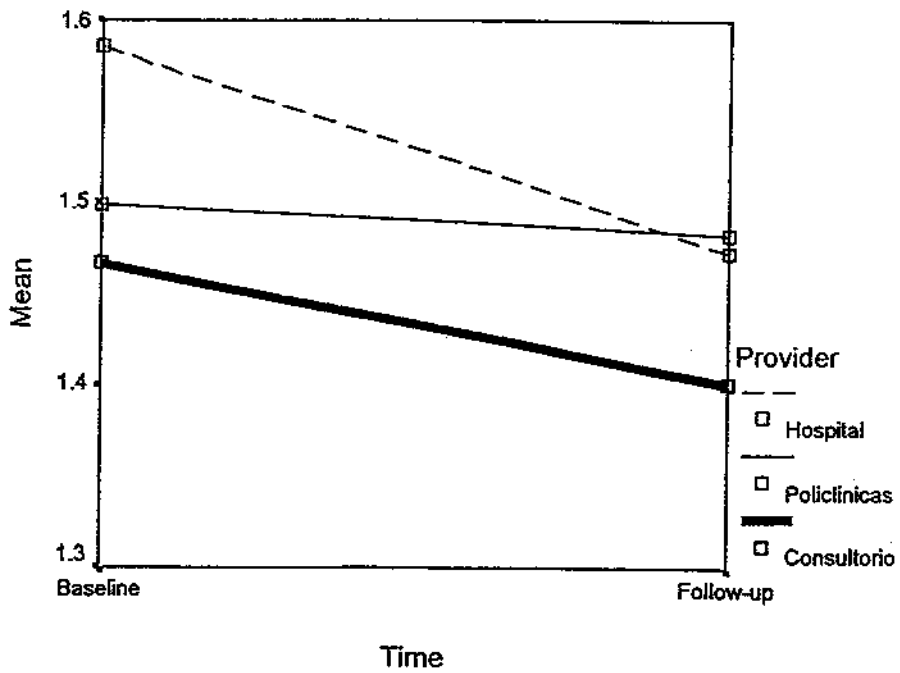
a R Squared = .167 (Adjusted R Squared = .130)

Profile Plots

Client Privacy, By Region



Client Privacy, By Provider Setting



Descriptive Statistics
Dependent Variable: INFO

Province	Provider	Time	Mean	Std. Deviation	N	
La Romana	Hospital	Baseline	2.3000	.7327	20	
		Follow-up	1.2319	.5983	23	
		Total	1.7287	.8491	43	
	Policlinicas	Baseline	2.0370	.7293	36	
		Follow-up	1.7451	.7524	34	
		Total	1.8952	.7498	70	
	Consultorio	Follow-up	1.8000	.4472	5	
		Total	1.8000	.4472	5	
		Total	2.1310	.7349	56	
		Follow-up	1.5591	.7161	62	
		Total	1.8305	.7769	118	
		Total	1.9667	.8977	20	
La Vega	Hospital	Baseline	1.9667	.8977	20	
		Follow-up	1.7895	.7873	19	
		Total	1.8803	.8394	39	
	Consultorio	Baseline	1.8551	.6877	23	
		Follow-up	1.6522	.7141	23	
		Total	1.7536	.7007	46	
	Total	Baseline	1.9070	.7845	43	
		Follow-up	1.7143	.7420	42	
		Total	1.8118	.7654	85	
San Cristobal	Hospital	Baseline	2.0926	.8308	18	
		Follow-up	1.8167	.7530	20	
		Total	1.9474	.7923	38	
	Policlinicas	Baseline	1.6349	.6575	21	
		Follow-up	1.4737	1.0203	19	
		Total	1.5583	.8419	40	
	Consultorio	Baseline	1.5000	.7802	24	
		Follow-up	1.6377	.7029	23	
		Total	1.5674	.7386	47	
	Total	Baseline	1.7143	.7848	63	
		Follow-up	1.6452	.8251	62	
		Total	1.6800	.8025	125	
	Total	Hospital	Baseline	2.1207	.8205	58
			Follow-up	1.5914	.7525	62
			Total	1.8472	.8266	120
Policlinicas		Baseline	1.8889	.7247	57	
		Follow-up	1.6478	.8584	53	
		Total	1.7727	.7975	110	
Consultorio		Baseline	1.6738	.7502	47	
		Follow-up	1.6601	.6782	51	
		Total	1.6667	.7099	98	
Total		Baseline	1.9095	.7837	162	
		Follow-up	1.6305	.7628	166	
		Total	1.7683	.7846	328	

Tests of Between-Subjects Effects

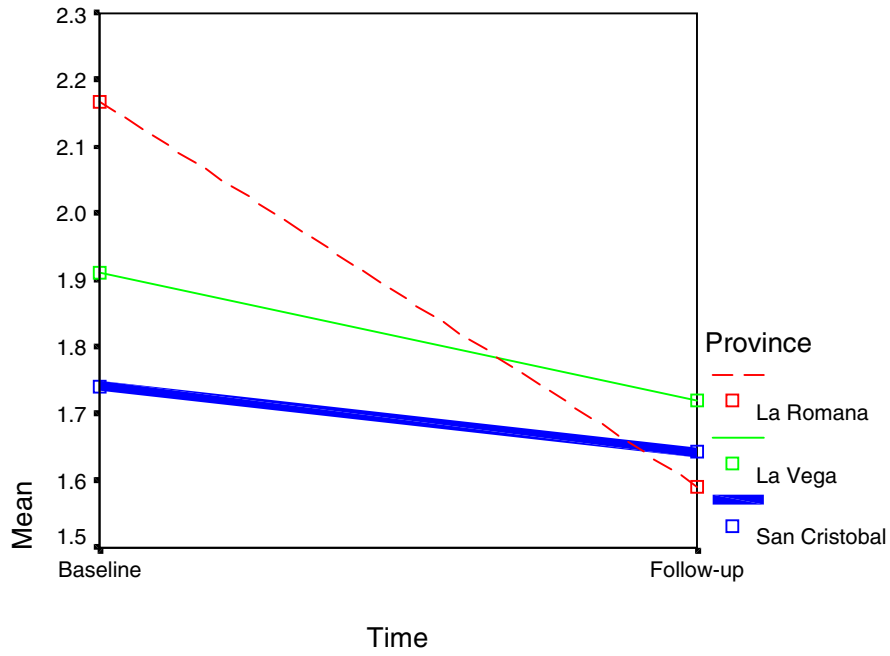
Dependent Variable: INFO

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	22.257	14	1.590	2.780	.001
Intercept	801.764	1	801.764	1401.792	.000
PROVINCE	1.217	2	.609	1.064	.346
PROVIDER	1.131	2	.566	.989	.373
TIME	6.518	1	6.518	11.397	.001
PROVINCE * PROVIDER	3.779	3	1.260	2.202	.088
PROVINCE * TIME	3.782	2	1.891	3.306	.038
PROVIDER * TIME	2.045	2	1.022	1.787	.169
PROVINCE * PROVIDER * TIME	2.383	2	1.192	2.084	.126
Error	179.022	313	.572		
Total	1226.889	328			
Corrected Total	201.279	327			

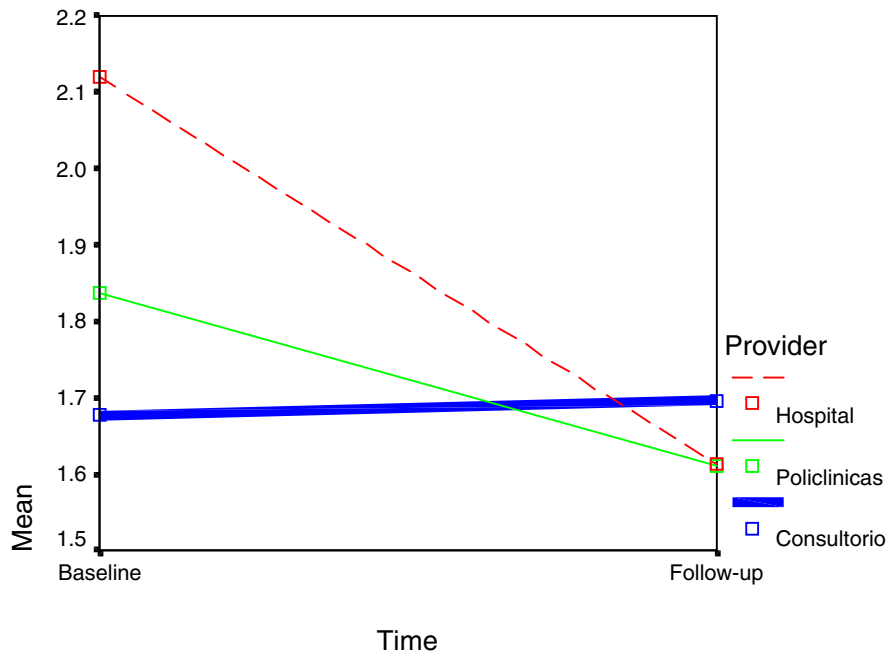
a R Squared = .111 (Adjusted R Squared = .071)

Profile Plots

Information Given to Clients, By Region



Information Given to Clients, By Provider



Dependent Variable: APPT

Province	Provider	Time	Mean	Std. Deviation	N	
La Romana	Hospital	Baseline	.5000	.5130	20	
		Follow-up	.5000	.5118	22	
		Total	.5000	.5061	42	
	Policlinicas	Baseline	.4706	.5066	34	
		Follow-up	.5758	.5019	33	
		Total	.5224	.5033	67	
	Consultorio	Follow-up	.0000	.0000	4	
		Total	.0000	.0000	4	
		Total	.4815	.5043	54	
La Vega	Hospital	Baseline	.3500	.4894	20	
		Follow-up	.6667	.4851	18	
		Total	.5000	.5067	38	
	Consultorio	Baseline	.2273	.4289	22	
		Follow-up	.2174	.4217	23	
		Total	.2222	.4204	45	
	Total	Baseline	.2857	.4572	42	
		Follow-up	.4146	.4988	41	
		Total	.3494	.4797	83	
San Cristobal	Hospital	Baseline	.5000	.5145	18	
		Follow-up	.8421	.3746	19	
		Total	.6757	.4746	37	
	Policlinicas	Baseline	.4762	.5118	21	
		Follow-up	.4211	.5073	19	
		Total	.4500	.5038	40	
	Consultorio	Baseline	4.348E-02	.2085	23	
		Follow-up	.4737	.5130	19	
		Total	.2381	.4311	42	
	Total	Baseline	.3226	.4713	62	
		Follow-up	.5789	.4981	57	
		Total	.4454	.4991	119	
	Total	Hospital	Baseline	.4483	.5017	58
			Follow-up	.6610	.4774	59
			Total	.5556	.4990	117
Policlinicas		Baseline	.4727	.5039	55	
		Follow-up	.5192	.5045	52	
		Total	.4953	.5023	107	
Consultorio		Baseline	.1333	.3438	45	
		Follow-up	.3043	.4652	46	
		Total	.2198	.4164	91	
Total		Baseline	.3671	.4835	158	
		Follow-up	.5096	.5015	157	
		Total	.4381	.4969	315	

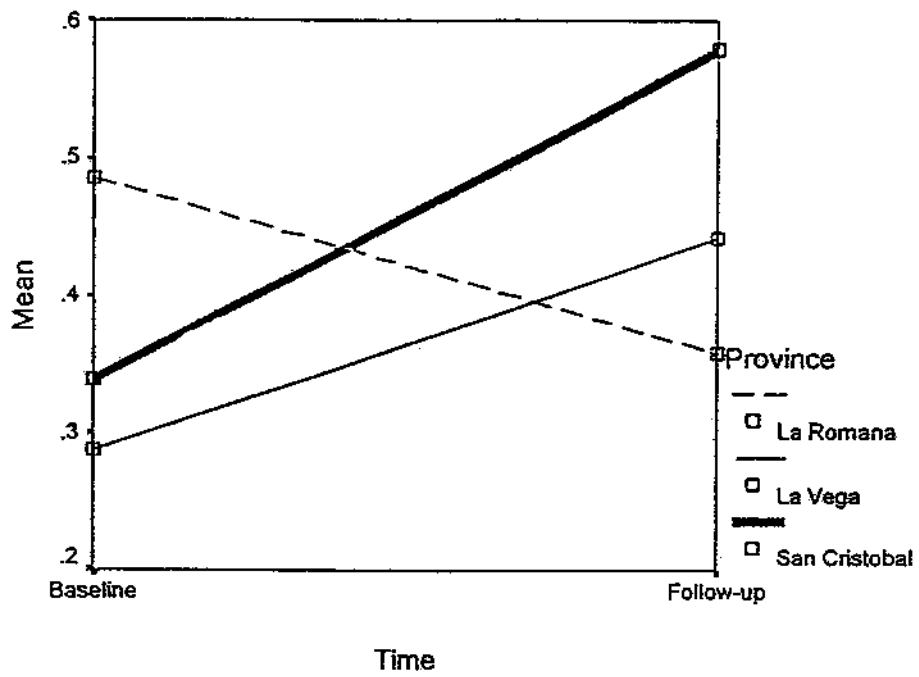
Tests of Between-Subjects Effects
Dependent Variable: APPT

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	11.596	14	.828	3.768	.000
Intercept	37.328	1	37.328	169.808	.000
PROVINC E	.504	2	.252	1.147	.319
PROVIDE R	4.728	2	2.364	10.755	.000
TIME	1.544	1	1.544	7.024	.008
PROVINC E * PROVIDE R	.988	3	.329	1.498	.215
PROVINC E * TIME	.443	2	.222	1.008	.366
PROVIDE R * TIME	.569	2	.285	1.294	.276
PROVINC E * PROVIDE R * TIME	1.562	2	.781	3.554	.030
Error	65.947	300	.220		
Total	138.000	315			
Corrected Total	77.543	314			

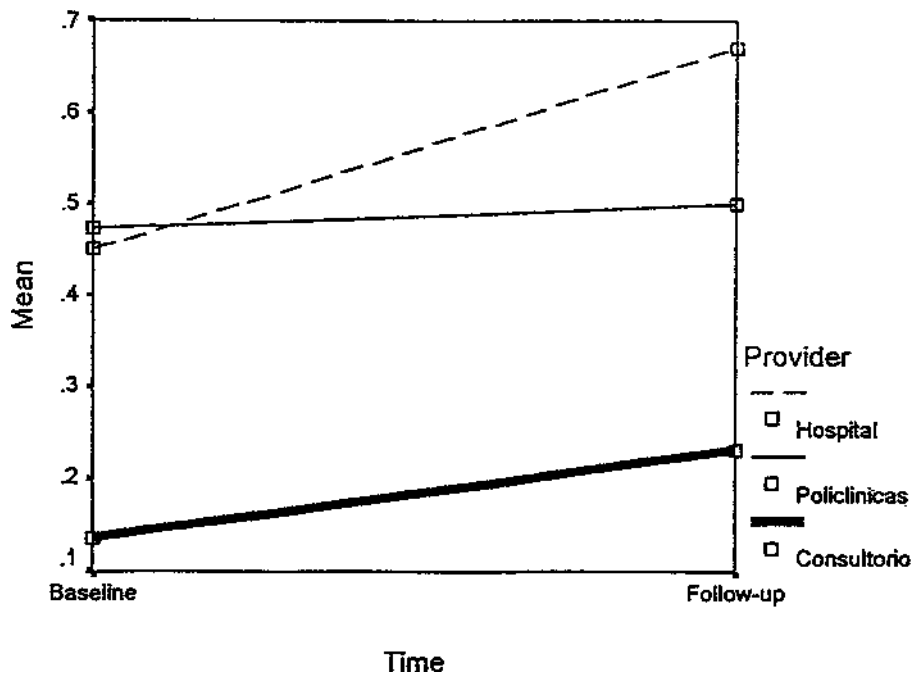
a R Squared = .150 (Adjusted R Squared = .110)

Profile Plots

Return Visit, By Region



Return Visit, By Provider



APPENDIX 5

EXISTENCE AND AWARENESS OF INTEGRATED RH DETAILED DATA PRESENTATION

Summary Analysis of Provider Interviews at Baseline

For the purposes of the baseline, reproductive health is defined as:

- _ MCH
- _ FP
- _ Gynecological cancers
- _ Breastfeeding
- _ STI/HIV/AIDS prevention

A provider received one point per RH component mentioned above.

Province	Center	# Providers Interviewed	Total Points Achieved	Possible Points	Percentage
La Vega	Hospital	11	6	55	10.9
	Consultorio Induveca	6	4	30	13.3
	Consultorio Jarabacoa	3	1	15	6.7
	Consultorio Zona Franca La Vega	5	2	25	8.0
	TOTAL		25	13	125
La Romana	Hospital	5	5	25	20.0
	Policlinica Zona Franca I	5	7	35	20.0
	Policlinica Zona Franca II	6	4	30	13.3
	Consultorio Batey Guaymate	1	0	5	0
	Consultorio Batey Higueral	3	3	15	20.0
	TOTAL		20	19	110
San Cristobal	Hospital	11	9	55	16.4
	Haina I	12	8	60	13.3
	Beta	3	2	15	13.3
	Zona Franca Villa Altagracia	3	1	15	6.7
	Nigua	5	3	25	12.0
	TOTAL		34	23	170

Summary Analysis of Provider Interviews at Follow-up

For the purposes of the follow-up, reproductive health is defined as:

- _ MCH
- _ FP
- _ Gynecological cancers
- _ Breastfeeding
- _ STI/HIV/AIDS prevention

A provider received one point per RH component mentioned above.

Province	Center	# Providers Interviewed	Total Points Achieved	Possible Points	Percentage
La Vega	Hospital	11	9	55	16.4
	Consultorio Induveca	6	3	30	10.0
	Consultorio Jarabacoa	2	0	10	0
	Consultorio Zona Franca La Vega	4	3	20	15.0
	TOTAL		23	15	115
La Romana	Hospital	9	3	45	6.7
	Policlinica Zona Franca I	8	5	40	12.5
	Policlinica Zona Franca II	6	3	30	10
	Consultorio Batey Guaymate	3	2	15	13.3
	Consultorio Batey Higueral	3	2	15	13.3
	TOTAL		29	15	145
San Cristobal	Hospital Villa Altagracia	6	18	30	60.0
	Policlinica Haina I	8	16	40	40.0
	Consultorio Beta	3	1	15	6.7
	Consultorio Nigua	4	6	20	30.0
	Consultorio Zona Franca Villa Altagracia	5	12	25	48.0
	TOTAL		26	53	130

APPENDIX 6

QUALITATIVE EVALUATION INTERVIEW QUESTIONS

D.R. PI Pilot Interview Subjects and Questions
DRAFT ONLY

INTERVIEW SUBJECTS

PRIME Staff

- _ Ann Lion-Coleman, PRIME LAC Director
- _ Wanda Jaskeiwicz, PRIME LAC Program Officer
- _ Dr. Milton Cordero, PRIME LAC Regional RH Specialist
- _ Leda Herasme, PRIME temporary staff
- _ Altagracia Bella (Tatika), PRIME temporary staff, PI local trainer
- _ Denise Ure“a, PRIME Consultant

IDSS Project Staff

- _ Dra. Clavel Sanchez, Encargada PSR
- _ Dr. Luis Lara
- _ Luz Mercedes

IDSS Management

- _ Dr. DavÁd Guzman, Director de Salud
- _ Dr. Ceballos, incoming Secretaria de Salud P_blica; outgoing Director General de IDSS

USAID Staff

- _ Paul Schenkel

Cooperating Agency Staff

- _ Nora Queseda, JSI FPLM project

Target Audienc(es)

- _ Clinic/Hospital/Consultorio directorÒ3
- _ Feedback Data Collector/tabulatorÛ2
- _ ProviderÒ3

List of possible questions:

1. What was your role in the IDSS/PRIME PI project?
Cual es el papel que ud. desempeña en este proyecto?
2. What is your impression of the PI methodology/process used for this project?
3. Was this PI methodology/process different in any ways than projects you've done in the past? If so, what do you see as the major differences?
4. Given your experience with the PI process, would you now do anything differently with other areas of your work?
5. After working with the PI process on your projects do you (does your staff) now have any new or improved skills? What are some of them?
6. What was your impression from participating in the meetings required for each step of the PI process?
7. For each of the stages in the PI process, what made an impression on you; what do you remember as good/bad/unusual about that step?
8. GPA
9. PNA
 - Confirm stakeholder involvement
 - Producing the instruments
 - Defining desired and actual performance
 - Root cause analysis/fishbone
 - Finding interventions
 - Cost/benefit analysis
10. DDI
 - Development of CPI norms
 - Feedback from clients
 - Training in CPI
 - Expectation setting for clinic services offered
 - Client educational materials on services offered
11. Implementation
12. Evaluation
13. What do you consider to be the greatest success/outcomes of the project?
Que considera ud. que han sido los resultados mas importantes del proyecto?
14. What changes would you recommend for future PI projects done in IDSS?

APPENDIX 7
CLIENT FEEDBACK/SUGGESTION CARD

FORMULARIO DE SATISFACCION DE USUARIA

Estamos realizando un sondeo con el fin de conocer las percepciones de las usuarias sobre el trato que reciben en las clínicas. Por favor responda en la manera m-s honesta a las siguientes preguntas. Sus respuestas ser-n confidenciales. Por favor, circule la respuesta que mejor contesta la pregunta. Agregue sus comentarios.

SER AMABLE

El personal médico:

- | | | | |
|--|----|----|------------------|
| 1. Le saludó y llamó por su nombre? | SI | NO | Comentarios_____ |
| 2. Le preguntó sobre el motivo de su visita, sus necesidades y preocupaciones? | SI | NO | Comentarios_____ |
| 3. Puso atención mientras hablaba: le hizo preguntas, la miraba? | SI | NO | Comentarios_____ |
| 4. Permitió que se expresara sin interrupciones? | SI | NO | Comentarios_____ |

Garantizar la privacidad y confidencialidad

El personal médico:

- | | | | |
|--|----|----|---|
| 5. Le aseguró un consultorio cómodo y privado en lo posible? | SI | NO | Comentarios_____ |
| 6. Respetó su pudor durante el examen físico? | SI | NO | No se hizo examen físico
Comentarios_____ |
| 7. Solicitó su permiso para que otras personas estuvieran con Ud. durante la consulta y explicó por qué? | SI | NO | Nadie m-s estuvo presente
Comentarios_____ |

8. Le habló sobre sus asuntos en una manera discreta? SI NO Comentarios _____
9. Le aseguró que lo que Ud. le dijo no se lo diría a otra persona? SI NO Comentarios _____

VOLTEAR LA PAGINA →

Brindar información

El personal médico:

10. Le brindó información correspondiendo a sus preguntas o necesidades? SI NO No tenía preguntas Comentarios _____
11. Era claro y completo en sus explicaciones usando un lenguaje sencillo? SI NO Comentarios _____
12. La invitó a que hiciera preguntas y expresara sus opiniones y desacuerdos? SI NO Comentarios _____
13. Se preocupó por saber si Ud. entendió lo que le explicó? SI NO Comentarios _____
14. Le explicó sobre su problema usando folletos/rotafolios? SI NO Comentarios _____

Buscar soluciones

El personal médico:

15. La ayudó a tomar una decisión para resolver un problema? SI NO No tenía problema Comentarios _____
16. La ayudó a planear su próxima cita? SI NO Comentarios _____

Razón por su visita _____

Quién le atendió? _____

APPENDIX 8
LIST OF KEY PROJECT PARTICIPANTS

Key Project Participants

Ministry of Health, El Salvador

Dra. Avalos, Director, Departamento de Atención a la Personal

Dr. Morán Colato, Coordinator, RH Programs

Dr. Eduardo Interiano, Former Minister of Health

PRIME El Salvador

Dr. Douglas Jarquín, Resident Program Coordinator

Ms. Luz Elda Aguirre, Senior Technical Supervisor/Administrator

Ms. Beatriz de Alonso, Quality of Care Coordinator

Ms. Ana de Herrera, Adolescent Coordinator

Ms. Sonia Hernandez, Secretary

PRIME/LAC Regional Office

Ms. Ann Lion Coleman, Director, PRIME Regional Office for Latin America

Dr. Milton Cordero, INTRAH/PRIME Reproductive Health Specialist

Ms. Sandra Echeverria, INTRAH/PRIME Evaluation & Research Specialist

Dr. Dan Edwards, PRIME/TRG Management Specialist

Mr. Sergio Luiz Lins, PRIME Contraceptive Logistics Consultant

Ms. Annie Portella, PRIME Materials Development Consultant

APPENDIX 9

LIST OF PERSONS INTERVIEWED

BY DIANE N. CATOTTI, MAY 1999

Persons Interviewed

Ministry of Health (Ministerio de Salud Publica (MOH))

San Salvador (Central Level):

Dr. Maria Elena Avalos, Director, Departamento de Atención a la Persona (RH Services)

Dr. Morón Colato, National Reproductive Health Coordinator

Departmental Level:

La Libertad:

Licda. Marivel Salazar de Criollo, Nurse, Departmental Nursing Supervisor

Dr. Gustavo Arnoldo Ostorga Alvarado, Medical Supervisor

La Paz:

Licda. Rafaela Diaz de Molina, Departmental Nursing Supervisor

Dr. Rene Victorino Coto Portillo, Departmental Medical Supervisor

Zona Occidental, San Salvador:

Licda. Sonia De Sanchez, Nurse, Facilitator of PRIME Parteras Training

Zona Norte, San Salvador:

Lic. Ana Sofia Deabego, Nurse, Midwife Coordinator and Facilitator

Health Unit (Local)/Community Level:

Ms. Cecilia Esmeralda Sanchez, PRIME-trained Promotor, Canton La Zereto,
Unidad de Salud Nonualco

Parteras in PRIME Training:

Sra. Teodora Palacios Viuda del Amir, Unidad Mexicano

Sra. Ana Catalina Martinez, Canton: Arenales, Depto. De San Salvador, Central, Unidad:
Habito Confien

Promotors in Basic MOH Training:

Sr. Santo Alberto Jimenez Guerrero, San Vicente, Depto. De La Paz

Sr. Francisco Eduardo Rojas Garcia, Canton: Guagoyo

USAID/El Salvador

Ms. MariCarmen de Estrada, Reproductive Health Officer

APSISA

Licda. Patricia Portillo de Reyes Hernandez, Director, APSISA Project

ADS:

Dr. Jorge Hernandez, Director (interviewed by telephone, 5/27/99)

ISSS:

Dra. Leona Melendez, Director, Reproductive Health

FHI:

Mr. Bill Conn, Senior Program Officer for Latin America

PRIME/El Salvador Staff

Dr. Douglas Jarquin, Resident Program Coordinator, PRIME/El Salvador

Ms. Luz Elda Aguirre, Senior Technical Supervisor/Administrator

Ms. Beatriz de Alonso, Quality of Care Coordinator

Ms. Ana de Herrera, Adolescent Coordinator

Ms. Sonia Hernandez, Secretary

PRIME LAC Staff/Consultants

Ms. Ann Lion Coleman, Director, INTRAH/PRIME Regional Office for Latin America

Dr. Milton Cordero, INTRAH/PRIME Reproductive Health Specialist

Ms. Sandra Echeverria, INTRAH/PRIME Evaluation & Research Specialist

Mr. Sergio Luiz Lins, PRIME Contraceptive Logistics Consultant

APPENDIX 10

INTRAH/PRIME EDD INTERVIEW INSTRUMENT

GUÍA DE UNA ENTREVISTA PARA DETERMINAR EL IMPACTO DE INTRAH/PRIME EN EDD - IDSS

WANDA - INTRO.

Gracias por su tiempo. El propósito de esta entrevista es obtener información sobre los efectos que el proyecto de PRIME ha tenido en el IDSS, además, entender mejor como ha funcionado el proceso de mejoramiento de desempeño. Le agradecemos mucho el tiempo que tan amablemente nos dedique. Le rogamos que responda a las preguntas en una forma imparcial y sincera. No se sienta mal al hacer críticas. También, para documentar mejor sus respuestas, le rogamos que dé ejemplos en sus respuestas.

(reference key: IIGQ# is original english impact interview guide question number.
CBQ# is revised english capacity building questionnaire number.)

DIANE with ALL INTERVIEWEES:

1. Primero, me gustaría aclarar su nombre y título, y confirmar cual es el papel que ud. desempeña en este proyecto?

2. ¿Cuál cree usted que ha sido el resultado más importante del proyecto de PRIME y cuáles han sido los principales factores que han producido tal resultado? (IIG #1. Resultado)

3. ¿Cómo ha sido afectado el IDSS por este proyecto? Como ha contribuido este proyecto al aumento de capacidad organizacional? y en que areas?

WITH ALL IF NO TIME SKIP TO LAST PAGE, RE: TA.

FOR CLAVEL/LARA/HOSPITAL DIRECTOR/ASST. DIRECTOR:
(others skip to #16 below)

*Tengo varias preguntas relacionadas con el sistema y la estrategia de servicios y/o capacitación en **salud reproductiva del IDSS**.*

(Para IDSS Central: Cambio en SR dentro del IDSS (la promoción de SR en el IDSS a nivel del Director))

4. Tengo entendido que el cargo y el estatus de SR y su posición ha cambiado en el último año. ¿Podría describirme que pasó y el impacto de estos cambios?

CBQ #1: Directrices (Directivas, Políticas, Manuales, Normas) de SR

5. *¿Existen directrices de servicios actualizados de servicios de SR (o directrices de capacitación)? (¿Cubren la PF o la SR o ambas?)

6. ¿Ya se completaron o se están elaborando? ¿Qué función desempeñó PRIME en la elaboración y la difusión de esas directrices?

7. Si las había, ¿cuáles directrices existían o se empleaban en 1998 (antes de PRIME)?

8. ¿Qué planes tiene actualmente sobre difusión (y/o distribución) y uso de estos directrices?

CBQ #2: política oficial

9. *¿Existe una política oficial y escrita para los servicios de SR o para la capacitación en SR?

CBQ # 9: Plan de trabajo en SR o capacitación

10. ¿Tiene el IDSS un plan escrito de trabajo para servicios de SR o un plan de capacitación en SR? ¿Se revisa periódicamente, por ejemplo, cada año?

CBQ # x:

11. ¿Se emplean normas para la mejora de la calidad de la atención y de los servicios en SR?

12. Además, ¿Podría explicarme sobre el uso y el desarrollo de los criterios básicos para la humanización de servicios?

CBO # 12: MD en el plan estratégico

13. ¿El mejoramiento de desempeño forma parte del plan estratégico del IDSS?

14. *¿Ha desempeñado PRIME una función en el fortalecimiento o la elaboración de estrategias, planes o políticas?

15. *¿Cómo era la situación en 1998, antes de la participación de PRIME?

START HERE FOR NON LEADERS (or if no time skip to 23 below)

IIG # 5: Salud Reproductiva Integrada

16. Ahora quisiéramos pedirle que nos dé sus comentarios acerca de la intervención de PRIME para proporcionar un marco de salud reproductiva integrada a los servicios que se ofrecen por conducto de su organización?

17. *¿Cómo han respondido los proveedores de servicios ante este nuevo enfoque o prioridad acerca de los servicios integrados de SR?

CBQ # 14: infraestructura/decentralización

18. ¿Podría describir el proceso de proveer servicios en SR? o sea, ¿Como están organizados? ¿Es descentralizada? ¿Existen servicios de SR en todas las provincias?

19. ¿Qué planes de expansion de servicios de SR tiene el IDSS? Y expansion o replicació del modelo de mejoramiento del desempeño?

CBQ # 4: EL PRESUPUESTO DE SR:

20. *¿De dónde provienen los fondos de los programas de servicios en SR? y de la Unidad de SR?

21. ¿Podría decirme qué porcentaje del presupuesto de los servicios en SR proviene de recursos del país? (puede ser un estimado) y de la Unidad de SR?

22. ¿Qué porcentaje proviene de ayuda extranjera?

CBQ # 3: Apoyo político

23. * ¿Ha habido demostraciones públicas de apoyo por parte del personal del IDSS en cuanto a los servicios de SR o a la capacitación en SR? ¿Desde que llegó PRIME? ¿Podría decirme lo que dijeron?

24. ¿A qué nivel (alto, intermedio, central, hospital, policlinica, consultorio)?

- 25.¿Cuál era la situación antes de la participación de PRIME?

IIGC #2: Acceso

Ahora quisiera hablar del acceso a los servicios de salud reproductiva.

26. *¿Ha habido cambios en el acceso general que se tiene a los servicios de salud reproductiva en el último año?
27. **¿Ha contribuido el proyecto PRIME al aumento del acceso que tiene la población a los servicios de salud reproductiva que ofrece su institución, y si ha contribuido, cómo lo ha hecho? Por favor, dé algunos ejemplos...

TRANSITION TO PI/MD:

IIGQ # 4/CBO # 11: impacto en el servicio

28. **¿Qué efecto cree que el proyecto PRIME ha tenido en la prestación de servicios?
29. *El trabajo con PRIME en el Mejoramiento de desempeño, ¿ha hecho que los servicios de SR sean más sensibles a cuestiones de calidad, como por ejemplo en ...la humanización de servicios?
30. ¿Han ocurrido los cambios oportunamente y conforme a lo que se esperaba? ¿Cuál era la situación antes de 1998?

(hold)

Por favor, describa la función que PRIME ha desempeñado en el aumento del número de:

- proveedores capacitados que prestan servicios (personal de la unidad de salud, promotores, parteras tradicionales);
- puntos de prestación de servicios (PPS) que prestan servicios;
- programas organizados para prestar servicios. En particular, en lo referente a la capacidad de llegar hasta las poblaciones subatendidas (por ej., adolescentes, hombres, población rural).

31. ¿Ha influido el proyecto de alguna manera en la administración de la clínica la integración de los servicios de SR, es decir, ha habido cambios en el horario de servicios de la clínica o se ha requerido una mejora del equipo?

32. ¿Hay señales de que ha aumentado el número de personas atendidas en la clínica? ¿de mayores tasas de aceptación? ¿de mayores tasas de continuidad de utilización de anticonceptivos?

(Don't use for now:

Por grupo (médicos/personal de la unidad de salud; promotores; parteras tradicionales):

¿Cuáles servicios prestaban estos profesionales antes?

¿Cuáles servicios están prestando ahora?

¿Se ha ilustrado esto en los datos estadísticos de los servicios? ¿Me puede dar ejemplos de los informes de esos datos?

¿Se están prestando servicios a otras poblaciones subatendidas? ¿Se está atendiendo a más hombres y a más adolescentes?)

CBQ # 16: Evaluación de Necesidades

33. ¿Se evalúan periódicamente los servicios de SR y/o el desempeño de los proveedores?

¿Y se emplean los resultados para mejorar los servicios?

CBQ # 19: Replica de MD/END (evaluación de necesidades de desempeño)

34. ¿Hay capacidad dentro del IDSS de replicar el proceso de MD? ¿De la evaluación de necesidades de desempeño? ¿Del análisis de costo-beneficio?

CBQ # 15. Desarrollo de Recursos Humanos y MD

35. *Podría explicarme como se combina el uso de promoción, incentivos, seguimiento o supervisión para fomentar el buen desempeño? ¿Cuales se usa?

STOP HERE - PASS TO MARC - AHORA, MI COLEGA TIENE MAS PREGUNTAS RELACIONADOS AL PROCESO DEL MEJORAMIENTO DE DESEMPEÑO. LUEGO, TENGO MAS PREGUNTAS RELACIONADAS AL AUMENTO EN LA CAPACIDAD DEL IDSS.

Capacity Building:

CBQ # 17: SISTEMAS DE INFORMACIÓN

Tengo varias preguntas relativas a los sistemas de información de servicios de SR. ¿Con quién me sugiere que hable acerca de eso?

36. * ¿Tiene un sistema de información de gestión para los servicios de SR o el desempeño de los proveedores?
37. ¿Este sistema recopile datos estadísticos del nivel de servicios, es decir, métodos suministrados, años de protección por pareja (APP), tasas de continuidad y discontinuidad de utilización de anticonceptivos?
38. ¿Se mantiene este sistema (sistema de información de gestión comparado con datos estadísticos de servicios) a nivel central? A nivel local? (define)
39. ¿Podría por favor darme ejemplos o dejarme ver informes de bases de datos?
40. ¿Qué función desempeñó PRIME en la elaboración o el fortalecimiento de esos sistemas?
41. ¿Cuál era la situación en 1998, antes de la participación de PRIME?

CAPACITACIÓN & PROGRAMAS DE ESTUDIOS:

Ahora, me gustaría hablar en mas detalle sobre el sistema de capacitacion en SR que utiliza el IDSS.

42. *¿Podría hablarme del sistema que usa el IDSS para capacitar a los proveedores en PF/SR?

CBQ # 8: formación de capacitadores/ K& S

43. ¿Imparten cursos de actualización en SR periódicamente?

44. ¿Se exige a los capacitadores que tomen y aprueben exámenes estandarizados sobre destrezas y conocimientos técnicos en SR?

45. ¿Tiene el IDSS planes de replicar estos talleres?

CBQ # 19: Replica de cursos, etc.

46. * ¿Participan en la replicación de esos cursos las personas que han recibido capacitación?

CBQ # 10: curricula

47. *¿Existen programas de estudios para la capacitación en SR? ¿Se revisan periódicamente? ¿A qué nivel? (el nivel central?)

48. ¿Se incluyen elementos de calidad de la atención en los manuales de capacitación también?

49. *¿Cuál ha sido la función de PRIME en la elaboración y la estandarización de esos programas de estudios?

50. *¿Podría describirme la forma en que PRIME puede haber influido en la forma en que ustedes realizan la capacitación? Por ejemplo, ¿al incorporar la interacción entre el cliente y el proveedor, los métodos de aprendizaje participatorio y los métodos de aprendizaje para adultos?

51. **¿Ha mejorado la capacitación de alguna manera? Por ejemplo, ¿con mejores elementos de consejería? ¿combinaciones de métodos mejores o ampliadas?

52. ¿Ha dado resultado esta capacitación adicional en la prestación de servicios (métodos que solicitados y proporcionados)?

PARA FACILITADORES/PARTICIPANTES:

53. ¿Qué impacto personal y profesional ha tenido ud. de este proyecto?

54. ¿Ha cambiado la forma de desempeñar su trabajo?

55. ¿Ha cambiado la manera de capacitar a otros profesionales?

IIGQ # 2 (tablas):

56. ¿Cuántos proveedores de servicios recibieron capacitación con el nuevo programa de estudios?

TOT: 11 facilitadores capacitados.

7 talleres: 125 participantes.

57. ¿Cuando fue la última vez que los proveedores recibieron capacitación al nivel en que se ofreció con PRIME?

CBQ # 13: colaboración interagencial

58. *¿Existe alguna colaboración entre agencias, por ejemplo, entre el sector público y el privado, en los servicios de SR o en la capacitación en SR??

¿Qué tan amplia es esa colaboración? ¿Me puede dar algunos ejemplos?

CBQ # 18: networking, E&R

59. Recibe o comparte materiales u informes u otras fuentes de informacion con otras agencias, por ejemplo, de estudios de evaluacion u investigacion para mejorar los servicios de SR?

CBQ # 20: PARTICIPACIÓN COMUNITARIA

60. * ¿Participan los representantes comunitarios en la planificación y la realización de servicios de salud reproductiva u actividades de capacitación, por ejemplo en la elaboración del contenido de programas de estudios o en la elaboración de planes de capacitación?

61. ¿Se incluye a estos representantes en las evaluaciones de necesidades?
62. ¿Participan en la evaluación del desempeño de los proveedores?
63. ¿Podría decirme un poco del desarrollo de los comentarios de los clientes? ¿Incluye la comunidad en este proceso?

CBQ #5: Venues

64. * ¿Con qué establecimientos cuenta el IDSS para la capacitación en SR (ej. salones de clase, salones de conferencias, auditorios)?
65. ¿Son estos establecimientos propiedad del IDSS o son alquilados? (Cada vez o anualmente)?

CBQ # 6: materiales, equipo y suministros

66. *¿Se cuenta con materiales de SR o de capacitación adecuados, equipo, y electricidad, por ejemplo, folletos educativos, proyectores periscópicos (retroproyectores), rotafolios, marcadores, etc.?
67. ¿Existen sistemas para actualizar, mejorar o proporcionar nuevos suministros de materiales de SR o capacitación? (CBQ # 7:)
68. ¿Cómo era la situación en 1998, antes de que PRIME participara en la República Dominicana?
69. ¿Podría, por favor, decirme qué función ha desempeñado PRIME en el suministro o mejora de materiales, equipo o establecimientos para los servicios de SR o en la capacitación en SR?

Logística

70. *Tengo entendido que PRIME ha ayudado a fortalecer el sistema de logística de anticoncepción. ¿Podría hablarme de eso? ¿Cuál era la situación antes de la participación de PRIME?

BACK TO DIANE: IF WENT STRAIGHT FROM PI.

IIGC # 6/7: PRIME TA

71. ***¿Podría hablarme un poco del estilo empleado por los representantes de PRIME y de la filosofía del proyecto respecto a sus necesidades?
72. En particular, ¿en qué medida los procesos y las intervenciones han sido participatorios, democráticos, apropiados y pertinentes?
73. ¿Hay algo que ha caracterizado la labor de PRIME en estos años? en particular en comparación con otras agencias?
74. ¿Puede sugerirnos algo, especialmente respecto a la forma en que podemos mejorar?

Le agradezco mucho su tiempo y sus comentarios.

APPENDIX 11
INTRAH/PRIME EDD IMPACT INTERVIEW GUIDE

INTRAH/PRIME EDD IMPACT INTERVIEW GUIDE

Thank you for taking the time to meet with me. The purpose of this interview is to obtain some accurate information on the effect that the PRIME project has had on the work of your unit/office. The interview should take about an 1 hour or so, for which we much appreciate the time you are generously giving us. We ask you to provide sincere, candid answers to the questions posed. Please do not feel uncomfortable in expressing any critical views. Also, in order to better document responses, please provide examples and illustrations to your answers.

1. I would like to begin with several questions related to the RH/FP training system and strategy of your institution.

I. National FP and/or RH GUIDELINES

1. First, Can you clarify for me the status of updated FP/RH service (and training guidelines)? (Do they cover FP or RH or both?)
2. Are they completed or in process?
3. What was PRIME's role in developing and disseminating these guidelines?
4. What, if any, guidelines were in place/were you using in 1997 (prior to PRIME/FHI?)
5. What are your current plans for dissemination and use of guidelines? (clarify which version...)

II. TRAINING STRATEGY, PLANS, STANDARDS

1. Can you tell me about the MOH system of training providers in FP/RH?
2. Can you tell me a little about the decentralized process of training? Are there decentralized training units in all departments? And are they administratively/financially strong or weak?
3. Is there an official, written policy (strategy) for RH training?
4. Does the MOH have a written RH training plan? Is it reviewed annually?

5. Has PRIME played a role in strengthening or developing the training strategy, plans, policy?
6. What was the situation in 1997, prior to PRIME involvement?
7. Are quality of care and service improvement standards (as defined by the guidelines) used in the development of training plans? (CPI, increasing method mix, ...)
8. Do you have any plans to further strengthen or formalize these training services?
9. Is training combined with use of promotion, incentives, follow-up and/or supervision to encourage good performance?
10. Are trainings evaluated and do the results feed into program improvement?

III. TRAINING & CURRICULA:

1. Does the MOH use training needs assessment to assess the need for RH training?
2. Are there official standard training curricula used for RH training?
3. Are these reviewed periodically? At what level? (central or departmental)
4. Are trainers required to take and pass standard tests on FP/RH technical skills and knowledge?
5. Do the training units conduct periodic refresher courses?
6. Are trainees involved in the replication of these courses?
7. What has PRIME's role been in the development and standardization of these curricula?
8. Has working with PRIME made these more sensitive to quality issues, for example on counseling to provide more method choice?
9. What was the role prior to 1997?
10. Can you tell me about how PRIME may have affected the way you conduct training? For example, by incorporating CPI? supportive supervision? Participatory learning methodology? Adult Learning Methodologies?
11. Are quality of care elements reflected in training manuals as well?

12. Can you tell me a little about any inter-agency collaboration there has been in the development of these curricula and/or manuals?

IV. THE TRAINING BUDGET:

1. What is the basis of funding for MOH RH training?
2. Can you tell me what proportion of the RH training budget is provided by in-country resources?
3. What proportion is supported by foreign assistance?

V. CONTRACEPTIVE LOGISTICS

1. I understand that PRIME has helped to strengthen the contraceptive logistics system; Can you tell me about that?
2. What was the situation prior to PRIME involvement?

(Could I please get some examples, i.e., data for 1997, 1998 and 1999 if possible.

VI. COMMUNITY INVOLVEMENT

1. Are Community representatives involved in planning and conducting training activities, e.g., developing curricula content, developing training plans, are included in training needs assessments?
2. Are they involved in assessing provider performance? Are they aware of their rights and/or demand competent provider performance?

VII. POLITICAL SUPPORT

1. Have there been any public shows of support by MOH personnel re RH or FP training?
Can you tell me a bit about what they said?
2. At what level (high, medium, national, central, departmental)?
3. Since PRIME?

4. What was the situation prior to PRIME?
5. Is there collaboration between the public and private sector in support for RH training?
How extensive is this collaboration? Can you provide examples?

VIII. TRAINING INFORMATION/SYSTEMS

I have several questions relating to training information systems, training facilities and equipment. Who do you suggest I speak to about these?

1. Do you have a management information system for training, where the number and characteristics of trainees and materials are tracked?
2. Can I please get examples or look at your database reports, for example, of who is being trained, and what information you collect on them?
3. Do you also have a system that collects service level statistics, i.e., methods provided, couple years of protection (CYP), continuation & discontinuation rates?
4. Is this system (MIS for training vs. service statistics) maintained at the central level?
5. What was PRIME's role in developing/strengthening these systems?
6. What was the situation in 1997, prior to PRIME involvement?

IX. TRAINING RESOURCES

1. What facilities are available to the MOH for training?
2. Are these owned or rented by the Ministry?
3. Can you tell me about the facilities and equipment?
4. Are they working well for you?
5. Do they have adequate equipment, power supply, training materials, i.e., overhead projectors, flipcharts, markers, etc?
6. Are there systems in place to update/upgrade/resupply training materials?
7. What was the status in 1997, prior to PRIME involvement in El Salvador?

8. Can you please tell me what role PRIME has played in the provision or upgrading of training materials, equipment, or facilities?

2. Now I would like to talk about access to health services...

1. Have there been changes in the overall access of reproductive health services over the past 2 years?
2. Has the PRIME project contributed to increased Access of the population to reproductive health services offered by your institution and if so how? Please provide examples...
3. Can you tell me about PRIME's role in helping to increase the number of:
 - a) trained providers delivering services? (health unit personnel, promotors, TBAs)
 - b) service delivery points (SDPs) delivering services ?
 - c) programs organized to deliver services? In particular, it refers to the capacity to reach underserved populations (e.g. adolescents, men, rural).
4. What affect do you believe the PRIME training had on service delivery? Was it improved in any way? for example, with improved counseling elements? improved/expanded method mix?
5. Have the changes happened in a timely manner and according to your expectations?
6. Can you provide examples or reports to help us document these changes? Is there someone (else) I can get these statistics from, if there are any?

- 1. # of service providers formed by PRIME, by year and type (if possible, obtain figures from before 1997 and figures on trained providers from 1997 to 1999 from other agencies **and the rate of training, e.g., 30 TBAs trained per quarter**);*
- 2. # of new cadres of providers trained or providers trained in new interventions; see illustrative tables below]*

3. Next, we would like to ask for your candid comments in terms of PRIME's intervention to provide an Integrated Reproductive Health

framework to services that are offered through your organization, i.e., the addition of family planning services to other reproductive health services.

1. By cadre (doctors/health unit personnel; promoters; tbas): What services were they providing before?
2. What services are they providing now?
3. Has the integration of RH & FP services affected clinic management in any ways, e.g., change in clinic hours, or in requiring an upgrade of equipment?
4. Is this illustrated in service statistics? Can I get examples of reports of these data?
5. How have service providers responded to this new approach/emphasis on integrated RH services?
6. How many service providers were trained in the new curriculum (e.g., CTU & CPI for health units; adding FP services to RH for promoters & TBAs)? (see table)
7. Has this additional training made a difference in service delivery (methods being requested and provided)?
8. Are services being provided to additional underserved populations? Are we reaching more men, adolescents?
9. Is there any evidence of increased clinic caseload? Increased acceptance rates? Increased continuation rates?

4. Can you tell me a little about the style used by PRIME representatives and of the project's philosophy with respect to the your needs?

1. In particular, how participatory, democratic, appropriate, relevant have processes and interventions been?
2. Is there something that has characterized the work of PRIME during these years?
3. Do you have any suggestions for us, especially in terms of how to improve?

5. Finally, what do you think has been the most important outcome of the PRIME project and the main factors responsible for such outcome?

Is there anyone else you suggest I speak with while I'm here?

I want to thank you very much for your time and comments.

APPENDIX 12

INTRAH/PRIME CAPACITY BUILDING IN TRAINING QUESTIONNAIRE

(EDD INSTRUMENT)

**INTRAH/PRIME
CAPACITY BUILDING IN TRAINING QUESTIONNAIRE**

Instructions: *These are the illustrative descriptions for each of the capacity building indicators. Please respond with the letter that describes as close as possible the status of your institution, providing examples and illustrations to your answers as required. Remember, what is needed is an **objective** assessment of where the institution stands on each indicator. There is no “positive” or “negative” answer, just a measure to help explain the present and real status of an institution. Do **NOT** leave any answers blank, as it would not permit completing the entire assessment. Thank you.*

COUNTRY: El Salvador

INSTITUTION:

NAME AND POSITION OF THE PERSON COMPLETING THE REPORT:

I - LEGAL-POLICY SUPPORT

⟨ **National FP/RH service guidelines and training are official**

1. Existence of updated official FP/RH service and training guidelines

Whether a) there are no guidelines for service delivery; b) guidelines are in initial/incomplete stage or are outdated; c) guidelines exist but have not been made official or have not been fully disseminated; d) guidelines are complete, updated, official and fully disseminated.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

⟨ **Political support for training institutionalization**

2. Official (written) policy supporting institutional training capacity (e.g. training units, cadre of master trainers, venues, etc.) for health providers

Whether a) there is no written policy supporting development of a national training strategy/capacity; b) there is some policy but is timid, not enforced or has not translated into actual support; c) there is a definite policy but it has not been made official or has not been fully disseminated; d) there is a strong, official policy that is put into practice through norms, regulations and implementation plans.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

3. Favorable public statements on FP/RH training (for the improvement of services) at least twice a year by senior officials

Whether a) there has been no mention by senior officials favoring/supporting FP/RH training (related to the improvement of services); b) there has been an occasional, timid or “wishful” statements only; c) statements have been made by either medium ranking officials or by high level officials but not in public or only occasionally; d) high level officials mentioned their ample support for FP/RH training on several private and at least twice on public occasions.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

II - RESOURCES

Financial

< Existence of sufficient and diversified Training Budget

4. The training budget relies mostly on internal (in-country, institutional) sources

Whether a) Training relies entirely on foreign assistance and/or there is no training budget; b) training relies heavily (at least 50%) on foreign assistance and/or training funds are allocated on ad hoc basis; c) in-country resources/budget account from between 50 and 80% of total training funds; d) in-country budget for training provide more than 80% of the budget. (One other way of looking at it is whether budget covers all aspects of training (including materials and equipment, travel and per diem by consultants and staff, venue hire and maintenance, etc.).

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Venues/Equipment

< Adequate venues

5. Accessible and available (own, rented) venues (at least one local venue in each training area) that are of standard quality (continuous power, good lighting, acoustics and sufficient capacity), accessible to participants and available when needed

Whether a) there are no adequate venues for training of health providers; b) there are few occasional venues and/or often unavailable; c) there are venues of adequate quality but cannot be readily secured for training; d) there are local venues that are fully accessible, of high quality and sufficient capacity for training.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Materials, equipment and supplies (MES)

< Appropriate and cost-efficient MES (incl. AV equipment & teaching aids)

6. MES are pertinent, updated and adapted to local culture (incl. locally produced)

Whether a) materials, equipment and supplies are outdated and/or not adapted/produced locally.... to d) MES are technically superior, updated/current and are adapted to the local/cultural context.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

7. Financial, printing and planning capabilities exist for replacing and upgrading MES

Whether a) there are insufficient means for making MES available and/or replacing old ones; b)MES are made available, but either insufficient or not of adequate quality; c) MES of standard technical and material quality and readability can be made available for each trainee, although there are occasional shortages; d) Systems are in place locally for continuous replacement and upgrading of quality MES, which are available as and when required.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Human

⟨ **Trainers/preceptors formed have updated and standardized technical and presentation K&S***

8. Trainers/preceptors are constantly formed (TOT) and do periodic refresher courses and pass standard tests on FP/RH technical & presentation K&S

Whether a) Trainers/preceptors are not regularly formed and/or do not update their technical & presentation K&S... to d) Trainers/preceptors constantly formed and undergoing periodic (at least once every two years) refresher courses.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

III - TRAINING PLANS & CURRICULUM

⟨ **Updated and periodically reviewed training plans**

9. Training plan exists and is reviewed annually

Whether a) There is no training plan per se (training conducted on ad hoc basis), to... d) Training plans are drawn periodically (at least annually) and reviewed

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

⟨ **Updated curriculum is official standard for training institutions**

11. Existence of a standard official training curriculum guiding training institutions

Whether a) There is no standard training curriculum, or is inadequate/outdated, different ones used by different institutions, b) there are some updated curricula, but not standardized or officially endorsed, c) A standardized curriculum is in place, but either not reviewed periodically or is not officially used by training institutions, to d) There is a standard curriculum, reviewed periodically (at least once every 2 years) and used officially by training institutions

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

IV - ORGANIZATIONAL

Leadership

⟨ **Vision of training as a means to improve services**

11. Training plans are linked with quality of care and increased service access

Whether a) Providers' training plans are ad hoc-not coupled with service and quality of care objectives, to... d) Training plans form part of Quality of Care and service improvement strategies.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

⟨ **Training is an integral part of organization's strategic planning**

12. A training plan and activities are part of the organization's strategic plans

Whether a) Training is not part of the organization's strategic plan (or the training institution has a strategic plan), to ...d) Training is part of the organization's long-term strategic plan (not yearly but multiannual)

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

⟨ **Promotion of public-private collaboration**

13. Evidence of public-private collaboration

Whether a) There is no (or no evidence) of public-private collaboration in training, b) there is some public-private collaboration, but is haphazard and loosely coordinated within the training institutions, c) public-private collaboration exist at different levels, however efforts are still disintegrated or not guided by joint planning/programming , d) there is ample public-private collaboration, guided by extensive planning/programming.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Infrastructure

< Existence of decentralized training units in all areas

14. Active training units exist at central and peripheral levels

*Whether a) There are no decentralized training units (even if there is one at central level, b) there are a **few** training units at peripheral levels but are administratively/financially weak (incl. documentation center and computerized equipment), c) **several** decentralized training units exist but are administratively/financially weak, d) Active and strong training units exist in central and peripheral levels.*

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Human Resource Development

< **Training (TOT, formative and refresher courses) is an integrated part of a Human Resource Development/Performance Improvement system (e.g. promotion and incentives, follow-up & supervision, efficacy)**

15. HR development is part of a HRD/PI strategy

Whether a) Training is not coupled with HRD or providers' improvement objectives, ...to d) Training is part of HR development and performance improvement system

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Administration

- ⟨ Existence of a reporting system for tracking number and characteristics of trainees and materials, according to needs

16. Existence and use of a Training Needs Assessment (TNA)

Whether a) There training is not based on some form of TNA, b) TNA is seldom done, or on a casual basis or results are not fed into the training plans, c)TNA is a regular practice in the institution, however their results are not fully exploited, d)TNA is customarily done to tailor training strategies and improve performance.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

17. Existence of a Management Information System (MIS) for training that includes information on trainees and materials

Whether a) There is no MIS for tracking training progress, b)there are some data on courses, trainees, materials, etc. but not integrated in a system, c)there is initial integration of data into an information system that helps evaluate progress and assists planning, to d) There is a fully automated and effective MIS for training.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Technical Capability

⟨ **Technological transfer and development through networking, evaluation & research (E&R)**

18. Contacts with other training institutions and institution’s E&R feed into training improvement (e.g. trainee selection, training contents and formats)

Whether a)there is no/little use of E&R or information from other national/international training institutions to improve and update training capabilities... to d) Extensive use is made of internal and external data & resources for quality assurance and technical improvement of the institution.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Track Record

⟨ Proven capacity to conduct/replicate courses autonomously

19. Replica/other courses carried out independently (w/institutional resources)

Whether a)There have been no replica or independent courses carried out by the organization (or only done with foreign assistance)... to d) There is ample evidence of ongoing replica/expansion of courses to wider areas and with institutional resources.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

V - COMMUNITY DEVELOPMENT-PARTICIPATION

⟨ **Community representatives are involved in planning and execution of training activities, are aware of their rights and/or demand competent provider performance**

20. Evidence of community involvement in providers’ training and/or performance assessment (e.g. quality of care circles)

Whether a)There is no/little community involvement contributing to curricula contents, drawing of training plans, or provider performance b)community representatives are included in training needs assessments and/or are aware of their rights in relation to CPI; c)Initial community involvement in shaping provider training and service needs, to d) Extensive involvement/participation in provider training and/or performance assessment; organized demand/petitions to improve services, etc.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

APPENDIX13
REFERENCES/PROJECT DOCUMENTS

Project Documents/Materials

Curricula:

Training of Trainers Manual in RH and FP (*Manual de Capacitación a Capacitadores en Salud Reproductiva y Planificación Familiar*), (TOT/CTU)), PRIME, 1998.

Manual on Training of Promoters in RH and FP (*Manual de Capacitación a Promotores(as) en Salud Reproductiva y Planificación Familiar*), PRIME, 1999.

Manual for Training of Parteras in RH and FP (*Manual para la Capacitación de Parteras sobre Salud Reproductiva y Planificación Familiar*), PRIME, 1999.

Training Support and Educational Materials:

Promoter Counseling Manual (*Manual de Orientación en Planificación Familiar para El Promotor*)

Promotor Reference Manual (*Manual de Consulta para el Promotor*).

3 Full-size Sheets (Mantas).

Contraceptive Method Poster.

Contraceptive Logistics:

Ministry of Health El Salvador Final Evaluation Report, Contraceptives Logistics Workshops , Sergio Lins, INTRAH/PRIME, March 1999.

Manual of Norms and Procedures in Contraceptive Method Administration, Sergio Lins, INTRAH/PRIME, 1999.

EDD Instruments:

INTRAH/PRIME Capacity Building in Training Questionnaire (EDD Instrument), May 1999.

INTRAH/PRIME EDD Impact Interview Guide (*Guía de una entrevista para determinar el impacto de INTRAH/PRIME en EDD*), May 1999.

PRIME LAC Staff/Consultant Trip Reports

Project Proposals:

APSISA Project Proposal: Improving the Quality and Availability of Family Planning and Reproductive Health Care at the Primary Level in El Salvador (March 1, 1998 -Sept. 30, 1999), INTRAH/PRIME, February 22, 1998.

Extension Project Proposal: Improvement of the RH/Family Planning Program in the MOH/El Salvador, INTRAH/PRIME, July 1998.

SALSA Project Proposal: Improving RH Care in the Ministry of Health through the USAID-funded SALSA project: PRIME Technical Assistance (February 1999 - September 1999), INTRAH/PRIME, January 20, 1999.

Proposal: Sustainability Project in Sexual and Reproductive Health, 1999-2002, Asociación Demográfica Salvadoreña, submitted to USAID/El Salvador, April 1999.

Other:

Promotor Effectiveness Study Report, Sandra Echeverria, submitted to USAID/El Salvador, July 1999.

Remarks of Outgoing Minister of Health, Dr. Eduardo Interiano, May 26, 1999