Technical Report # 29

Baseline Survey on Licensing and the Performance of Primary Reproductive Health Care Providers in Region 7 – Olancho, Honduras: Primary Provider Performance, Its Factors and Client Perception

Final Report

August 2002

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PRIME Project

Honduras

This publication was produced by Intrah at the University of North Carolina at Chapel Hill for the PRIME II project and was made possible through support provided by the G/PHN, Global, U.S. Agency for International Development, under the terms of Grant No. HRN-A-00-99-00022-00. The views expressed in this document are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.

PRIME II is a project aimed at training and providing support to primary providers of reproductive health care services throughout the world. PRIME II is spearheaded by Intrah, in collaboration with Abt, AVSC International, Ipas, PATH, and TRG, Inc.

ISBN 1-881961-72-9

Suggested Citation: Alfredo Fort; Calix, M.; Carias, D.; et al. Baseline Survey on Licensing and the Performance of Primary Health Care Providers in Region 7 – Olancho, Honduras: Primary Provider Performance, Its Factors and Client Perception. Chapel Hill, NC: Intrah, PRIME Project, 2002. (PRIME Technical Report 29)

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Acknowledgements

The authors and PRIME II staff would like to thank everyone who contributed to the performance survey and to the following report (See Appendix 1 for the full list of contributors). In particular, we wish to thank all PHR/Abt Associates staff in Honduras including Dr. Francisco Vallejo, Dr. Ely Domínguez, Rossany Auceda, and Carolina Castillo.

In addition to PHR/Abt Associates, various organizations and institutions contributed financial and human resources. We would like to thank the Japanese International Cooperation Agency (JICA), ASDI/the Pan-American Health Organization, and

PRIESS/the Interamerican Development Bank (IDB), who enabled the expansion of the study to all of Region 7.

Acronyms

AOP	Annual Operations Plan
CESAMO	Rural Health Center with Doctor
CESAR	Rural Health Center
CPI	Client-Provider Interaction
FP	Family Planning
HR	Human Resources
NGO	Non-government Organization
PHR	Partnerships for Health Reform
PI	Performance Improvement
PNA	Performance Needs Assessment
PNC	Prenatal Care
RH	Reproductive Health
SPSS	Statistical Program for Social Sciences (software package)
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development

Executive Summary

Honduras began reforming its Health Sector in 1998. One of the first activities to be carried out was a Situation Analysis study in nine areas of the country to determine the quality of health care services. In particular, the study found management needs, which not only include skills and knowledge, but also managerial interest and commitment to service excellence and high performance. One of the recommendations — as an important step in reforming the health sector — was to find a way to strengthen managerial responsibilities. This means that, in addition to improving factors such as infrastructure, equipment and qualified staff, staff performance needs to be improved.

In April 2000, the PRIME II project, based at the School of Medicine of the University of North Carolina, in collaboration with Abt/PHR/USAID, submitted a proposal to work with the Health Sector Reform Project of Honduras. Initially, PRIME developed the Performance Improvement (PI) initiative to improve project results through a broad examination of factors that affect staff performance. This initiative was carried out through a pilot intervention in the State of Olancho (Region 7), Honduras. A baseline survey was conducted between September and October 2000, which included assessment of the status of basic equipment and supplies in health facilities, observation of providers' skills in delivering family planning and prenatal care services, and application of provider interviews to enquire about performance factors and client exit interviews to assess satisfaction with services received. The first instrument was applied in all facilities while the remainder were applied in a sample of between 50 and 75 percent of facilities. This report covers results found with the last 3 instruments, since the larger inventory was PRIME's contribution to the health reform efforts by the MOH and will be used to license their facilities.

Results indicated around 44 and 60 percent of providers were able to perform correctly prenatal and family planning care skills respectively, with little variation found between auxiliary nurses in CESAR facilities and physicians in CESAMO facilities, except for a few items. The performance factors questionnaire revealed important deficiencies in the areas of job description, feedback, motivation/incentives and environment. A particular finding of interest is the lack of supervision (less than 50% were supervised in the last 6 months) and when it occurred it was mostly of administrative nature. The client perspective indicated around 70% of satisfaction with services, with areas still in need for improvement.

The results of this performance needs assessment led to a workshop where stakeholders compared the performance found with the performance desired for the providers. A root cause analysis was made of the resulting gap and a prioritizing exercise helped select four interventions that would be carried out by the project: facilitative supervision, training, motivation/incentives and organizational support. These interventions are now gradually implemented in Region 7.

Introduction

Within the health care sector reform process begun in 1998, the Honduran Health Secretariat hopes to reestablish its regulatory role and to develop a licensing process for health care facilities that ensure efficient and equal care to the neediest sector of the population.

To achieve this, the Health Secretariat has proposed strategies to improve the quality of care. These strategies are included in the document entitled "Lineamientos de Política [Policy Guidelines], 1999-2001," and affirm the commitment to provide high quality health care. Health policy in Honduras focuses on improving service quality by increasing efficiency and equity. Quality is defined by the availability of a team who provide health care services within a caring environment that ensures client satisfaction.

The Situational Analysis carried out in 1998 in nine areas of regions 1, 2 and 3, identified service deficiencies and differences existing between equally complex services. However, it is evident that the main issue of the study is that management style is essential and includes not only skills and knowledge, but also managers' interest in and commitment to excellence and the achievement of objectives. The Situational Analysis recommended that managerial responsibilities be strengthened to begin reforming the health sector. This shows that, in addition to improving factors such as infrastructure, equipment and qualified staff, staff performance be improved.

The PRIME II Project, based at the School of Medicine of the University of North Carolina, is collaborating with the Honduran Health Sector Reform Project together with Abt/PHR/USAID. PRIME has developed the Performance Improvement (PI) initiative to improve project results through a broad examination of factors that affect staff performance. These factors were examined in Region 7 via a baseline study.

Region 7 was selected for this pilot intervention due to the interest of Health Secretariat officials and for being a USAID planning area. The PRIME II team established a point of departure by defining the current situation using a representative sample of public health facilities that provide inpatient and outpatient Reproductive Health (RH) services in Region 7. In the public system, 60 to 70% of the total number of cases requiring medical attention are related to RH. The purpose of this baseline study is to document progress in fulfilling facility needs, for the purpose of **licensing** those facilities that comply with minimal efficiency requirements. Specifically, this report focuses on the questions that were added to the baseline study to address provider performance. A separate report will provide detailed results on the progress made thus far to license these facilities.

The baseline study will examine:

1. Staff: number, qualification, knowledge and application of the norms for puerperal care, emergency obstetric care protocols at the institutional level.
2. Infrastructure: compliance with architectural norms (including waiting room chairs, private examination rooms), hygiene and basic sanitary conditions, electricity, etc.

3. Equipment and materials/supplies: type and quantity in good condition and corresponding to the demand and the size of the facility.
4. Staff performance and factors affecting performance improvement (i.e., motivation, support systems, environment, tools, etc.)

The present study focuses mainly on need Number 4.

Honduras: Demographic and Health Situation

In 1998, Honduras had an estimated population of 5,901,239, with an annual increase rate of 2.7% and an average density of 53 inhabitants per Km^2 (Health Ministry, 1998). Fifty-five percent of the population lives in rural areas. In 1996, 19% of the population was illiterate. It is also estimated that, in 1994, 76% of families were below the poverty line (Ministry of Health, 1998). Together with other Central American countries, Honduras shares an array of indicators that show that it still has far to go to improve the health of its population. Table 1 shows how the Honduran economy is one of the poorest of the region. Maternal mortality (147 pr 100,000 n.v.) and AIDS incidence (168 per M) rates are the worst in Central America. The health resources situation is not encouraging either: there are an average of eight doctors and less than three nurses for every 10,000 inhabitants, numbers that are clearly insufficient and currently among the lowest of the region.

Table 1: Health indicators chosen by Central American countries

Indicator	Honduras	Guatemala	El Salvador	Nicaragua	Costa Rica	Panama
GDP per capita	740	1580	1810	410	2680	3080
% of the population in poverty	50	58	48	50	11	30
Child Mortality Rate	36.0	35.7	35.0	45.2	12.6	17.2
Maternal Mortality Rate	147	101	63	139	16	60
Overall Fertility Rate	4.1	4.7	3.1	4.2	2.8	2.5
Prevailing use of contraceptives	50	31	53	49	75	58
AIDS Incidence (per M)	168	82	72	6	58	87
Doctors/10,000 inhabitants	8.3	9.6	11.8	6.2	15	12.1
Nurses/10,000 inhabitants	2.6	3.3	4.2	3.3	11.3	10.8

Source: OPS, Situación de Salud de las Américas, Indicadores BASICS, 1999

Despite the substandard health situation, progress has been steady since the last decade. For example, in 1989 the child mortality rate (CMR) was 57 per thousand and in 1987 the overall fertility rate was 5.6 per thousand. Immunization coverage has risen to 90% for BCG, polio, and DPT and to 80% for rubella (polio was declared eradicated in 1994). Almost 83% of mothers receive prenatal care and institution-based births have risen from 40.5% in 1987 to 54.2% in 1996 (ENDESA, 1996).

Problems limiting sector development persist, such as failure to prioritize health budgets as opposed to other sectors. Basic services are not available in all parts of the country. Infrastructure, equipment, and human resources of peripheral health facilities are significantly deficient. Finally, the quality of staff management, health care records and even maternal and child care needs to be improved. (Health Secretariat, 1998; Health Sector III project, 1999).

The health sector is divided administratively into eight health regions. The present report deals with the survey carried out in Region 7 - Olancho. Region 7 has 383,751 inhabitants, or 6.5% of the total population; the population is mostly rural and the density is relatively low (see detailed description, below).

Description of the State of Olancho (Region 7)

The State of Olancho (Region 7) is the largest state of the country. It has 24,390 square kilometers and is located in the east central part of the country. The main center of activities is Juticalpa, followed by the city of Catacamas. The economic and political power of the region has been historically in the hands of landowners who, for the most part, are involved in cattle raising and agriculture. Olancho has 23 towns of which 22 belong to the Service Network of Region 7 and one (Esquípulas del Norte) to Region 6 (Ceiba). The state has 106 Rural Health Clinics (CESAR); 27 Health Clinics with a physician (CESAMO); four Maternal and Child Care Clinics, and one Regional Hospital.

Purpose and Objectives

The main objective of the study was to conduct a diagnostic study on the application of essential, minimal requirements in institutional health care within the public subsector, focusing upon infrastructure, equipment and human resources. This includes an evaluation of provider performance needs to begin the facilities' licensing process. The second objective was to determine the percentage of providers giving prenatal and family planning (FP) care according to established norms, client-provider interaction (CPI) at the institutional level and, finally, to identify those factors that positively or negatively affect performance.

General Framework for Performance Improvement

Performance Improvement (PI) is a strategy that provides organizations with the tools needed for determining the essential components of good performance, and for enabling them to adapt their interventions to close the gap between current and desired performance. This is a systematic methodology used to improve access and quality of health care services by encouraging organizations to find the causes of obstacles that prevent providers from performing at their best. The process is directed initially to defining desired performance, identifying current performance, determining were gaps exist and identifying those factors that lead to gaps and, finally, to identifying what steps might be taken to close the gaps. The factors that influence performance are:

- Clear Work Expectations

- Performance Feedback
- Physical Environment and Adequate Supplies
- Motivation
- Organizational Support
- Skills and Appropriate Knowledge

Once the causes of the problems have been established, PI asks the organizations to identify and choose appropriate solutions from an array of possible interventions. These not only include traditional ones but also include solutions that are innovative and economically feasible. For more information on PI methodology procedures, see Appendix 4.

Methodology

Strategy

The methodology chosen for the study consists of the following:

- Interviews with providers (doctors, nurses, nurse auxiliaries, etc.) and managers/administrative heads regarding needs in their facilities and performance factors
- Inspection and needs assessment (via an inventory)
- Observation of client-provider interaction (CPI)
- Exit interviews with clients

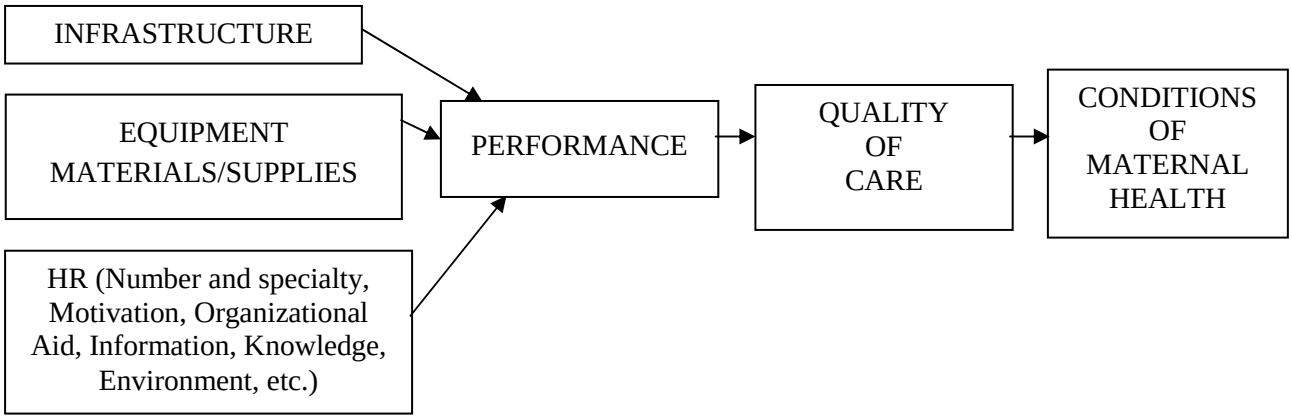
The PRIME II team developed instruments for each evaluation strategy and each service level. Three types of instruments were needed for the various service levels: 1) primary level; 2) maternal-perinatal clinic and; 3) hospital (divided into outpatient, inpatient, and neonatology). The instruments were divided into: 1) observation of skills in real or simulated interactions with a checklist for prenatal or family planning visits; 2) an in-depth interview regarding performance factors using a semi-structured questionnaire; 3) an exit interview with clients to obtain their perceptions about the quality of care offered.

The PRIME team adapted PAHO's Maternal/Child health services instruments and added a component to evaluate staff performance (knowledge, skills and client interaction), as well as factors affecting such performance (i.e., motivation, information, environment, etc.). The team also included client exit interviews to evaluate their level of satisfaction with the services and to gather their opinions on current facility conditions and staff.

Although all facilities in the region were visited to gather data for licensing, only approximately 50% were included in this study.

Hypothesis

The hypothesis was that improvements in infrastructure, equipment, materials/supplies and human resources (including PI factors) would have a positive impact on staff performance, which in turn, will increase the quality of maternal health care. A better quality of care will, in the long term, lead to a decrease in maternal illness and death (see graph). The project, because of its limited scope, will only measure the immediate effect of the intervention on performance improvement. It is hoped that future interventions within health care reform on a more long-term scale will permit broader measurements, including such subjects as the decrease of fertility and maternal illness (using family and fertility surveys).



Study Design

This was a descriptive, pre- and post-intervention cross-sectional study that collected both quantitative and qualitative data. The present baseline is a pre-intervention evaluation. At the time of the intervention, another similar cross-section evaluation will be carried out to determine if there were any changes in the collected indicators.

Study Population

The PRIME II team interviewed most of Region Seven's public health facilities that offer outpatient and in-patient maternal care: 106 CESARS (Clinics without physicians), 27 CESAMOS (Clinics that rely on one physician), four Maternal/Child Clinics and one Regional Hospital. See the below table for the complete list of facilities and providers.

Instruments	Completed Surveys
Licensing	
CESAR	100
CESAMO	27 (44 others)
1 hospital and 4 private clinics	5
Performance Data	
Observation of Skills - FP Observation of Skills - Prenatal	CESAR – 48 CESAMO – 16 CESAR – 37 CESAMO - 16 Clinics – 3
Performance Improvement Factors	94
Exit Interview with Clients	CESAR – 90 CESAMO - 28 Clinics - 11

Interviewers

The PRIME II team used an average of eight interviewers and two supervisors to carry out the baseline evaluation. The team traveled to each of the four areas of Region 7 and applied the instruments in each area's health care facilities. The team, drawn from these same areas, included doctors, nurses, and nutritionists who

benefited from the experience by being trained in on-site research (and who will be able to facilitate future trainings). During a two-week training workshop in Juticalpa, interviewers were sensitized to sexual and reproductive rights issues and to Honduras' health situation and, most importantly, they were trained in how to fill out and validate the instruments, prepare critical approaches, and define variables. During September - October 2000, interviewers worked in pairs for seven weeks to gather data. The teams did not conduct interviews in the areas they were from (cross strategy).

Data Processing and Analysis

The on-site data collected were inspected before being entered into the computer. Data related to licensing requirements was analyzed via Epi Info 6.04b. The percentages of efficiency factors were analyzed according to levels of complexity, areas and category. Data regarding provider performance, performance factors and exit interviews with clients were analyzed using SPSS Version 9.

Results

The performance results presented in the following section correspond to CESAR and CESAMO providers, as the number of Maternal and Child Clinics was not statistically significant and therefore not comparable. These data can be analyzed separately. Note: the total number of answers in some questions is larger than the sample size due to the option of providing more than one answer.

Provider Skills

Provider skills were analyzed by focusing on two important areas: FP and Prenatal Care, the former being the most representative of the preventive/promotional programs and the latter – although it is also preventive – representing clinical care, in this case, provided to pregnant women. The results are first presented separately and then summarized.

Family Planning Skills

Data collectors used a checklist to observe minimal standards of quality of service. These ranged from the most general such as the provider "Greets and calls the woman by name and introduces him/herself," to the most technical such as "Takes her blood pressure correctly" or "Discusses [method] side effects with the client and how to handle them" (see instruments in Appendix 2). All in all, 24 common areas were covered in the client-provider encounters in the two main types of facility listed in Table 2.

Table 2: Percentage of providers by facility who perform FP skills capably[1]

#	ITEMS	FACILITY	
		CESAR % (n)	CESAMO % (n)
1	Greets and calls the client by name and introduces him/herself	56.3 (48)	62.5 (16)
2	Makes sure the client is in a comfortable and has privacy	45.8 (48)	75.0 (16)*
3	Explains the purpose of the examination and the nature of the procedures	31.3 (48)	37.5 (15)
4	Asks questions and permits the client to speak	95.8 (48)	100.0 (16)
5	Pays attention and is interested in her personal problems	70.2 47)	68.8 (16)
6	Takes her blood pressure correctly	55.6 (45)	25.0 (12)
7	Washes hands with soap and water, dries them in the air or with a towel	4.5 (46)	18.2 (11)
8	Asks the reason for the visit	100.0 (48)	93.8 (16)
9	Asks about the client's reproductive expectations	52.1 (48)	62.5 (16)
10	Asks about her reproductive intentions and preferred contraceptive method(s)	77.1 (48)	81.3 (16)
11	Offers information about her preferred method or offers information about available methods	83.3 (48)	66.7 (15)
12	Tells her about the advantages and disadvantages of the methods and especially about her preferred method	54.2 (48)	93.8 (16)**
13	Discusses side effects with the client and how to handle them	54.2 (48)	81.3 (16)

#	ITEMS	FACILITY	
		CESAR % (n)	CESAMO % (n)
14	Discusses and informs the woman about contingencies and/or possible danger signs	54.2 (48)	56.3 (16)
15	Speaks clearly	79.2 (48)	93.8 (16)
16	Encourages the client to ask questions and lets her express herself	60.4 (48)	75.0 (16)
17	While respecting cultural beliefs, tries to dispel doubts and fears	36.2 (47)	31.3 (16)
18	Tells the client how contraceptive methods help to prevent STIs	8.3 (48)	18.8 (16)
19	Gives the client a sufficient quantity of non-clinical methods – pills	85.1 (47)	86.7 (15)
20	Sets her next appointment date at a time most convenient for the client, makes a note of it on her card and encourages her not to miss it	50.0 (48)	87.5 (16)**
21	Encourages the woman to come to her checkups with her partner if she so wishes	29.2 (48)	12.5 (16)
22	Urges the client to come to the center in the event she has a problem	64.6 (48)	68.8 (16)
23	Takes note of all findings, evaluations, diagnoses and care provided to the client	89.6 (48)	87.5 (16)
24	Places the client's record into the appropriate folder	83.3 (48)	81.3 (16)
	Average Percentage	**58.8**	**64.2**
	Total Score for Skills (Items 1 to 24) [2]	**14.1**	**15.4**

[1] Percentages for the total number of valid observations

[2] Derived by adding up the answers to all the questions: range 0 – 24 (0 = Useless; 24 = Excellent)

* Significant difference $p < 0.05$ ** Significant difference $p < 0.01$

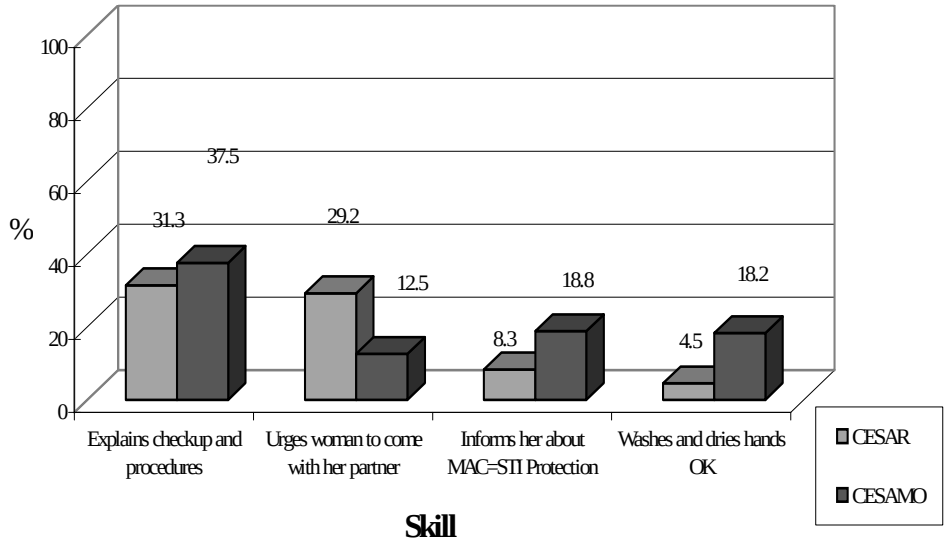
The data yielded some interesting results. First, a great majority of providers (at least 80%) of both types of facility perform capably such tasks as "Asks questions and permits the client to speak;" "Asks the reason for the visit;" "Speaks in a way that is clear and understood by the client;" "Gives the client a sufficient quantity of non-clinical methods;" "Makes a note of all findings, evaluations, diagnoses and care provided to the client" and "Places the client's record into the appropriate folder". Most of these can be considered of a general or administrative nature (except for the item regarding providing the client a sufficient quantity of non-clinical methods, which could be attributed to institutional policies, put in place as a result of extensive training and promotion).

In contrast, there are areas where few service providers perform the expected skill (See Graph 1). Such is the case of item # 3 "Explains the purpose of the visit and the nature of the procedures." For the crucial item "Washes hands with soap and water, air dries them or uses a towel" (item # 7), findings show an alarming, almost non-compliance of a vital infection prevention norm[1]. In addition, a very low percentage "Tells the client how contraceptive methods help to prevent sexually transmitted infections (STIs)" (item # 18), which is crucial information for all clients. Finally, it is to be noted that the staff itself does not contribute to improving balanced gender

[1] These data must be interpreted carefully, since there is no technical justification for hand washing if the purpose of a FP visit is only to ask the provider questions and not to perform a clinical examination.

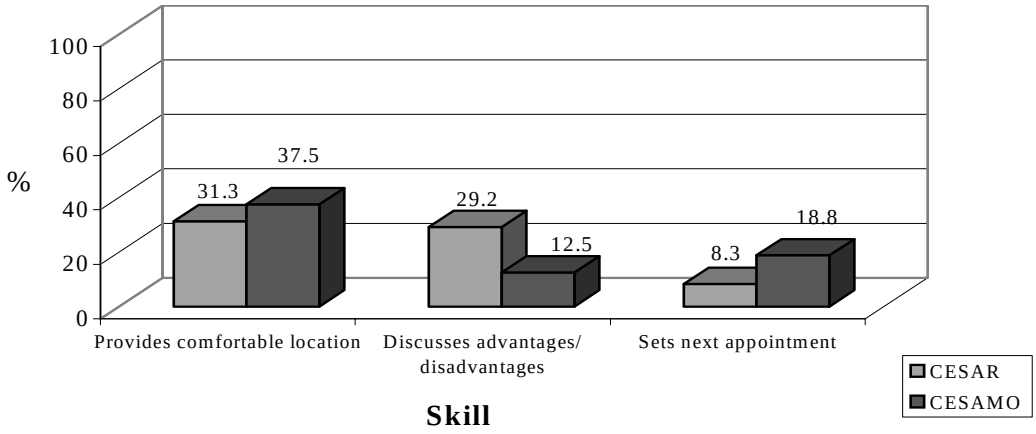
participation by not "Encourag[ing] the client to come to her checkups with her partner if she so wishes," something that also rarely occurs (item # 21).

Graph 1: Performance of FP skills by type of facility



In addition to skill performance at the intermediate level, findings show that the CESAMO staff has significantly better skills than CESAR staff (See Graph 2). For example, while 76% of the CESAMO staff "make sure the client is comfortable and has privacy," less than half of the CESAR staff do this. It is important to determine if this is due to attitudinal or structural factors (i.e., The CESARs may not have sufficient space/rooms to offer comfort and, above all, privacy). Even more significant is the difference between the two types of facilities when answering the item "talks about the advantages and disadvantages of the methods and especially about her preferred method." In this case, only slightly more than 50% of the CESAR staff complies compared with most of the CESAMO staff. This topic is not so technical that it could be argued that only clinical staff could handle it. Finally, when observing an item important item to quality of care: "sets her next appointment date at a time most convenient to the client, makes a note of it on her card and urges her not to miss it," we again see that the CESAMO staff does a better job than CESAR staff.

Graph 2: Significant differences in the performance of FP skills, by type of facility



Prenatal Care Skills

Similar to what was achieved in FP, staff performance was also observed in facilities that provided Prenatal Care services. In this case, answers were measured differently (0 = Not carried out; 1 = Yes, carried out) and were codified using an ordinal scale from 0 to 3 (0 = Is not carried out or is in less than 50% of the cases; 1 = Conforms to the norms in only 50% of the cases; to 2 = Is carried out in conformity with the norms). For the analysis, a skill was considered finished when it was completely (100%) executed. The range of skills to be executed in this case numbered 42. Logically, they included more technical areas varying from "Listens to heart rate – breast exam," "Provides information about danger signs: bleeding and loss of fluids through the vagina," to "Informs her about anti-tetanus vaccination and administers it." See Table 3 for results.

Table 3: Percentage of providers by facility who perform prenatal care skills capably ("Fulfills in conformity with the norms")[&]

	ITEMS	FACILITY	
		CESAR % (n)	CESAMO % (n)
1	Has soap, water, clean tower for hands, gloves...	8.1 (37)	18.8 (16)
2	Has blood pressure cuff, stethoscope, fetoscope, watch...	32.4 (37)	66.7 (15) *
3	Provider washes his/her hands with soap and water and then dries them …	8.1 (37)	6.3 (16)
4	Greets and calls the client by name, introduces him/herself if it is the 1st visit	57.1 (35)	60.0 (15)
5	Makes sure the client is in a comfortable location and has privacy	37.8 (37)	37.5 (16)
6	Explains the purpose of the consultation and the nature of the procedures	36.1 (36)	37.5 (16)
7	Asks questions and allows the client to speak	83.8 (37)	81.3 (16)
8	Pays attention and is interested in her personal problems	58.3 (36)	81.3 (16)
9	Reviews previous clinical history of follow-up clients	95.0 (20)	100.0 (10)
10	Prepares the clinical history of new clients	100.0 (17)	100.0 (6)
11	If this is the first consultation, previous pregnancies: number, development, conclusion	76.5 (17)	85.7 (7)
12	Current pregnancy: last menstrual period, pregnancy symptoms, and lab tests…	51.5 (33)	50.0 (14)
13	Determines general data: vital signs, blood pressure, temperature	18.9 (37)	36.4 (11)
14	Obtains anthropometrical data: weight, height	22.2 (36)	40.0 (10)
15	Examines the conjunctiva	43.2 (37)	25.0 (16)
16	Feels thyroid glands, oral exam	13.5 (37)	6.7 (15)
17	Listens to heart rate – breast exam	2.7 (37)	6.3 (16)

	ITEMS	FACILITY	
		CESAR % (n)	CESAMO % (n)
18	Examines and determines if there is any edema, redness or varicose veins	59.5 (37)	75.0 (16)
19	Inspects and feels abdomen to detect scars, pigmentation…	59.5 (37)	93.8 (16) *
20	Feels uterus and performs necessary maneuvers to determine fetal position and placement	81.1 (37)	87.5 (16)
21	Measures uterine height and listens to fetal heartbeat	70.3 (37)	81.3 (16)
22	Determines the length of the pregnancy and estimated delivery date	83.8 (37)	86.7 (15)
23	Defines the relationship between fetal development and uterine height…	45.9 (37)	73.3 (15)
24	Defines the state of health of the woman and fetus, based upon the evaluation…	37.5 (32)	69.2 (13)
25	Informs the client about the progress of the pregnancy	52.8 (36)	40.0 (15)
26	Informs the client about her state of health	52.8 (36)	66.7 (15)
27	Informs the client about the state of health of the fetus	43.2 (37)	46.7 (15)
28	Informs the client about any complication	51.4 (37)	53.3 (15)
29	Asks the client about her medical care	13.5 (37)	13.3 (15)
30	Provides information about nutritional needs	56.8 (37)	20.0 (15)
31	Provides information about handling common discomforts	32.4 (37)	26.7 (15)
32	Provides information about personal hygiene	2.8 (36)	6.7 (15)
33	Provides information about sexuality and the prevention of infections	100.0 (36)	100.0 (15)
34	Provides information about danger signs: bleeding and loss of liquid through the vagina	33.3 (36)	33.3 (15)
35	Informs her about anti-tetanus vaccination and administers it	45.9 (37)	57.1 (14)
36	Gives her a supply of iron supplements and follates	86.1 (36)	66.7 (15)
37	Shows her how to take medications	67.6 (37)	60.0 (15)
38	What are the positive and negative effects of the medications	21.6 (37)	13.3 (15)
39	Asks client to ask questions so as to be sure she has understood everything	13.5 (37)	33.3 (15)
40	Sets her next appointment date at a time most convenient for the client	37.8 (37)	18.8 (16)
41	Makes a note of all findings, evaluations, diagnoses and the care provided to the client	83.8 (37)	81.3 (16)
42	Places the client's record into the appropriate folder	100.0 (87)	100.0 (16)
	Average Percentage	**43.3**	**45.0**
	Total Score for Skills (Items 1 to 42) ^	**18.2**	**18.9**

& Percentages for the total number of valid observations * Significant difference $p < 0.05$

^ Derived by adding up the answers to all the questions: range 0 – 42 (0 = Useless; 42 = Excellent)

** Significant difference $p < 0.01$

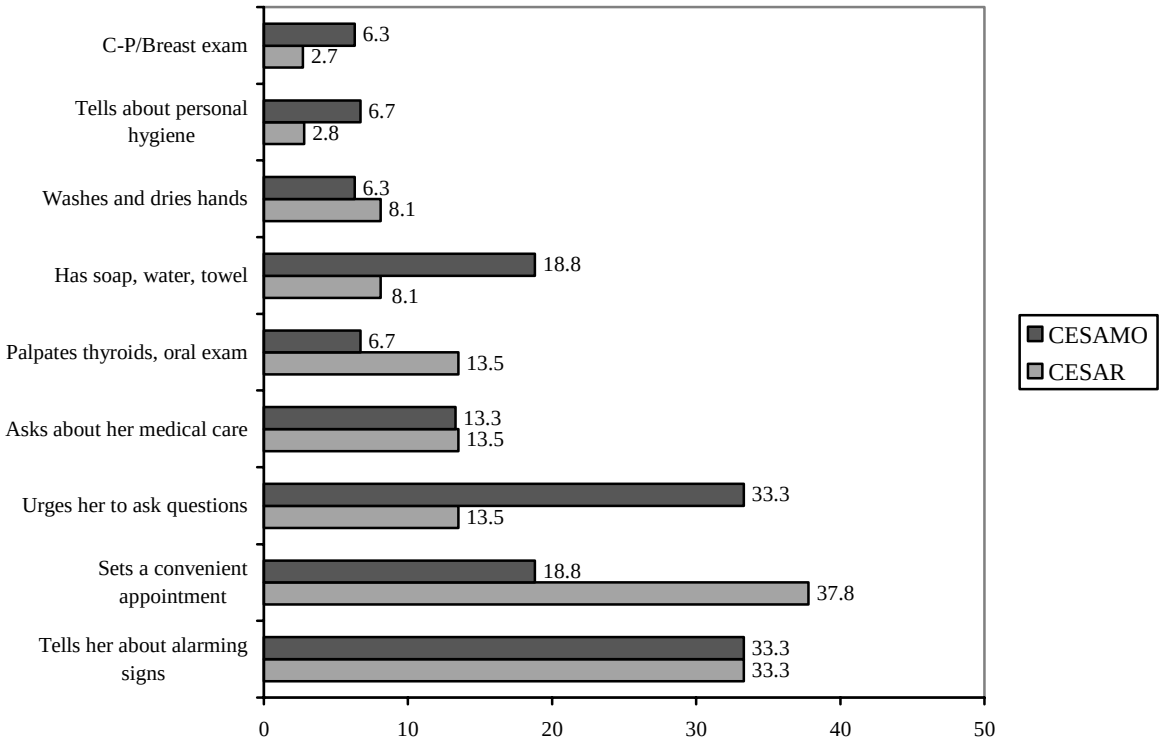
Results show a wide variation in Prenatal Care (PNC) skills. First, the majority of providers in both types of facilities perform administrative/general skills in a similar fashion. An example is asking questions and allowing the client to speak, or updating/preparing the clinical history in accordance with the type of client, or always calculating the length of the pregnancy and estimated date of delivery. Similarly, providers give information about sexuality and infection prevention, record their findings and treatments, and maintain updated records. It is important to point out that 100% of the providers in both CESAMO and CESAR inform pregnant women about STI prevention while a small number does so with clients during FP visits. This may be due to a difference in facility standards or in the perception of possible risk factors.

Yet specific areas are observed where a much lower percentage of providers completely perform the necessary skill. This is the case for the topic of hygiene and infection prevention, where between 8 to almost 20% of providers have soap, water and a towel for hand washing, and 6 to 8% in fact do it. This is confirmed by the low

percentage (between 3 and 6%) of providers who give the client information on personal hygiene. Few feel the thyroid glands and perform an oral exam, fewer still perform a cardio-pulmonary exam and breast exam, the latter being a very important element within the scope of complete Maternal and RH care. A relatively low percentage (13%) asks for the client's medical record. Finally, only 19 to 38% of providers set a next appointment in accordance with a client's needs, something considered today as an important element of quality care. It is alarming that only one-third of the women are provided with information about pregnancy danger signs (See Graph 3).

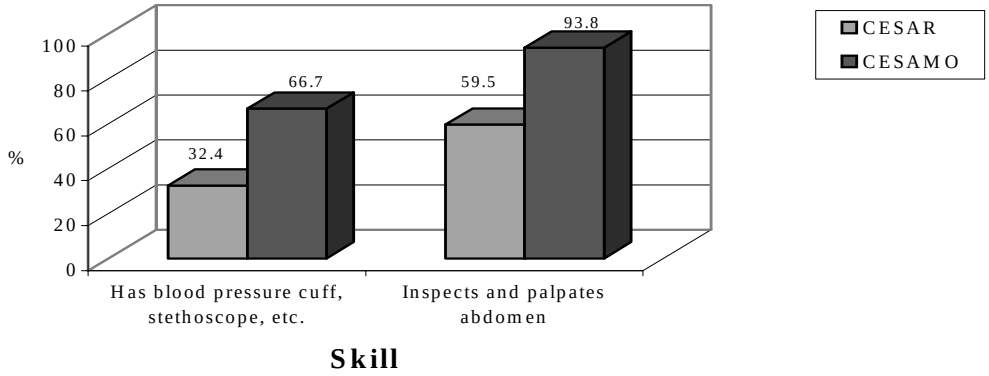
There are various indicators where performance is average, as is the case with calling the client by her name, making sure she is comfortable, explaining the purpose of the checkup, paying attention to her problems, being more forthcoming and caring in speaking about the current pregnancy, determining her general data, examining the conjunctiva, examining and determining if there is any edema or varicose veins, explaining the relationship between uterine height and fetal development, informing the client about her pregnancy, her health, the state of the fetus, any complication, her nutritional needs, and how to handle common discomforts, etc. Finally, it must be noted that 50% of providers inform the client about anti-tetanus immunization and vaccinate her and a slightly higher percentage tells her how to take her medications. This "gray" area, comprised of topics that are key to high quality of care, must be improved.

Graph 3: Performance of PNC skills by type of facility



There are a few areas where there is a significant difference between CESAR and CESAMO provider performance. For example, while one third of the CESAR providers have a blood pressure cuff, stethoscope, fetoscope, etc., two thirds of the CESAMO providers have them (something that could explain the low compliance with examining vital signs, blood pressure, etc. — item 13, among CESAR staff). While only 60% of CESAR providers inspect and feel the abdomen of a pregnant woman, almost all CESAMO staff do it (See Graph 4). Unfortunately, there are other obvious differences between providers such as those who determine uterine height and fetal development (46% vs. 73%) or those who evaluate the health status of the client and her fetus (38% vs. 69%). Although CESAR staff skills appear to be the most deficient, there is no statistical significance probably due to a small sample size.

Graph 4: Differences in PNC skill performance by type of facility



The average percentage for these 42 prenatal care items is between 43 and 45%, which shows that various factors within the client provider relationship as well as technical and clinical factors need to be improved.

Performance Factors

This section presents the results of interviews held with providers to ask them about factors that might facilitate or hinder their on-the-job performance. Such factors include Expectations Feedback/Information, Motivation/Incentives, Environment (tools, HR, equipment), Organizational support (leadership, management, supervision, etc.) and Knowledge/Skills. The section concludes with the addition of specific information regarding FP methods offered by the providers. Tables/Graphs are presented for each factor below.

Expectations

This performance factor investigates whether the worker has a clear understanding of what s/he is expected to do as part of his/her job. This is achieved by having a job description as well as annual performance reviews performed by or with the supervisor and/or others (See Table 4 for results.)

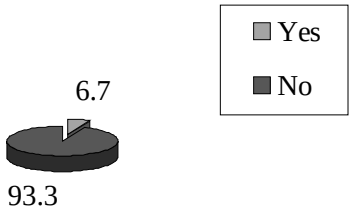
Table 4: Percentage by facility of providers by their answers about expectations and performance

#	ITEMS	FACILITY	
		CESAR % (75)	CESAMO % (19)
1	Has a description of his/her job responsibilities	6.7%	15.8%
2	How does s/he know what has to be done in his/her job (74) Answers related to his/her job Technical answers, not job-related Others/irrelevant (i.e., "for the clients' welfare," "because of the way in which care is provided")	 35.1% 18.9% 46.0%	 63.2% * 21.1% 15.8%
3	Knows objectives/goals for his/her job (AOP)	90.7%	94.7%
4	Was involved in establishing these objectives in some way	95.6% (68)	100.0% (18)

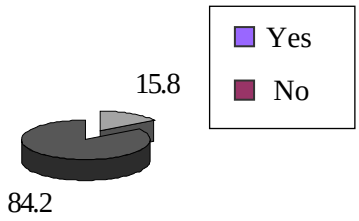
***** Significant statistical difference ($p<0.05$)

Results show that few providers have a current job description (Graphs 5 and 6). On the other hand, another question (not included here) showed that almost 100% claim to know what they had to do in their jobs. Yet, when asked the question "How do you know what you have to do in your job?" only the CESAMO staff members provided a significantly higher number of correct answers. It must be emphasized that in spite of these results, all baseline study participants were identified as having objectives/goals in their AOP. It is not clear whether such objectives/goals are related to their individual performances or to facility objectives.

Graph 5: Existence of a job description – CESAR



Graph 6: Existence of a job description – CESAMO



Feedback/Information

Another performance improvement factor, complementing the previous one, is that of constant feedback received by the worker from his/her supervisors, or any other source of information regarding performance, which allows him/her to identify weak points to be strengthened. Answers to this factor are included in Table 5.

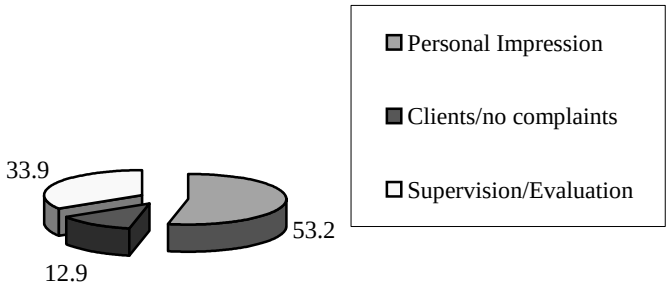
Table 5: Percentage by facility of providers from answers about feedback/information and their performance

#	ITEMS	FACILITY	
		CESAR % (75)	CESAMO % (19)
5	Knows if his/her performance is as it should be	78.7%	73.7%
6	Reason for knowing if performance is adequate (various opinions)	(62) 53.2%	(14) 57.1%
	Personal impressions/self-evaluation/experience	12.9%	28.6%
	By clients/no complaints	33.9%	14.3%
	By supervision/monitoring/evaluation/AOP/meetings		
7	Receives personal help or information to improve in his/her job	92.0%	84.2%
8	Form in which this help is received (various responses)	(100)	(20)
	Logistics, cadre, materials	13.0%	30.0%**
	Training, technical orientation, manuals, coordination	55.0%	45.0%
	Feedback, evaluations, counseling	27.0%	10.0%
	Through human resources	5.0%	5.0%
	Monetary/savings	0.0%	10.0%
9	From whom does this help come (various responses)	(88)	(21)
	Supervisors, directors, Health Secretariat	76.1%	66.7%
	Peers, colleagues, the center's team	15.9%	14.3%
	Mayor, NGO, Church, "engineers"	2.3%	14.3%
	Volunteers, collaborators, clients	5.7%	4.7%
10	How often is this help received	(69)	(16)
	Daily	4.3%	6.3%
	Monthly	55.1%	37.5%
	Every 2-6 months	7.2%	6.3%
	Annually	1.4%	6.3%
	Not specified, variable	31.9%	43.8%

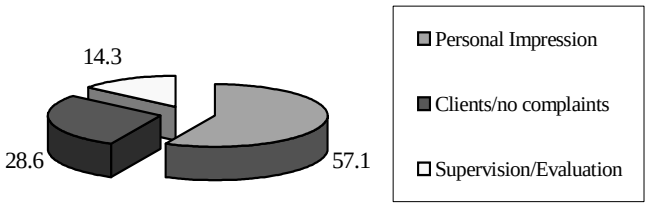
* Significant difference $p < 0.05$ ** Significant difference $p < 0.01$

In the above table, 75% of those interviewed said they knew if their performance was as good as it should be, but, when questioned more thoroughly, half or more or them based it on personal impressions. The remaining providers base their knowledge of their performance on what clients tell them or on comments made when they are being evaluated or supervised (See Graphs 7 and 8). Although a significant number acknowledges having received support/information to improve their job skills, only 27% of CESAR staff and a low 10% of CESAMO staff indicated receiving it via feedback, evaluations, or counseling. In contrast, CESAMO staff receive more support through logistics, equipment, and materials as well as monetary support than CESAR staff. Supervisors or Secretariat staff provide most of support on a monthly basis (especially for CESAR staff) or at varying times.

Graph 7: Way of knowing if performance is adequate - CESAR



Graph 8: Way of knowing if performance is adequate - CESAMO



Motivation/Incentives

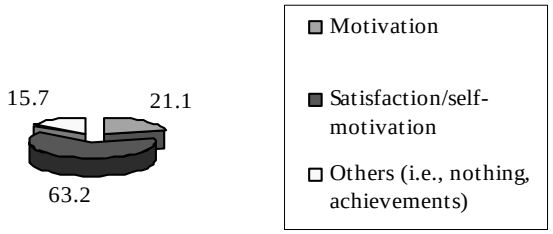
Non-monetary incentives given by organizations to their employees are important factors in improving performance. A motivated worker will obtain personal satisfaction from his/her job by knowing that s/he is being recognized when s/he performs well. Responses regarding this subject are presented below in Table 6.

Table 6: Percentage of providers by facility and by answers about motivation/incentives and their performance

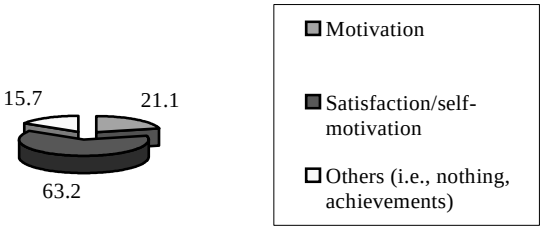
#	ITEMS	FACILITY	
		CESAR % (75)	CESAMO % (19)
11	What happens if you do your job well?		
	Self-motivation	64.0%	63.2%
	Technical/unimportant responses (i.e., accomplishes proposed goals)	9.3%	5.3%
	Motivation (i.e., They congratulate him/her, raise his/her salary)	20.0%	21.1%
	No motivation (i.e., Nothing, It doesn't matter)	6.7%	10.5%
12	What happens if you do your job poorly?		
	Feedback	44.0%	42.1%
	Risk loosing job	2.7%	0.0%
	Technical/unimportant responses (i.e., insufficient comments)	49.3%	47.4%
	There is no feedback (i.e., corrects self for s/he has no one to counsel him/her)	4.0%	10.5%
13	Has received recognition for his/her work	25.3%	36.8%
14	What was the nature of this recognition?	(19)	(7)
	Verbal	47.4%	57.1%
	Written	47.4%	28.6%
	Verbal and written	5.3%	14.3%
15	Are there opportunities for growth or for promotions in your job	53.3%	68.4%
16	How are these opportunities given?	(40)	(13)
	Training	80.0%	84.6%
	Good/better position	2.5%	0.0%
	Technical/unimportant responses (i.e., Based on performance)	17.5%	15.4%
17	Are there other incentives/awards given?	36.0%	15.8%
18	What form do these incentives/rewards take?	(27)	(3)
	Gifts/personal kit	29.6%	66.7%
	Per diems/economic	18.5%	0.0%
	Awards/souvenirs/food	29.6%	33.3%
	Rides/leaves/transport	7.4%	0.0%
	Technical/unimportant responses (i.e., For good work)	14.8%	0.0%

Results show that participants obtain greater satisfaction for doing a good job not from being motivated by their supervisors (approximately 20%), but from self-motivation (approximately 60%), (See Graphs 9 and 10). This contrasts with the high percentage who receive feedback when they have performed poorly. Only a quarter to a little more than a third of providers say they have received recognition for their work, and half of them have only received it verbally. This is an important point for improvement within a human resources development system since, rather than motivating employees, feedback that is provided only when performance is inadequate leads to discouragement.

Graph 9: What happens if you do your job well? - CESAR



Graph 10: What happens if you do your job well? - CESAMO



Other questions related to the topic are opportunities and specific incentives. In this case, the first development opportunity is training which, as we know, is tied to incentives such as traveling, per diem, in addition to the intrinsic value of learning new skills that increase the likelihood of being promoted. Other incentives include giving gifts or personal items or other symbolic awards. It is interesting to point out that among CESAR staff, the topic of per diems/economic incentive appears to be more relevant than for CESAMO staff, although the data is not statistically significant.

Environment (tools, human resources, equipment)

Every effort aimed at performance improvement, whether it is based on providing job-related information, incentives or recognition, can be considered inadequate if staff do not have the tools, equipment, etc. to perform well and effectively. Responses to this factor can be found in Table 7.

Table 7: Percentage of providers by facility and by answers regarding job environment and their performance

#	ITEMS	FACILITY	
		CESAR % (75)	CESAMO % (19)
19	Has all equipment/instruments/human resources necessary to perform his/her job well	9.3%	0.0%

We know that the majority of individuals, when asked if they have all the equipment/instruments/human resources necessary to perform well, will very likely answer "no," that they need more or fewer resources. Nevertheless, we must draw attention to the mostly negative response of all those interviewed.

The topic is examined in detail through direct questions intended to identify all resources that the staff considers necessary. Since they were allowed to give more

than one answer, the list includes 306 different responses. From this long list, the 10 most frequently mentioned needs appear below in Table 8. Though we know that providers lack the equipment mentioned, it is still not clear if performance is related to the absence or availability of the equipment/instruments.

Table 8: Percentage of providers by facility and by answers regarding resources needed to render a quality performance (based upon 306 responses)

#	ITEMS	FACILITY	
		CESAR % (n)	CESAMO % (n)
1	Nebulizer	26.7 (20)	15.8 (3)
2	Pediatric scales	24.0 (18)	10.5 (2)
3	Sphygmomanometer	14.7 (11)	21.1 (4)
4	Desk	17.3 (13)	10.5 (2)
5	Minor Surgery Kit	9.3 (7)	36.8 (7) **
6	Suturing Kit	13.3 (10)	15.8 (3)
7	Adult scales	10.7 (8)	5.3 (1)
8	Stethoscope	5.3 (4)	26.3 (5) *
9	Filing cabinet	6.7 (5)	10.5 (2)
10	Fetoscope	6.7 (5)	5.3 (1)
Total of opinions for the 10 most requested resources: 101 (42.8% of total opinions)			

* Significant difference $p < 0.05$
** Significant difference $p < 0.01$

As one can see the equipment needed the most by both CESAR and CESAMO staff is the nebulizer, with 23 opinions, followed closely (20 opinions) by pediatric scales, needed mostly by CESAR staff, and then the Sphygmomanometer (Tensiometer) needed in both facilities. Among equipment needed in particular by one type of facility are the minor surgery kit and the stethoscope, required mostly by CESAMO staff. As expected, staff responded to the question "What can you not do without this equipment?" with many answers based upon their own shortages (not included here). The most frequent answer is "It is not possible to provide good care," followed by other more specific ones such as "There is no gynecological exam," "The fetal heart rate is not checked," "Blood pressure is not taken," "no nebulizer," etc.

Organizational Support (leadership, management, supervision, etc.)

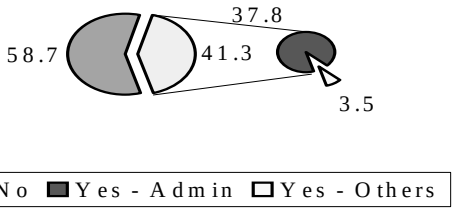
Organizational support ranges from involvement in joint inspections and decisions, perceptions related to leadership and image, identification with the institution, to routine staff supervision. Some of these aspects are discussed in this study and are found in Table 9.

Table 9: Percentage of providers by answers regarding organizational support and their performance and by facility

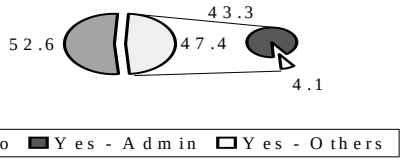
#	ITEMS	FACILITY	
		CESAR % (75)	CESAMO % (19)
20	Staff are involved the decisions that are made in your facility	97.3%	89.5%
21	How is the staff involved in the decisions?		
	Health committee meetings	89.0%	100.0%
	Others (i.e., communal staff, maintenance)	11.0%	0.0%
22	Is there any kind of inspection tied to facility performance?	85.3%	89.5%
23	Kinds of facility performance inspection		
	Meeting focused on the facility/ monitoring/quality	39.1%	58.8%
	By supervision/Evaluations/AOP	60.9%	41.2%
24	Number of supervisor visits in the past six months		
	Not one	58.7%	52.6%
	Once	32.0%	26.3%
	Twice	6.7%	15.8%
	Three times	2.7%	5.3%
	Average	0.53	0.74
25	What does the supervisor do when s/he visits the facility? (various opinions)	(71)	(23)
	Deals with administrative aspects	91.6%	91.3%
	Provides orientation/training	8.5%	4.3%
	Provides supplies	0.0%	4.3%

The table shows that the majority of staff from both types of facilities feel involved in decisions and reviews, leading to a positive feeling of identification. However, CESAR staff appear to review facility performance during evaluations of their own performance, in comparison to CESAMO staff who seem to do so during meetings focused upon the facility itself. This distinction might indicate that CESAR staff are not valued as sources of facility performance or that since most CESAR are alone in a facility, the only meetings where they have the opportunity to discuss facility performance is during supervisory visits. Regarding supervision, it is interesting to note that 50% or more of the staff in both facilities have not been visited in the last six months, and, although there is no statistically significant difference, CESAMO staff is supervised more. Most outstanding, however, is that although there has been supervision, most staff said that it was purely administrative, meaning that it did not really address support, orientation and training (See Graph 11 and 12). This is a very important point, since within the PI *Facilitative* Supervision framework, helping staff improve their skills and solve performance problems, must take precedence over purely administrative factors.

Graph 11: Percentage supervised at least once in the last six months and nature of the supervision - CESAR



Graph 12: Percentage supervised at least once in the last six months and nature of the supervision - CESAMO



Knowledge and Skills

This section has been worked on extensively to produce current observations of skills in FP and Prenatal Care. Some complementary questions based upon providers' perceptions can be found in Table 10.

Table 10: Percentage of providers by answers regarding knowledge, skills and their performance and by facility

#	ITEMS	FACILITY	
		CESAR % (75)	CESAMO % (19)
26	Year in which you received your last FP/prenatal care training		
	Has not received any	2.7%	5.3%
	1998	2.7%	0.0%
	1999	13.3%	5.3%
	2000	81.3%	89.5%
27	Topics in which you were trained (various training focuses)?	(110)	(41)
	AIEPI	44.5%	31.7%
	RH risk	3.6%	2.4%
	FP	3.6%	0.0%
	Breastfeeding	20.9%	31.7%
	Well woman care	12.7%	4.9%
	PAI	14.5%	2.4%
	Obstetric pathologies	0.0%	2.4%

#	ITEMS	FACILITY	
		CESAR % (75)	CESAMO % (19)
28	Have you been able to apply what your learned in the training course?	94.5% (73)	100.0% (18)
29	Do you think you lack important skills for doing your job?	61.3%	52.6%

The table shows that the majority of those interviewed have recently received training. The subjects vary, but most are in AIEPI and in Breastfeeding (curiously the two subjects that are mentioned in the questionnaire as examples). Note the small percentage that mentions having received training in FP. Almost everyone questioned said that they could apply what they learned (which confirms the need of carrying out objective observations of performance in order to determine the true extent to which new knowledge and skills are being applied). In spite of training, slightly more than half of those interviewed think that they lack important skills for doing their job. Checking over the specific skills that they mention, there is an impressive variety among the 56 interviewees who responded. However, the most common topics were "working quickly when caring for AIEPI clients" (10), "taking cytologies" (7), determining the fetal heart rate and fetal position" (6) and then other minor items such as "IUD Insertion," "dealing with special pregnancies," "communicating with the family" and "handling administrative paperwork."

Available FP Methods

A couple of questions were added to the performance section to determine if the providers interviewed promoted and kept available FP methods. As for the first question, all those interviewed said they promoted the program. The percentages that follow in Table 11 are based upon those who indicated each method as "available."

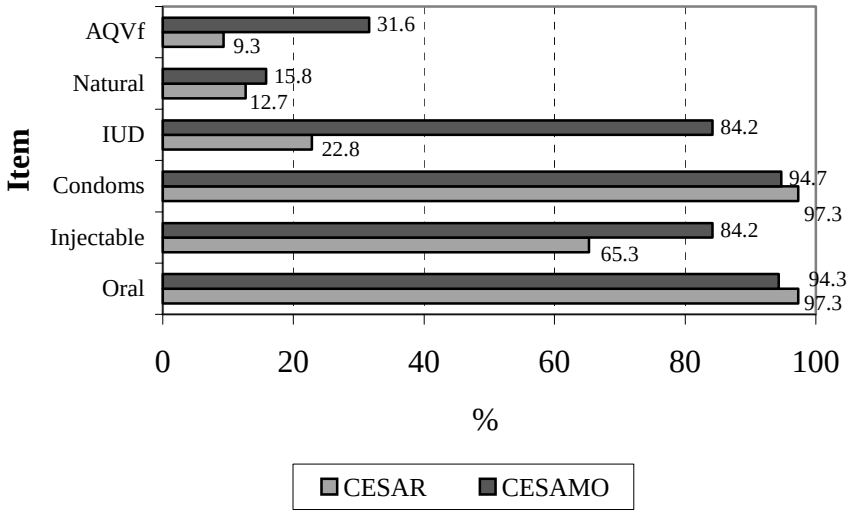
Table 11: Percentage of providers by answers regarding available FP methods and by facility

#	ITEMS	FACILITY	
		CESAR % (75)	CESAMO % (19)
1	Oral	97.3%	94.3%
2	Injectables	65.3%	84.2%
3	Condoms	97.3%	94.7%
4	IUD	22.8%	84.2% **
5	Natural	12.7%	15.8%
6	Tubal Ligation	9.3%	31.6%
7	What do you do if you do not have the requested method		
	Refer	22.7%	5.3%
	Offer alternatives	29.3%	36.8%
	Refer and offer alternatives	45.3%	57.9%
	Other	2.7%	0.0%
8	Do you use any educational or reference materials in FP/PNC/childcare consultations (esp., Flipcharts, Posters and Fold-outs/Leaflets)	65.3%	42.1%

** Significant difference $p < 0.01$

The table shows that most of the providers in both facilities say they have available oral contraceptives, injectables and condoms (See Table 13). Differences between the facilities logically appear for the more invasive methods, like the IUD (highly significant difference) and tubal ligation (which is not statistically significant). When they do not have a requested method, CESAR staff depend more on referring clients to larger centers. Slightly more CESAR staff than CESAMO staff use educational or reference materials, although it must be noted that less than half of the CESAMO staff uses them.

Graph 13: Availability of contraceptive methods, by type of facility



Exit Interview with Clients

An important complementary aspect of provider performance analysis is the exit interview with clients, the purpose of which is to obtain their opinions about the quality of the service offered. Considering that 102 CESARs and 27 CESAMOs were included in the Licensing process, we can say that exit interviews were conducted on an average of one interview per client per facility visited, which is a major achievement. Table 12 shows the average age and parity of those interviewed. It appears that CESAR clients are slightly older and of greater parity than CESAMO clients, although the differences are not statistically significant.

Table 12: Characteristics (average age and parity) of the clients interviewed by facility[&]

#	CARACTERISTIC	FACILITY	
		CESAR % (N)	CESAMO % (N)
1	Average age	26 (87)	25 (28)
2	Average number of children living	3.0 (88)	2.4 (27)

[&] Percentages for the total number of valid observations

Table 13 details the positive responses of clients interviewed about the various aspects of client-provider interaction (CPI). The data reveal their perspectives and provide an indication of the quality of the service provided to the population.

Table 13: Percentage of clients who speak of items of quality/satisfaction by facility[&]

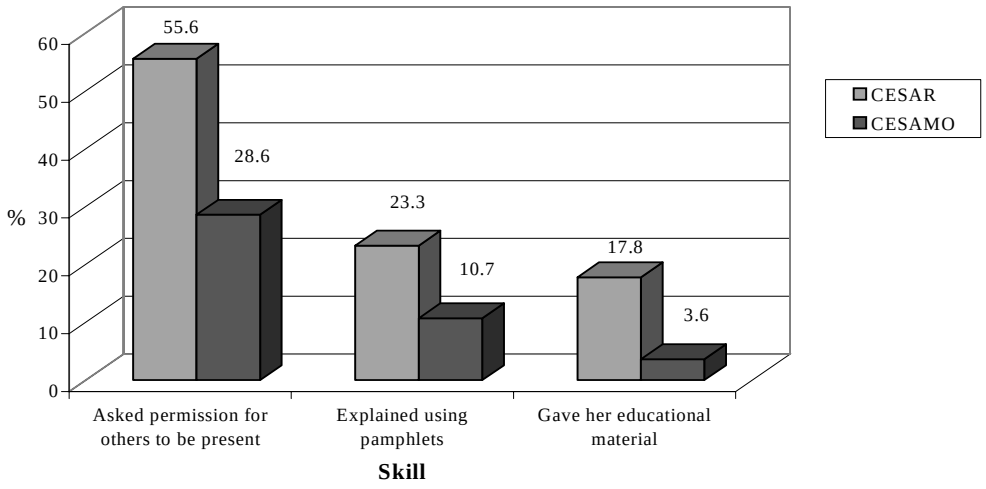
#	ITEMS	FACILITY	
		CESAR % (90)	CESAMO % (28)
1	Greeted you	84.4%	60.7% *
2	Called you by your name	82.2%	89.3%
3	Asked you the reason for your visit, about your needs and concerns	93.3%	85.7%
4	Asked you the reason for your visit, asked questions, looked at you	92.2%	96.4%
5	Allowed you to speak without interrupting	93.3%	89.3%
6	Provided you with a private place where no one else could see or hear you	68.9%	75.0%
7	Asked your permission for other people to be present during the consultation	55.6%	28.6%
8	Assured you that whatever you said would not be said to anyone else	44.9% (89)	39.3%
9	Provided information corresponding to your questions or needs	87.8%	57.1% **
10	Spoke in such a way that you understood his/her explanations	95.6%	96.4%
11	Invited you to ask questions and to express your opinions and disagreements	53.3%	39.3%
12	Provided information about your case or problem using pamphlets/flip charts	23.3%	10.7%
13	Gave you educational materials (pamphlet, flyer, poster)	17.8%	3.6%
14	Provided an answer about what you came to see him/her about today	100.0%	92.9%

#	ITEMS	FACILITY	
		CESAR % (90)	CESAMO % (28)
15	Helped you plan your next appointment and/or referral	45.6%	46.4%
16	Do you know if there was a talk in the center today?	7.8%	25.0% *
17	Do you plan to or are you using FP?	51.1%	50.0%
Average percentage		**69.3**	**60.7**
Index of Quality/Satisfaction for the Client (Items 1 to 15) ^		**10.4**	**9.1 ***

& Percentages of the total number of valid observations
^ Obtained by adding up the answers to all the items: range 0 - 15 (0 = Useless; 15 = Excellent)
* Significant difference $p < 0.05$
** Significant difference $p < 0.01$

First, a number of items are observed that we might term "generic" or "soft," where a great majority of the clients indicate having received the requested care. Such items range from being greeted, called by name, asked about the reason for the visit, being allowed to speak, use of language easy to understand, or providing an answer about the reason for her visit. About half of those questioned gave positive answers to questions such as, for example, assuring privacy, providing information corresponding to her questions or needs, helping her plan her next appointment or referral, assuring her of confidentiality or asking her to ask questions and express herself. These are topics that one must continue reinforcing. However, in weaker areas (where percentages are disturbingly low), staff at both facilities need to increase the use and distribution of educational materials to strengthen and reinforce new or difficult topics like FP (See Graph 14).

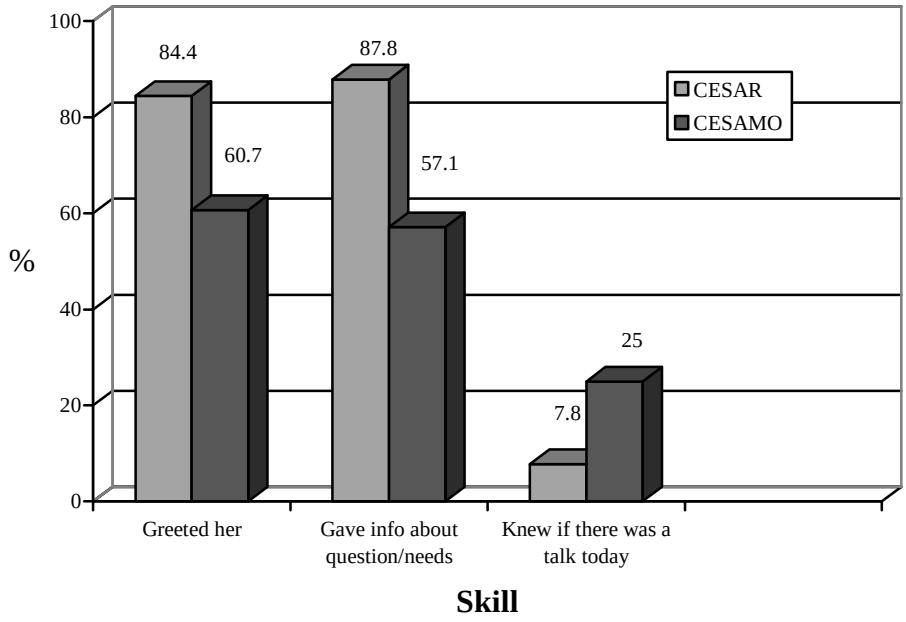
Graph 14: Low percentages in service quality, by type of facility



Areas of significant difference between the facilities become evident when clients say that a greater number CESAR staff greeted them or satisfied their questions/needs. On the other hand, the only question in which a greater number of CESAMO clients responded positively is the one that asks if the client knew on the day of the survey that there was a talk in the center (See Graph 15). This subject is of obviously

uncertain importance with regard to service, indicating only that the larger number of staff at CESAMO facilities allow staff to organize talks in addition to providing clinical care.

Graph 15: Significant differences in service quality, by type of facility



In conclusion, even though average client satisfaction is relatively high (between 60 and 70% satisfaction), this is due to questions that refer to easily performed items that cause the average to rise. Yet, this allows us to identify areas where more effort must be made to improve specific skills.

Conclusions

Skills. The levels of provider improvement were generally high, nearly 60% for FP, but less in Prenatal Care which dropped to about 45%. Yet, both point counts benefited from various "easy" items that reveal skills of general courtesy (i.e., "Asks questions and permits client to speak"), of basic clinical care (i.e., "Asks the reason for the appointment") or required administrative functions (i.e., "Records all findings … as well as care provided the client").

Yet within the checklists we found areas of significant weakness such as hygiene, STI information, and the important complementary clinical examination factors such as feeling thyroids, oral examination, cardio-pulmonary examination and breast exam. Weaknesses were also found in scheduling follow-up exams for pregnant women. Even though there are no great differences generally speaking, between CESAR auxiliary staff and CESAMO physicians and nurses, the latter tend to provide more information and conduct more complete clinical exams.

It must also be noted that CESAMO facilities are better equipped and more comfortable and provide more privacy. They also schedule more appointments than CESAR facilities. This shows a greater need for training and equipment in the CESARs. Perhaps some consideration should be given to building and fitting out separate areas for checkups in the CESARs to ensure client privacy.

Performance Factors

Interviews with providers revealed various PI deficiencies. To begin with, very few staff have a **job description** — the document that determines not only if one has the qualifications required for the job, but also provides in detail the functions, tasks and responsibilities related to the job. It would seem that the AOP would somehow correct this need, however it is not clear whether the AOP is more focused on facility performance or on staff performance.

Similarly, there is very little staff performance **feedback**, something that must be sustained and improved to strengthen weak areas and verify progress in other areas. The analysis of responses to other questions seems to show that feedback is provided only when "the job is done poorly." This is a flawed form of feedback and one that is not necessarily conducive to improving performance.

Motivation/Incentives is still a poorly developed area. Staff members widely exercise self-motivation and personal satisfaction, this being a social services discipline. However, no systematic apparatus for staff recognition exists (i.e., regular and written/disseminated to the remaining staff). Staff feel that training serves as recognition, which is a flawed view of training. Further analysis would have to be conducted to determine if it is the additional aspects of training, i.e., traveling or per diems that are perceived as motivators. To a lesser extent, other tangible incentives exist such as personal gifts, awards and mementos, a practice that should be increased.

Regarding **Environment** (**Tools, etc**.), there are many deficiencies in available technical equipment and furnishings, something that — unlike previous factors — requires more funding.

As for **Organizational Support**, the analysis reveals on the one hand that staff participate in decision making within the facility, fostering identification with the institution. On the other hand, it also reveals a serious lack of staff **supervision**, as less than 50% have been supervised over a period of six months and, for those who are, it is mostly administrative, wasting a valuable opportunity to orient, solve problems, and support performance. The Knowledge and Skills factor has already been discussed, yet it is interesting to note that in spite of the almost universal and recent staff training, almost 60% say "they lack the skills necessary to do their jobs."

Quality of Service from the Client's Perspective. This final component, complementing the previous ones, shows how performance is viewed from the client's perspective, who thereby takes on a more active role in improving services. Thus, a satisfaction rate in this area (around 70%) for fulfilling service-quality items appears to indicate that not much needs to be done in this area. However, there are here, just as in the skills area, a gamut of "soft" items, easily fulfilled, that the client says were performed. Given this premise, this area should have a 100% rate of fulfillment. Therefore, staff need to focus on improving weak areas such as greeting the person, assuring her of her privacy, asking her permission to have other persons present during the visit, urging her to express her opinions and disagreements, using educational materials to reinforce what is said, and helping her schedule a follow-up visit. As long as clients are not 100% satisfied, such breaches can lead to discontent and discontinuity in the use of the service.

Methodology/Instruments. Although the baseline study was an important tool for obtaining highly valuable information for both the Licensing process as for the improvement of the Quality and Friendliness of Health Services in Honduras, the analysis also discovered that the way questions were phrased in some of the instruments resulted in a degree of uncertainty in the responses. This happened in questions such as "how do you receive help for doing your job," which was not necessarily interpreted solely with regard to the subject of feedback, but also with regard to other staff support or infrastructure/equipment. Others, like "What happens if you do your job well," did not necessarily involve responses about motivation, and yet opened the door for candid statements of self-satisfaction. In the case of "opportunities to develop or promotions" the question was bivalent, producing precise answers, such as training (for development) apart from incentives (such as promotions). Such questions and instruments can be perfected in future versions. Yet, for the sake of maintaining consistency in the baseline survey, the following survey of progress or outcome must use the same questions and instruments for the purpose of measuring respective changes.

Recommendations

Based on the results of this survey, the recommendation is to proceed with a *Performance Needs Evaluation* (PNE) in Region 7 de Honduras, for the purpose of:

- Identifying the desired performance of CESAR and CESAMO providers;
- Comparing with it the performance revealed in this baseline study and identifying **the performance gap**;
- Choosing and implementing priority interventions that must occur in order to close such gaps and achieve the Performance Improvement (PI) of the personnel; and
- Determining how the said PI has impacted the quality and use of the service by the clients and population.

Such a *Performance Needs Evaluation* (PNE) must be carried out with the support of all Region 7 and Health Secretariat key officials at the central level, as well as other funding and cooperating agencies and organizations interested in the topic. The process used to achieve the PNE objectives cited above will therefore be participative and collaborative. The same officials will define the desired primary provider performance of both CESAMO and CESAR. Given their vast knowledge about the health system, the evaluators will identify the major factors that cause performance gaps and will choose the most appropriate interventions for solving the problems. During this workshop, the group will begin to develop the interventions that are to be used in the selected site.

Epilogue - Results of the Performance Needs Assessment

While the present report was being finalized, the Performance Evaluation Workshop took place. Most key staff involved in this topic participated in the workshop, including area administrative chiefs, sector supervisors and directors and rectors for service quality and facilities (see Appendix 2). The workshop was conducted in Juticalpa from March 13 to 15, 2001. Participants identified the desired performance in terms of the percentage of providers who would carry out various functions in the four areas of maternal health: FP, prenatal care, humanization of services and supervision. The desired performance actions for the four components with the desired percentages given separately for CESAR and CESAMO are presented in Appendix 3. In some cases, they defined "desired" as total compliance with the action by all providers in the Region. In other cases, they requested less than 100% provider compliance (90-95%), indicating the difference between what would be an ideal performance and a desired performance.

Such a desired performance was compared with the Baseline Study results, allowing them to identify providers' *Current Performance*. Using both data, *Performance Gaps* were identified, such as mathematical differences (by percentages) between desired and current performance, that is to say the difference between what we want the providers to do and what they actually do in their work. Details regarding the gap for each performance action are found in Appendix 3. Given the fact, however, that a wide range of gaps are presented in this evaluation, the participants prioritized the gaps in each component, using one or more of the following criteria:

- It has the greatest gap
- It is essential that it be solved (i.e., It affects the well-being of the client, life or death situation)
- It is a performance action that impacts other actions

The gaps prioritized by the groups are presented in the table in Appendix 3 and are written in **boldface**. These are the gaps that are used to decide upon the interventions needed to resolve them. The remaining gaps were left for a future intervention, although the table shows that various gaps would require similar interventions.

Once the priority gaps had been chosen, the groups did a "root cause" analysis to find the main cause for the existence of the performance gap. Participants used the technique of asking 'Why? Why? Why?' over and over and exhaustively until they reached the most fundamental point for which an intervention might be undertaken. For example, one of the significant gaps is that of primary providers having washed their hands before beginning a family planning consultation or checkup. Having investigated this gap, the participants indicated that it was due to the absence of water and that there is no water because of the lack of infrastructure in many centers. But

they also mentioned that there was no one to deliver water, therefore the subject is also related to an administrative/managerial failure.

Once the root causes of the gaps were defined, the groups expressed them in terms of the support factor related to each one (i.e., job expectations, organizational support, knowledge and skills, etc.). The vast majority of the roots are related to organizational support factors, motivation/incentives and knowledge and skills.

To reach the last methodological step, the *selection of interventions*, the groups used a simplified tool for cost-benefit analysis (on a scale of one to ten) based upon financial costs, time and human resources and benefits like how well will the intervention close the gap). The benefit is divided by the cost to calculate the cost-benefit rate. The list of interventions proposed by the participants and their cost-benefit analyses are also found in Appendix 3. The four interventions mentioned most frequently are **facilitative supervision, training, motivation and incentives and organizational support.** The participants agreed to consider these four interventions as priorities in order to close the prioritized performance gaps. They then carried out a preliminary designing of the interventions, determining activities, staff to be involved, and the schedule. Results are presented in Appendix 3. Training interventions were focused on teaching providers about communication techniques and about human rights, gender and masculinity as they pertain to RH. The organizational support intervention is focused on the development of a logistical plan, sensitizing and collaborating with other institutions to assure support factors and define expectations and levels of functions and jobs for the providers.

In this way the **Performance Needs Assessment** became not only a valid diagnostic tool, but went further with its participative methodology by creating **consensus** and, for the participants involved, the **ability to select and design** interventions.

Appendix 1

Honduras Report Contributors

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Celeo Lobo, HRSK Catacamas
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Appendix 2

Agenda for the presentation of the results of the baseline study and PNE, and List of Participants

March 13 - 15, 2001

Date and Hour	Subject	Presenter
Tuesday, March 13		
10:00-10:20	Opening of the Conference	Dr. Hector Luis Escoto Dr. Francisco Vallejo
10:20-10:30	Background of the Study	Margarita Calix
10:30-11:15	Conceptual Bases for Improvement and Methodologies used	Wanda Jaskiewicz
11:15-11:35	On-site Experiences	Dania Velásquez
11:35-11:45	Instruments used and Interpretation	Ely Dominguez
11:45-12:30	Report on the Results of Current Performance	Dr. Alfredo Fort
13:30-13:45	Lunch	
13:45-14:15	Questions and Answers on the First Part	All
14:15-15:00	Continued Presentation regarding Current Performance	Dr. Alfredo Fort
15:00-15:20	Break: Snack	
15:20-16:00	Questions and Answers on the Second Part	General Assembly
Wednesday, March 14		
9:05- 9:15	Questions	All
9:15- 9:20	Group Formation	Sara Borjas
9:20-10:20	Working in Groups: Desired Performance	All
10:20-10:40	Break	
10:40-11:20	Plenary Session: Group Reporting	All
11:20-12:00	Discussion – Agreements	All
12:00-12:30	Lunch	
13:00-13:15	Presentation	Sara Borjas
13:15-13:45	Explanation of Gaps: Group Work: Definition of Gaps	Wanda Jaskiewicz
13:45-14:10	Group Plenary Report	All
14:10-14:30	Discussion	
14:30-15:30	Case Analysis of Gaps	All
15:30-15:45	Break-Coffee	
15:45-16:20	Group Plenary Report	All

Date and Hour	Subject	Presenter
16:30-16:30	Discussion	All
Thursday, March 15		
8:00- 8:00	Plenary Session: Group Reporting	All
9:00-10:00	Group Work: Choosing Interventions	All
10:00-10:15	Break	
10:15-10:20	Forming of New Skills Groups	Sara Borjas
10:20-12:00	Group Work: Designing Interventions	All
12:00-12:30	Group Plenary Report	All
12:30-13:30	Lunch	
13:30-14:00	Continuation of Plenary Session	All
14:00-15:00	Group Work: Action Plan	All
15:00-15:45	Plenary Report	All
15:45-16:05	Conclusions: Evaluation, Adjournment	All

Participants

Baseline Study Meeting – Health Region No. 7
Preliminary Performance Results Presentation

1.	Francisco Fortin	Public Relations, Ministry of Health
2.	Dr. Marco Pinel	Acceso Project
3.	Dr. Ramon Pereira	Acceso Project
4.	Lic. Marcia Rodriguez	Facilities Department, Ministry of Health
5.	Dr. Dafne Carias	Administrative Head, Facilities Department, Ministry of Health
6.	Dr. Franklin Cerrato	Administrative Head, Department of Regulation, Ministry of Health
7.	Dr. Ivo Flores	Maternal/Child Department, Ministry of Health
8.	Dr. Mario Chiesa	Administrative Head, Dept. of Quality Control – M. of Health
9.	Lic. Leticia Isabel Izaguirre	Department of Quality Control – Ministry of Health
10.	Lic. Sara Elizabeth Borjas	Department of Quality Control – Ministry of Health
11.	Dr. Norma Aly	Garantía De Calidad Project
12.	Lic. Ana Rosa Gutiérrez	Garantía De Calidad Project
13.	Ing. Virna Rodríguez	Priess/Bid
14.	Dr. Ruben Alcantara	Priess/Bid
15.	Dr. Luis Vieira	Priess/Bid
16.	Lic. Anabell Rivera	Priess/Bid
17.	Maribel Lozano	Priess/Bid
18.	Dr. Humberto Jaime Alarid	Ops/Oms
19.	Dr. Hector Luis Escoto	Director, Health Region # 7
20.	Dr. Eda Sofia Calix	Epidemiologist, Health Region # 7
21.	Licda. Maria Elena Sabonge	Nurse, Health Region # 7
22.	Licda. Aida Figueroa	Maternal/Child Trainer
23.	Licda. Margarita Calix	Administrative Head, Planning Department
24.	Dra. Reina Flores	Prosare Technical Coordinator
25.	Dr. Tamotsu Nakasa	Prosare Chief Consultant– 7
26.	Licda. Sachiko Egashira	Prosare long-term Expert – 7
27.	Licda. Fumiko Kudo	Prosare long-term Expert - 7
28.	Dr. Ely Catalina Dominguez	Prime Supervisor, Health Region # 7
29.	Nazario Lopez	Educator, Health Region # 7
30.	Reina Santos Santos	Municipal Supervisor of Culmi
31.	Liliana Maribel Henriquez	Nutritionist, Health Region # 7
32.	Dania Yaneth Velasquez	Assistant, Planning Department
33.	Tania Olivera	Civil Engineer, Health Region # 7
34.	Dr. Luis Barahona	Administrative Head, Area # 1
35.	Licda. Digna Duarte	Municipal Supervisor of Patuca

36.	Licda. Gladys De Navas	Supervisor, Area # 1
37.	Licda. Sulay Rodriguez	Municipal Supervisor, Campamento
38.	Dr. Orles Escobar	Administrative Head, Area # 2
39.	Licda. Lourdes Mencia	Administrative Head, Cmi De Catacamas
40.	Dr. Oscar Gonzales	Administrative Head of Cesamo, Tatabicoche
41.	Licda. Ada Luz Aguiriano	Supervisor, Ups De Predisa
42.	Licda. Carmen Lobo	Head Nurse, Predisan
43.	Dr. Lisandro Martinez	Administrative Head, Area # 3
44.	Licda. Mirna Torres	Supervisor, Area # 3
45.	Licda. Dora Cartagena	Municipal Supervisor, Salama
46.	Dr. Jose Hernan Eveline	Administrative Head, Area # 4
47.	Licda. Gladys Cruz	Supervisor, Area # 4
48.	Licda. Sandra Garcia	Cesamo Nurse, San Martin
49.	Licda. Argelia Gallo	Head Nurse, San Francisco Hospital
50.	Dr. Zoila Rivera	Head Physician, Out-patient Clinic, San Francisco Hospital

Appendix 3

Table of Results of the Performance Needs Evaluation

Component		Actions of Desired Performance	Performance					Root of the Cause and Support Factor	Interventions	Analysis		
			Desired	Current		Gap				Cost-Benefit		
			Both	CR	CMO	CR	CMO			Cost	Benefit	Rate
	The Provider:		%	%	%	%	%					
1. Humanization of Services	1	Greets, calls the person by name and introduces him/herself.	90	56.3	62.5	33.7	27.5					
	2	Makes sure the person is in a comfortable location, with privacy.	90	45.4	75.0	44.6	15.0					
	3	Explains the purpose of the consultation and the nature of the clinical examination.	85	31.3	37.5	**53.7**	**47.5**	Not knowing patients' rights (Knowledge and skills)	--Training on human and patient rights	9	10	1.11
	4	Asks questions and allows the person to speak.	100	95.8	100.0	4.2	0.0					
	5	Pays attention and is interested in her personal problems.	85	70.2	68.8	14.8	16.2					
	6	Speaks in a way that is clear and understandable to the person.	95	79.2	93.8	**15.8**	**1.2**	Lack of knowledge about how to communicate (Knowledge and skills)	--Training specifically in communication techniques	9	10	1.11
									--Incentives plan: small recognitions (scrolls, note, diploma); awarding a better job; promotions	4	10	2.5

Component		Actions of Desired Performance	Performance					Root of the Cause and Support Factor	Interventions	Analysis		
			Desired	Current		Gap				Cost-Benefit		
			Both	CR	CMO	CR	CMO			Cost	Benefit	Rate
	The Provider:		%	%	%	%	%					
	7	Urges and encourages the person to ask questions, allows her to express herself freely.	85	60.4	75.0	**24.6**	**10.0**	Knowledge of RH too limited to respond to patients' questions (Knowledge and skills)	--Reproductive Health Training	9	10	1.11
	8	Tries—while respecting cultural beliefs—to dispel doubts and fears.	80	36.2	31.3	43.8	48.7					
	9	Sets her appointment at a time that is most convenient to the person and notes the date of it on her card.	95	50.0	87.5	45.0	7.5					
	10	Encourages the client to come to appointments with her partner, if she so desires.	95	29.2	12.5	**65.8**	**82.5**	Lack of knowledge about gender and reproductive health (Knowledge and skills; motivation)	--Training in the area of gender, reproductive health and masculinity	9	10	1.11
	11	Urges the client to come to the center in the event of a problem.	95	64.6	68.8	**30.4**	**26.2**	Lack of able supervision in the service (Organizational Supervision; skills and knowledge; feedback on performance)	--Development and execution of supervisory plans: designing manuals; technical guides for supervision	5	10	2
									--Training for supervision	9	10	1.1
									--Oral, written communication regarding ones performance	3	10	3.3

Component		Actions of Desired Performance	Performance					Root of the Cause and Support Factor	Interventions	Analysis		
			Desired	Current		Gap				Cost-Benefit		
			Both	CR	CMO	CR	CMO			Cost	Benefit	Rate
	The Provider:		%	%	%	%	%					
2. Family Planning	1	Asks the reason for the consultation.	100	100	93.8	0.0	6.2					
	2	Washes his/her hands with soap and water, then air dries them or uses a clean towel.	100	4.5	18.2	**95.5**	**81.8**	Lack of direction, management (there is no one who brings water) (Organizational support; physical environment; motivation/ incentives)	--Discussion with local public officials, institutions with local officials and sponsoring institutions (SANAA)	5	10	2
									--Development of infrastructure through the construction and repair of the water basin and through water storage and the improvement of the supplies network	10	10	1
									--Transporting water	2	10	5
									--Effective workshops on sensitization	1	10	10
	3	Asks about the client's reproductive intentions.	100	52.1	62.5	47.9	37.5					
	4	Asks about her intentions in the use of contraceptive methods and her preferences.	100	77.1	81.3	22.9	18.7					
	5	Offers information about her preferred method or about the available methods.	100	83.3	66.7	16.7	33.3					

		Actions of	Desired	Current		Gap		Root of the Cause and		Cost-Benefit		
Component		**Desired Performance**	**Both**	**CR**	**CMO**	**CR**	**CMO**	**Support Factor**	**Interventions**	**Cost**	**Benefit**	**Rate**
	The Provider:		**%**	**%**	**%**	**%**	**%**					
	6	Tells her about the advantages and disadvantages of the methods and especially about her method of choice.	100	54.2	93.8	45.8	6.2					
	7	Discusses side effects with the client and how they are dealt with.	100	54.2	81.3	45.8	18.7					
	8	Provides information and discusses with the client developments and possible danger signs	100	54.2	81.3	45.8	18.7					
	9	Tries to dispel myths and fears while respecting cultural beliefs.	100	36.2	31.3	**63.8**	**68.7**	Does not appreciate the importance of the client's opinion and way of thinking. (Knowledge and skills)	--Development of a participative methodology	10	10	1
									--CAP Investigation	8	10	1.25
									--Intercultural encounters; integrate the institutional staff into the community	10	10	1
	10	Informs the client about STI protection derived from contraceptive methods.	100	8.3	18.8	**91.7**	**81.2**	Lack of motivation; performance feedback	--Incentives plan	6	10	1.6
									--Facilitated supervision	7	10	1.42

		Actions of	Desired	Current		Gap		Root of the Cause and		Cost-Benefit		
Component		**Desired Performance**	**Both**	**CR**	**CMO**	**CR**	**CMO**	**Support Factor**	**Interventions**	**Cost**	**Benefit**	**Rate**
	The Provider:		**%**	**%**	**%**	**%**	**%**					
	11	Gives the client an adequate supply of non-clinical methods.	100	85.1	86.7	14.9	13.3					
	12	Sets her appointment at a time that is most convenient for the client, notes the date of it on her card and urges her not to miss it.	100	50.0	87.5	50.0	12.5					
	13	Encourages the client to come to appointments with her partner, if she so desires.	100	29.2	12.5	**70.8**	**87.5**	Inappropriate knowledge of gender issues (Knowledge and skills)	--Effective workshops focused on gender (with experts) --Group meetings --Supervision	10 8 7	10 10 10	1 1.25 1.42
	14	Takes notes of all findings, evaluations, diagnoses and care provided to the client.	100	89.6	87.5	10.4	12.5					
	15	Places the client's record into the appropriate folder.	100	83.3	81.3	16.7	18.7					
3. Prenatal Monitoring	1	Washes his/her hands with soap and water and dries them.	80	8.1	6.3	**71.9**	**73.7**	Washing hands does not seem important; motivation	--Enabling supervision --Knowledge	6 2	10 8	1.66 4

Component		Actions of Desired Performance	Performance					Root of the Cause and Support Factor	Interventions	Analysis		
			Desired	Current		Gap				Cost-Benefit		
			Both	CR	CMO	CR	CMO			Cost	Benefit	Rate
	The Provider:		%	%	%	%	%					
	2	Explains the reason for the appointment and the nature of the procedures.	90	36.1	37.5	**53.9**	**52.5**	Lack of humanization on the part of the staff (Knowledge and skills; motivation)	--Sensitizing and humanizing services --Knowledge	3 2	6 8	2 4
	3	Reviews clinical history of follow-up clients	100	95.0	100.0	5.0	0.0					
	4	Prepares a clinical history for new patients.	100	100.0	100.0	0.0	0.0					
	5	If this is the first appointment, reviews clinical history of previous pregnancies: number, evolution, conclusion.	100	76.5	85.7	23.5	14.3					
	6	In the case of the current pregnancy: date of last menstruation period (LMP), pregnancy symptoms and lab tests.	70	51.5	50.0	18.5	20.0					
	7	Takes vital signs: blood pressure, temperature.	90	18.9	36.4	**71.1**	**53.6**	Lack of empowerment in processes; lack of self-evaluation; lack of supervision (Organizational Support; feedback)	--Enabling Supervision --Reflective classes	6 3	10 6	1.66 2

Component		Actions of Desired Performance	Performance					Root of the Cause and Support Factor	Interventions	Analysis		
			Desired	Current		Gap				Cost-Benefit		
			Both	CR	CMO	CR	CMO			Cost	Benefit	Rate
	The Provider:		%	%	%	%	%					
	8	Obtains anthropometric data: weight, height	90	22.2	40.0	**67.8**	**50.0**	See above				
	9	Examines the conjunctiva	100	43.2	25.0	**56.8**	**75.0**	See above				
	10	Palpates the thyroid glands, oral examination	80	13.5	6.7	**66.5**	**73.3**	See above				
	11	Listens to heart rate and performs a breast exam.	90	2.7	6.3	**87.3**	**83.7**	See above				
	12	Examines and determines if there is any edema, redness or varicose veins.	100	59.5	75.0	**40.5**	25.0	See above				
	13	Inspects and feels abdomen to detect scars, pigmentation.	100	59.5	93.8	**40.5**	6.2	See above				
	14	Palpates the uterus and performs necessary maneuvers to determine fetal position and situation.	100	81.1	87.5	18.9	12.5					
	15	Measures uterine height and listens to fetal heartbeat.	100	70.3	81.3	29.7	18.7					
	16	Determines week of pregnancy and due date.	100	83.8	86.7	16.2	13.3					
	17	Defines the relationship between fetal development and uterine height.	90	45.9	73.3	**44.1**	16.7	Lack of a training plan differentiated by levels (Knowledge and skills)	--Differentiated training	6	10	1.66

Component		Actions of Desired Performance	Performance					Root of the Cause and Support Factor	Interventions	Analysis		
			Desired	Current		Gap				Cost-Benefit		
			Both	CR	CMO	CR	CMO			Cost	Benefit	Rate
	The Provider:		%	%	%	%	%					
	18	Determines mother's and fetus' health based upon the evaluation.	90	37.5	69.2	**52.5**	20.8	See above				
	19	Informs the mother about the progress of her pregnancy.	90	52.8	40.0	**37.2**	**50.0**	Lack of supervision and medical audit; management deficiency (Organizational support)	--Enabling supervision	6	10	1.66
									--Transmission and reinforcement about knowledge of the norms	3	8	2.66
								--Lack of goals	--Spreading out provider functions	2	8	4
	20	Informs the mother of her health status	90	52.8	66.7	**37.2**	23.3	See above				
	21	Informs the mother about her fetus' s health status.	90	43.2	46.7	46.8	43.3					
	22	Informs the mother about complications	100	51.4	53.3	**48.6**	**46.7**	See above				
	23	Asks the mother about her medical care	80	13.5	13.3	**66.5**	**66.7**	See above				
	24	Provides nutrition information	80	56.8	20.0	**23.2**	**60.0**	See above				
	25	Provides information on how to handle common discomforts	80	32.4	26.7	**47.6**	**53.3**	See above				

Component		Actions of Desired Performance	Performance					Root of the Cause and Support Factor	Interventions	Analysis		
			Desired	Current		Gap				Cost-Benefit		
			Both	CR	CMO	CR	CMO			Cost	Benefit	Rate
	The Provider:		%	%	%	%	%					
	26	Provides information on personal hygiene	80	2.8	6.7	**77.2**	**73.3**	See above				
	27	Provides information on STI prevention	100	100.0	100.0	0.0	0.0					
	28	Provides information on danger signs, e.g., vaginal bleeding and loss of fluids	100	33.3	33.3	**66.7**	**66.7**	See above				
	29	Informs her about tetanus vaccination and administers it	100	45.9	57.1	**54.1**	**42.9**	See above				
	30	Provides her with iron and folate supplements	100	86.1	66.7	13.9	33.3					
	31	Explains how to take medications	100	67.6	60.0	**32.4**	**40.0**	See above				
	32	Explains positive and negative effects of medications	90	21.6	13.3	**68.4**	**76.7**	See above				
	33	Sets her appointment at a time that is most convenient for her	100	37.8	18.8	**62.2**	**81.2**	See above				
	34	Notes all findings, evaluations, diagnoses and care provided to the client	100	83.8	81.3	16.2	18.7					
	35	Places the client's record in the appropriate folder.	100	100.0	100.0	0.0	0.0					

Component		Actions of Desired Performance	Performance					Root of the Cause and Support Factor	Interventions	Analysis		
			Desired	Current		Gap				Cost-Benefit		
			Both	CR	CMO	CR	CMO			Cost	Benefit	Rate
	The Provider:		%	%	%	%	%					
4. Supervision	1	Forms a multidisciplinary team through CESAMO composed of a physician, nurse, health promoter, educator, others.	100	0.0	0.0	**100.0**	**100.0**	Management deficiency (Organizational Support)	Inducement of resources recently added to the position, relative to his/her operative level	1	10	10
	2	Will visit the UPS every three months.	100	6.7	15.8	**93.3**	**84.2**		To develop and circulate a plan for supervision that includes a manual of functions	9	10	1.1
									To establish coordination levels with the participation of all those involved in the process	3	10	3.3
	Must carry out during each visit:											
	3	--Direct observation of care (2-3 cases)	100	0.0	0.0	**100.0**	**100.0**					
	4	--Evaluation of different programs.	100	91.6	91.3	**8.4**	**8.7**					
	5	Will inform the team of the supervisory method	100	0.0	0.0	**100.0**	**100.0**					
	6	Will delegate functions for subsequent visits.	100	0.0	0.0	**100.0**	**100.0**					

Component		Actions of Desired Performance	Performance					Root of the Cause and Support Factor	Interventions	Analysis		
			Desired	Current		Gap				Cost-Benefit		
			Both	CR	CMO	CR	CMO			Cost	Benefit	Rate
	The Provider:		%	%	%	%	%					
	7	Will record all findings made during the visit in the supervision book by date, hour, supervisor's name and the name and recommendations of the UPS resource.	100	0.0	0.0	**100.0**	**100.0**					
	8	Will provide technical support to the providers.	100	0.0	0.0	**100.0**	**100.0**					
	9	Will provide the providers with feedback.	100	0.0	0.0	**100.0**	**100.0**					
	10	Will discuss the next steps with the providers.	100	0.0	0.0	**100.0**	**100.0**					
	11	Will design a plan of action with the providers.	100	0.0	0.0	**100.0**	**100.0**					

Gap*-- the gaps indicated in boldface represent prioritized gaps

Appendix 4

Description of interventions for closing prioritized gaps

Intervention 1: Enabling Supervision

What	How	When	Who
Designing an enabling supervision system	Review and revision of the current supervisory model	2nd trimester of 2001	Combined technical committee for the region and area
Socializing the supervisory model	Plan for a work session with institutional personnel who are responsible for the revalidation of the instrument	June 2001	Team that developed the instrument and staff responsible for supervision
Training in the resources used in the job	By means of a training workshop	July, 3rd week	Technical committee for supervision (COMSUR 7)
Implementation of the supervisory model	By copying and distributing the instrument	July 2001	COMSUR 7
Guaranteeing the continued use of the instrument	Direct supervision for the various levels and information system	3rd trimester 2001	Region, area, local

Intervention 2: Enabling Supervision

What	How	When	Who	For Whom
Communication techniques	Focus: Training of the trainers Reflective meetings	1-year period	Region, Area, Sector	Doctor, Nurse, Promoter
Reproductive Health: Human rights, masculinity, gender	In-service training Designing a curriculum	1-year period	Sector en la UPS	Doctor, Nurse, Promoter, community

Intervention 3: Organizational Support

What	How	When	Who	For Whom
1. Establishment of levels of coordination with the participation of all involved with the process	1.1 Socialization of findings from the baseline survey on licensing and the performance of primary reproductive health care providers in regional, area and municipal levels	Trimester II	Regional, area and municipal levels	
	1.2 Work session with local governments and other institutions to plan activities to improve the desired performance (physical environment and supplies)	Trimester II	IDEM	The POA has to be included by levels
	1.3 Execution, monitoring and evaluation (self-evaluation of the plan)	Trimesters III-IV	IDEM	By request and justification
2. Design a manual describing functions for various levels of care	2.1 Designing and developing a functions manual	Trimesters III-IV	Regional department of human resources	
	2.2 Validation	Trimester IV	IDEM	
	2.3 Socialization and training	Trimester IV	Region, Area	
	2.4 Supervision of compliance	Trimester IV	Region, Area	
3. Legal framework (Knowledge of laws and regulations that regulate health workers	3.1 Workshops for socialization, participatory sessions of reflection with the institutional staff	Trimesters III-IV	Regional human resources; Area Administrative Heads	
4. Strengthening logistics	4.1 Weekly and monthly programming of activities (Coordinated programming of activities)	Trimesters I-IV	Region, Area, Municipal Local	
	4.2 Continue the process of deconcentration and decentralization	Trimesters I-IV	Region, Area, Municipal and Local	

What	How	When	Who	For Whom
	4.3 Efficient handling of funds related to his program on the part of each administrative head	Trimesters I-IV	Region, Area, Municipal and Local	
	4.4 Diagnosis of transport situation	Trimesters I-IV	Region, Area	
	4.5 Maintenance	Trimesters I-IV	Region, Area	
	4.6 Dealing with per diems and supplies in a timely fashion	Trimesters I-IV	Regional and Area Administrator	

Intervention 4: Motivation/Incentives

What	How	When	Who
Provide recognition	Supervision Special courses Certificates Fellowships Verbal and written recognition Promotion Salary increase Awards	Trimesters I-IV	Motivation and incentives team
Technical confidence	Provide them with technical training to make decisions and solve problems Supervision	Trimesters I-IV	Motivation and incentives team
Be attentive to the providers	Visits from the administrative head of the area, from supervisors, from project staff	Trimesters I-IV	Motivation and incentives team
Provide economic benefits	Adequate salary Per diems Bonuses Location	Trimesters I-IV	Motivation and incentives team
Work as a team; maintain adequate team	Form work teams Be certain of having a suitable team, adequate environment	Trimesters I-IV	Motivation and incentives team
Fulfillment of goals	Assigning functions Providing support Stimulating interest in the work Evaluating providers	Trimesters I-IV	Motivation and incentives team