



**JHPIEGO** An Affiliate of  
Johns Hopkins  
University  
WORKING TO IMPROVE THE HEALTH OF WOMEN AND FAMILIES THROUGHOUT THE WORLD

technical report

# **High-Performing Reproductive Healthcare Facilities in Kenya: Why They Exceed Expectations**

**JHP-22**

Prepared by

**Barbara Rawlins, MPH  
Kama Garrison, MPH  
Pamela Lynam, MBBS  
Susan J. Griffey Brechin, BSN, MPH, DrPH  
Anne Njeru, KRN, M, DAN  
Chris Podo Rakuom, KRN, M**

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## ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
CA	Cooperating agency
CBD	Community-based distribution
CHAK	Christian Health Association of Kenya
COC	Combined oral contraceptives
COPE®	Client-oriented, provider-efficient services
CYP	Couple years of protection
DRH	Division of Reproductive Health
DTC	District training center
FP	Family planning
FPAK	Family Planning Association of Kenya
HIV	Human immunodeficiency virus
IP	Infection prevention
IUD	Intrauterine device
MOH	Ministry of Health
NGO	Nongovernmental organization
PI	Performance improvement
PICG	Performance Improvement Consultative Group
POC	Progestin-only contraceptives
RH	Reproductive health
USAID	United States Agency for International Development



# EXECUTIVE SUMMARY

This report summarizes findings from Phase 2 of a two-phase case study to determine why certain reproductive healthcare facilities in low-resource settings perform better than others. The study examined the characteristics, behaviors, and coping strategies of high-performing reproductive healthcare facilities in Kenya, exploring elements of resilience and factors influencing performance. The study investigated the applicability of a performance improvement (PI) model that hypothesizes that both individual and organizational performance are influenced by seven performance factors: job expectations; motivation; knowledge and skills; performance feedback; infrastructure, equipment, and supplies; leadership and management systems; and client and community focus. The study further examined the presence or absence of elements of organizational resiliency at each facility.

Thirteen high-performing reproductive healthcare facilities operating in four provinces across Kenya were included in the study. These facilities were selected from a list of "high-performing" facilities generated by stakeholders during a series of workshops held in Nairobi in November 2000. The study team loosely defined "high-performing" facilities as those facilities whose performance exceeded expectations, or that one would recommend to a friend or relative.

The 13 high-performing facilities shared five of the seven performance factors measured: knowledge and skills; infrastructure, equipment, and supplies; leadership and management systems; motivation; and client and community focus. For example, in all 13 facilities, staff knowledge and skills were strong. Staff exhibited appropriate infection prevention (IP) practices and took advantage of learning opportunities in order to stay up-to-date. Staff reported that when both off- and on-site learning opportunities became available, those who attended these workshops were responsible for updating their colleagues once they returned to their site.

Exemplar facilities also had adequate infrastructure, equipment, and supplies. At the majority of these facilities, IP supplies and contraceptives were readily available, and basic infrastructure, which included a clean waiting room and toilet, was in place. In cases where there was a performance problem (e.g., a shortfall in supplies), many of the high-performing facilities developed coping strategies such as forming partnerships with other healthcare facilities or using funds gathered through cost-recovery mechanisms to purchase needed supplies to maintain their high performance.

Effective leadership and management systems were also crucial to maintaining high performance. High-performing facilities maintained an open environment for communication and had either a strong leader, such as the facility in-charge or manager, or strong operating systems, such as standardized performance and financial monitoring procedures. In addition, high motivation among staff was found to be linked to teamwork—an important part of the culture at the exemplar facilities—as well as a sense of equality among all staff and a set of common religious or professional values. Teamwork also served as a motivating factor for staff in addition to small incentives, such as tea breaks for staff, with the tea supplied by the facility, and access to free medical care for staff and their families. These appeared to go a long way in improving morale.

The high-performing facilities included in the study also provided client and community-focused services. Clients interviewed indicated that they chose to come to the high-performing site not just because it was the closest one to their homes or because they had no other options, but



because they received what they came for (e.g., supplies, services) at a place that was clean and where the staff treated them with friendliness and respect. Waiting times were also acceptable and affordable to most clients.

In addition to possessing these five performance factors, high-performing facilities were found to have mechanisms in place to help achieve performance goals and at the same time effectively innovate and adapt to rapid and turbulent changes. These qualities are key elements of organizational resiliency. For example, many of the high-performing facilities included in the study held regular staff meetings to discuss problems affecting the delivery of high-quality health services and to identify creative solutions to those problems. These meetings also served to inform other staff about new knowledge gained through attendance at trainings.

This study showed that five of the seven performance factors essential to effective individual and organizational performance, as well as all the attributes associated with organizational resiliency, contribute to the high performance of healthcare facilities in Kenya, a low-resource setting. In fact, the presence of organizational resiliency characteristics appeared to enable many of the high-performing facilities to maintain their high performance over time.

Study results suggest that, to improve the quality and efficiency of healthcare delivery facilities in a sustainable way, interventions may need to focus on assisting on-site supervisors/managers and providers to effectively manage change by strengthening innovative decision-making and problem-solving approaches. Findings from this study will now be used to shape and prioritize interventions aimed at improving the performance of average and low-performing healthcare facilities.



# High-Performing Reproductive Healthcare Facilities in Kenya: Why They Exceed Expectations

## INTRODUCTION

Healthcare is continually changing, strongly affected by the complex and turbulent environment in which medical organizations and providers must function. Surviving in this context requires the ability to perform in the face of constant flux. Nowhere is this more evident than in healthcare systems in low-resource settings. In these settings, resilience could be the key characteristic that a healthcare delivery facility needs to provide consistently high-quality healthcare services.

Robb (2002) defines a resilient organization as “an organization which has the capability to do two things simultaneously: deliver excellent performance against current goals; and effectively innovate and adapt to rapid and turbulent changes in market technologies.” Coutu (2002) posits that much of the literature about resilience identifies three primary characteristics of a resilient organization:

- ◆ Staunch acceptance of reality
- ◆ Deep belief often buttressed by strongly held values
- ◆ Uncanny ability to improvise

JHPIEGO's interest in exploring resilience in healthcare organizations in low-resource settings led to a two-phase study examining factors illustrating resilience and influencing performance among high-performing reproductive healthcare facilities in Kenya. Findings from both phases of this study have yielded a greater understanding of the factors that affect an organization's ability to provide high-quality reproductive health (RH) services in low-resource settings. These findings are intended to create a foundation for JHPIEGO's future work in performance improvement (PI) and assist RH facilities in performing to their full potential (Rawlins et al 2001). JHPIEGO and other collaborating agencies will be able to target their future programmatic interventions and resources more appropriately in order to achieve improved healthcare outcomes among average and low-performing healthcare facilities.

This report concludes Phase 2 of the study (Rawlins et al 2001) and examines the extent to which the theories of resilience and the behavior engineering model (otherwise referred to as performance factors) developed by Thomas Gilbert, the founding father of performance technology, are present among the selected reproductive healthcare facilities (Gilbert 1996).

This study differs from many assessments of healthcare facilities in that it focused on facilities' assets and resilient qualities, rather than on the problems in or constraints to the delivery of high-quality health services. Once a better understanding of the performance factors and site characteristics that contribute to performance and resilience are understood, the information can be used to better target resources and plan and design more appropriate performance-enhancing interventions in healthcare facilities that are not performing at the level desired.



## BACKGROUND

JHPIEGO is committed to the provision of reproductive healthcare training and the strengthening of national training systems in developing countries, and has recognized the importance of integrating capacity-building efforts (e.g., training with other support mechanisms such as supervision and logistics systems) in order to improve and sustain the delivery of high-quality RH services. For individuals and organizations or healthcare facilities to perform at their fullest potential, many factors must be integrated and aligned with this mission. One way to promote this integration is by using a PI approach to explore areas peripheral to training that have a direct impact on training effectiveness. The factors that affect performance have been articulated in many ways, most recently by Gilbert (1996).

JHPIEGO, as a member of USAID's Performance Improvement Consultative Group (PICG), adapted Gilbert's performance factors as a key component in the PI process. This process identifies performance gaps through the comparison of actual performance to the desired performance, and seeks to analyze the gaps and design and implement interventions that respond to these gaps. The performance factors serve as the framework for identifying root causes of gaps as well as opportunities for intervention. The PI model identifies seven factors that are believed to affect individual and institutional performance: job expectations; motivation; knowledge and skills; performance feedback; infrastructure, equipment, and supplies; leadership and management systems; and client and community focus (as shown in the text box). Although the applicability of these factors to the performance of corporations in Western countries has been widely studied, the extent to which these factors are relevant in developing country contexts, particularly in public-sector organizations such as government health institutions, is unknown.

Performance Factors from PI Model
<ul style="list-style-type: none"><li>• Job expectations</li><li>• Motivation</li><li>• Knowledge and skills</li><li>• Performance feedback</li><li>• Infrastructure, equipment, and supplies<sup>1</sup></li><li>• Leadership and management systems</li><li>• Client and community focus</li></ul>

Several studies in developing countries have shown, however, that healthcare facilities with similar resources (i.e., funding levels and access to supplies and equipment) perform very differently. For example, the 1995 Kenya Situation Analysis study of family planning (FP) service delivery facilities conducted by the Population Council demonstrated consistency with the 80/20 split exhibited in other health sectors—that is, often 20% of the facilities provided 80% of the services. This finding appeared to be true across location (i.e., rural/urban) and across type of site affiliation (i.e., public sector, nongovernmental organization, and private), and seemed to be independent of the availability of equipment and supplies (Population Council 1996). The questions JHPIEGO wanted to answer were what factor (or combination of factors) allows some facilities to perform well, and how did these facilities remain resilient in the face of adversity?

### Summary of Phase 1 of the Study

In November 2000, JHPIEGO staff and consultants conducted formative research to better understand the factors that contribute to high performance among facilities delivering RH services in Kenya. This exploratory investigation, Phase 1 of the two-phase study, employed a case-study

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<sup>1</sup> To avoid confusion in this report between this factor and the use of the word “facilities” to refer to healthcare institutions, the original wording of this factor has been changed from “facilities, equipment, and supplies” to “infrastructure, equipment, and supplies.”



approach to describe high-performing facilities. The investigation focused on the provision of RH services and used the healthcare facility as the unit of analysis. The results from Phase 1 were used to inform the design of research instruments for Phase 2 of the study (Rawlins et al 2001).

High-performing facilities in Kenya were identified by a group of stakeholders during a series of workshops in Nairobi in November 2000. Participating agencies and organizations—15 people in total—included the Kenyan Ministry of Health (MOH), Marie Stopes/Kenya (MSK), the Christian Health Association of Kenya (CHAK), the Family Planning Association of Kenya (FPAK), and several USAID cooperating agencies (CAs). The purpose of these sessions was to identify characteristics of high-performing facilities and identify facilities meeting these criteria in Kenya. The stakeholders' criteria for selection were facilities whose performance exceeded expectations or facilities one would recommend to a friend.

Two of the meetings—those held with the MOH staff and CA representatives—were half-day workshops with similar agendas. The initial session consisted of a presentation of the PI model adapted by the PICG and a discussion of its relevance to the Kenya context. Subsequent brainstorming sessions asked participants to:

- ◆ Think of specific RH service delivery facilities in Kenya that they consider to be high-performing.
- ◆ Write down the characteristics of these facilities and share them with the group.
- ◆ Identify reasons for the high performance of these facilities (i.e., why the facilities exhibit these characteristics).
- ◆ Describe actions or strategies, in their experience, that have been successful in turning around performance when it has not been at the desired level.
- ◆ Vote to narrow down the number of high-performance criteria to the most important.
- ◆ List facilities that they believe are high-performing and that the team should consider visiting.

A list of high-performing (and a few low-performing) facilities was compiled from the suggestions made by the different stakeholder groups. From this list, a sample of 10 facilities was selected for the team to visit. The facilities were selected taking into consideration factors such as the level of site (e.g., dispensary, health center/clinic, hospital); geographic location (i.e., district and province); rural/urban location; whether the site was public or private; and resource and time constraints dictated by the duration of the trip and by staff and consultants allocated to the study.

During the second week of November 2000, the research team visited the 10 facilities located in four provinces. Of this sample, 9 were high-performing facilities and 1 was a low-performing site. The team conducted in-depth interviews with a total of 13 clients, 12 supervisors, 11 providers, and several other key staff members. A facility audit of supplies and equipment was also conducted for each site. Of the facilities, 3 were government facilities, 6 were private facilities, and 1 was a faith-based site. There were 7 urban facilities, 2 rural facilities, and 1 peri-urban site. Other stakeholders at these facilities, such as District Training Centre (DTC) trainers, were also informally consulted as to their perceptions of why the facilities performed well.

Findings from the Phase 1 visits suggested that high-performing RH service delivery facilities in Kenya exhibited one or more of the following characteristics: community involvement in facility administration or, at a minimum, feedback from clients on services being offered; a cost-



recovery system that benefited the facility's performance because it had the autonomy to use the funds; a well-trained and motivated staff (the site offered learning opportunities and job incentives); and a strong, honest leader who was a role model and delegated responsibility.

Phase 1 of the study concluded that no single performance factor explained why some RH service delivery facilities performed better than average—a combination of related performance factors is usually present in high-performing sites. Of the seven performance factors hypothesized to affect the performance of facilities and individuals, three appeared to have the strongest influence in the context of the study:

- ◆ Leadership and management systems
- ◆ Motivation
- ◆ Client and community focus

Furthermore, these factors seemed to be closely associated. For example, a good and respected leader could affect the level of motivation among staff. High-performing facilities were found to be resilient and able to maintain their performance through strategies such as participating in self-assessment and problem-solving exercises, having an appropriate leadership style, conducting community outreach and marketing, and using facilitative supervision of staff. Facilitative supervision is an approach to supervision that promotes team problem solving (with a shift to coaching), use of data for decisions, and open communication between the staff and supervisor (as opposed to inspection and critique of staff).

Phase 2 of the study, described in this report, was intended to expand upon these findings, and present a clearer picture of the strategies that help facilities improve and maintain performance, and how those strategies can be replicated effectively.

## **PURPOSE OF STUDY**

The purpose of this study was to describe characteristics, behaviors, and coping strategies of high-performing facilities in low-resource settings to understand what makes these facilities function well despite multiple constraints. In addition, this study determined the extent to which the seven performance factors hypothesized to affect performance were present among the high-performing facilities sampled.

The primary objectives for this study were to:

- ◆ Identify characteristics that classify service delivery facilities as high-performing.
- ◆ Identify performance factors—such as motivation, management systems, and leadership—that have an important influence on the effective delivery of RH services in low-resource settings.
- ◆ Identify strategies used by RH service delivery facilities for overcoming performance barriers and building on existing capabilities and strengths.
- ◆ Describe strategies that contribute to the resiliency of service delivery facilities' performance, or the maintenance of high performance over time.

## **METHODOLOGY**



A cross-sectional, exploratory case study was conducted at 13 high-performing RH facilities in Kenya. This design supports the research objectives of explaining how and why these selected facilities are considered high-performing facilities, and allows the description of the characteristics that constitute a high-performing site in a low-resource setting, and the behaviors and coping strategies exhibited by the facilities' staffs.

## **Data Collection**

### ***Data Sources***

Data sources for this study were numerous, permitting synthesis from complementary and overlapping measures to cross check and validate observations (Feagin, Orum, and Sjoberg 1991). The various data collection instruments contained the same or similar questions so it could be determined whether or not responses from different data sources were in agreement and supported emerging theories. The unit of analysis used in the study was the RH service delivery site, or the RH/maternal and child health unit in larger facilities, enabling an institutional perspective. In addition to the facility, units of measurement included on-site supervisors, providers, clients, and community members. Within each facility, aspects of individual provider and supervisor performance (e.g., motivation and leadership qualities) were assessed in the context of how they affected the overall performance of the facility or RH unit. Client and community perceptions of performance and level of satisfaction were also analyzed.

In total, 14 RH facilities were randomly selected from a list of high-performing facilities generated by stakeholders during a series of workshops held by JHPIEGO in Nairobi in November 2000. Although 14 facilities were originally selected, 1 site was dropped from the study because it did not meet the criteria for size and number of providers. The resulting 13 facilities were analyzed for this case study. Because this study was formative in nature with the purpose of describing high-performing facilities, a sample size calculation was not required.

The study used a mix of quantitative and qualitative data collection methods. In-depth interview guides were used with site supervisors and providers and included pre-coded and open-ended questions, as did the client exit interview guides. Interviews with site supervisors and providers sought the same information regarding potential performance factors and site operations, both technical and managerial. Client exit interviews examined the satisfaction of clients with the services and physical site, as well as the reasons for choosing a particular site. A facility audit form gathered data on the availability of services, contraceptives, and supplies, as well as data on the maintenance of the facility and infection prevention (IP) practices. Focus group discussions with community members, held in the catchment areas of 2 high-performing facilities included in the study, were to elicit characteristics of community members' "ideal" RH site. Moreover, the discussions brought out perceptions of the services and staff at the nearby high-performing facility as well as other local healthcare facilities used by the respondents over the previous year.



A total of 302 in-depth interviews were conducted at the 13 facilities. Respondents included:

- ◆ 34 supervisors
- ◆ 45 providers
- ◆ 223 clients

Ten focus groups were held, five in each of two high-performing facility catchment areas selected. There were 74 respondents in total, divided into the following five age and gender categories:

- ◆ Females 15–24
- ◆ Females 25–34
- ◆ Females 35–49
- ◆ Males 15–24
- ◆ Males 25–49

### ***Procedure***

A 3-day training workshop was held in July 2001 to prepare the assessment team to conduct interviews with clinic staff and clients and to conduct community focus groups. The assessment team comprised both interviewers and focus group researchers. Interviewers and focus group researchers were instructed in how to obtain verbal informed consent from participants and how to guarantee the confidentiality and anonymity of all responses. All facility-based data collection instruments were pretested by the team at a site in Nairobi at the end of the training workshop; suggested modifications were subsequently incorporated. All of the interview instruments were pretested in English. The client exit interview was translated into Kiswahili following pretest modifications. Focus group discussion guides were translated into Kiswahili and then pretested at a later date with community members living in the catchment area of a high-performing site in Central Province.

Fieldwork was carried out during July and August 2001. Staff participation in the study was voluntary. At each site, every supervisor in charge of RH services who was present at the time of the research team's visit and willing to participate was interviewed. Similarly, every RH provider available and willing at the time of the team's visit was interviewed. Clients' participation was completely voluntary. At least 15 client exit interviews were conducted at each facility; thus, the final number of interviews completed at each site was determined by the total number of potential respondents present at the facility on the days of the team's visit and the availability of those staff and clients. In addition, facility audits and community focus groups were conducted. At the facilities, client exit interviews were conducted in Kiswahili, while interviews with supervisors and providers were conducted in English. Only trained clinician interviewers collected clinical information using the facility audit form. Focus group discussions were held in two communities. The sessions were conducted in Kiswahili and recorded on tape recorders.

Completed data collection instruments and focus group notes were duplicated—one set was stored in a secure area in the JHPIEGO office in Nairobi, and the originals were stored in the JHPIEGO office in Baltimore. Data entry and analysis were carried out in Baltimore. No participants' names were included in the electronic dataset.



## Measures and Indicators

Indicators and indices used in the study were designed to capture the reasons high-performing facilities exceed performance expectations. Questions and indicators included in the data collection instruments were informed by: the *QIQ Investigation of Quality*, produced by the MEASURE Evaluation Project; the Population Council's series of situation analyses; the PI model adapted by USAID's PICG (and later modified by JHPIEGO); and the Bruce framework for quality of care in FP (The Measure Evaluation Project 2000).

The seven performance factors were aggregated into three categories to organize the indicators measured:

- ◆ **Abled (supplied with or having sufficient ability, knowledge, and skills to do something): Knowledge and skills** of providers were measured by observations of IP practices as well as provider, supervisor, client, and community perceptions of provider performance and degree of confidence and learning opportunities available to providers.
- ◆ **Enabled (supplied with or having the means, resources, and/or opportunity to do something): Job expectations** were measured by the existence of written job descriptions, staff perceptions regarding interactions with supervisors, and/or a review of the duty roster. Staff motivation was measured by the existence and utilization of diverse incentives and rewards as perceived by supervisors and providers. The **infrastructure, equipment, and supplies** factor was measured by the availability of supplies and contraceptives, the availability of services including laboratory tests, and reported and observed IP practices. The **management systems and leadership** factor was measured by the existence of a "good leader" who provided an open environment and other means to foster good communication. How teamwork was developed was another topic explored. Performance feedback was measured using the number of supervisory visits conducted, the setting and monitoring of site performance targets, and on-site supervisor interactions with providers.
- ◆ **Motivated (supplied with or having an incentive or motive to do something): Performance feedback** of staff was measured by individual written or verbal performance feedback (given and received) as well as supervision visits received. Whether or not providers were **motivated** was measured using a "self-report" scale. Measures of **client and community focus** included client expectations of the RH site and their feedback on services. Also measured was the degree to which clients were afforded privacy during consultations with the provider and had their questions answered. The level of comfort and cleanliness of the environment was observed. Other measures of client and community focus included the degree of community participation in the management of the RH site, and the extent to which the RH site engaged in community outreach and marketing.

**Table 1** presents each of the data collection instruments used and describes the different measures associated with the three measurement categories defined above.



**Table 1. Summary of Data Collected by Research Instrument and Category**

Abled	Enabled	Motivated
<b>Instrument 1: In-Depth Interviews with FP/RH Supervisors</b>		
<ul style="list-style-type: none"> <li>• Perceptions of providers' skills and confidence; learning opportunities for staff</li> </ul>	<ul style="list-style-type: none"> <li>• How and how often external and on-site supervisors interact with staff and provide guidance</li> <li>• Extent to which supervisors monitor and evaluate staff and facility performance</li> <li>• How the facility diagnoses performance problems</li> <li>• How the facility obtains feedback from clients</li> <li>• Existence of written job descriptions and/or verbal communication of expectations</li> <li>• Communication mechanisms</li> </ul>	<ul style="list-style-type: none"> <li>• Extent to which supervisors provide performance feedback to providers</li> <li>• Perceptions of provider motivation; how staff are rewarded/motivated</li> <li>• Teamwork</li> </ul>
<b>Instrument 2: In-Depth Interviews with FP/RH Providers</b>		
<ul style="list-style-type: none"> <li>• Perceptions of their own skills and confidence</li> <li>• Learning opportunities for staff</li> <li>• Basic and inservice training</li> </ul>	<ul style="list-style-type: none"> <li>• How and how often on-site supervisors communicate with staff and provide guidance</li> <li>• Extent to which supervisors monitor and evaluate staff and facility performance</li> <li>• How the facility diagnoses performance problems</li> <li>• How the facility obtains feedback from clients</li> <li>• Existence of written job descriptions and/or verbal communication of expectations</li> <li>• Qualities of leader</li> <li>• Communication mechanisms</li> </ul>	<ul style="list-style-type: none"> <li>• Extent to which supervisors provide performance feedback to providers; level of motivation; how staff are rewarded/motivated</li> <li>• Teamwork</li> </ul>
<b>Instrument 3: Client Exit Interviews</b>		
<ul style="list-style-type: none"> <li>• Perceptions of providers' skills and confidence</li> </ul>	<ul style="list-style-type: none"> <li>• Extent and type of communication with providers and staff</li> <li>• Supplies, equipment, and tests available</li> </ul>	<ul style="list-style-type: none"> <li>• Comfort level asking provider questions</li> <li>• Degree of privacy</li> <li>• Extent to which clients received the services they came for</li> <li>• Level of satisfaction with services received</li> <li>• Reasons for choosing that facility for care</li> <li>• Waiting time</li> </ul>
<b>Instrument 4: Facility Audit</b>		
<ul style="list-style-type: none"> <li>• IP practices by providers</li> </ul>	<ul style="list-style-type: none"> <li>• FP and IP supplies available</li> <li>• Presence of key equipment for delivery of FP services and maintenance of adequate IP</li> <li>• Record review of service statistics for FP and other RH services</li> </ul>	<ul style="list-style-type: none"> <li>• Days and times services offered</li> <li>• Cleanliness of facility</li> <li>• Comfort of infrastructure</li> </ul>
<b>Instrument 5: Community Focus Groups</b>		
<ul style="list-style-type: none"> <li>• Perceptions of different "modern" health resources used</li> <li>• Perceptions of high-performing facilities</li> <li>• Community outreach and participation</li> <li>• Description of "ideal" health services</li> </ul>		<ul style="list-style-type: none"> <li>• Perceptions of services, providers, and other staff at the high-performing site in their area compared to other nearby facilities they have used</li> <li>• Characteristics of the "ideal" healthcare facility</li> </ul>



## Analysis

Qualitative analysis identified major themes from the responses to open-ended questions from supervisors, providers, clients, and those from focus group discussions with community members. Summary statistics, such as means and proportions, were generated from the quantitative data. Cross tabulations were performed using the following site variables: external affiliation, location, and level of facility. Subfactors were then identified for six of the seven different performance factors, and composite measures, or indices, were created for each subfactor. These indices were an attempt by team members to categorize key behaviors and characteristics as representative of the subfactors and factors.

**Table 2. Subfactor Indices Constructed**

<b>Factor and Associated Subfactors</b>	<b>Number of Items in Index<sup>a</sup></b>
<b>Knowledge and Skills</b>	
IP practices	6
Provider training	3
<b>Infrastructure, Equipment, and Supplies</b>	
Availability of supplies	7
Basic infrastructure	8
<b>Management Systems and Leadership</b>	
Leadership	2
Communication	6
Supervision	4
Board/Management committee	3
<b>Motivation</b>	
Incentives	3
Teamwork	4
<b>Client and Community Focus</b>	
Access	8
Community outreach	5
Counseling/Interpersonal communication	5
Client satisfaction	4
<b>Performance Feedback</b>	
Client feedback	4

<sup>a</sup> Items to create the subfactor indices were drawn from the facility audit form and the three interview guides: 1) In-Depth Interview Guide for FP/RH Supervisors; 2) In-Depth Interview Guide for FP/RH Providers; and 3) Client Exit Interview Guide.

## Limitations and Potential Biases

One limitation of the study was the lack of a comparison group. A comparison group of average and/or low-performing facilities was not included in the study because of budgetary constraints. This lack of a comparison group limits the findings of the study because it cannot be determined whether or not the hypothesized performance factors are also present in facilities not classified as high-performing. Therefore, the results of this study simply highlight commonalities among those sites considered high performing.

The research team also experienced difficulty in designing measures for culturally defined information. For example, performance feedback in the facilities studied appeared to be largely based on informal feedback rather than Western-style employee appraisal systems. In addition, the factor for job expectations was largely measured by the presence or absence of job descriptions, which often did not exist or had not been seen by providers if they did exist.



Therefore, the indicators used in this study may not have adequately captured both the factors for performance feedback and job expectations and, as a result, their importance may be underestimated.

Finally, selection of the high-performing facilities for this study may be biased given that clients were not part of the original group of stakeholders who selected the high-performing facilities. Clients also did not have input into devising the criteria for selection of these facilities. The omission of clients may have introduced bias in the sample selection process.

## FINDINGS

### Overview of Perceptions of High Performance

Providers and supervisors were asked to describe why they thought their facility had been identified as “high performing.” Clients were questioned about the reputation of the high-performing facility they had attended and about what they had heard about the facility in their communities. Community focus group members were asked to describe the high-performing facility in their area. (**Table 3** summarizes the different perspectives of these groups.)

**Table 3: Perceptions of High Performing Facilities**

Characteristic or Behavior	Providers	Supervisors	Clients	Community Members
Supplies and drugs, services available	X	X	X	X
Teamwork	X	X		
Leadership or management systems	X	X		
Comfortable/clean infrastructure			X	X
Providers friendly and respectful	X	X	X	X
Knowledgeable providers	X	X	X	X

Clients and community members were also asked why they chose to go to the high-performing facility that they had attended. The top four responses to this question were: 1) staff provide good service; 2) always come here/closest facility; 3) short waiting time; and 4) cleanliness of the facility.

Performance factors found to be common among all facilities studied included knowledge and skills; infrastructure, supplies and equipment; and leadership and management systems. Two performance factors—job expectations and performance feedback—were found to have little relevance in the context of this study.

Common facility characteristics, staff behaviors, and strategies used related to the different performance factors are discussed in the following three sections of the report under the categories of *Abled*, *Enabled*, and *Motivated*. Subfactors associated with the common performance factors are italicized and underlined for easy reference.



## Abled

### ***Knowledge and Skills***

Supervisors and providers both listed "competent providers" as one of the three greatest strengths of their RH site. According to clients, in their community, the facility was most known for being a place where the providers were skilled/provided good services and treated clients well. Many clients also commented that the providers seemed to know what they were doing. In addition, clients and researchers observed that there was an overall cleanliness of the environment at all facilities. Community members noted that:

*"[The high-performing facility] guarantees safety, and has trained and qualified staff." (Male, age 15–24)*

*"Diagnosis is best." (Male, age 15–24)*

*"Doctors are more qualified than those at private hospitals." (Male, age 15–24)*

Providers' knowledge and skills were assessed in two ways—by observing IP practices and documenting reported practices, and by assessing prior exposure to various kinds of training, both formal and informal.

IP practices, including proper procedures for handwashing and correct decontamination of used instruments, were observed or reported at all facilities. Providers' knowledge and skills in the area of IP practices were judged to be sufficient if the providers reported that they performed or were observed to be performing the following six IP elements correctly:

- ◆ Decontamination of used instruments before cleaning
- ◆ Use of protective clothing
- ◆ Preparation of bleach solution
- ◆ Handwashing with soap and water before seeing clients
- ◆ Use of bleach for decontamination
- ◆ Use of disposable containers for contaminated waste/supplies

Of the 13 facilities, 10 had providers who performed all six steps correctly. Of the other 3 facilities, 1 had providers who performed five of the six steps correctly. The 2 remaining facilities had providers who performed four of the six steps correctly.

Provider training was judged to be sufficient at a facility if the trained provider reported adequate knowledge and skills to effectively carry out her/his job, the supervisor reported that the staff had the requisite knowledge and skills to perform their jobs effectively, and the staff reported having opportunities for inservice training in the last 3 years. By these criteria, 9 of the 13 facilities had staffs with adequate knowledge and skills. Of the 4 facilities excluded, all reported having adequate knowledge and skills, but a lack of inservice training opportunities.

Supervisors at 12 of the 13 facilities felt that providers at their facility had adequate knowledge and skills to perform their jobs, while 78% of providers felt that they had sufficient training to carry out their current duties effectively. Providers reported that they kept their skills and knowledge current through on-site trainings (38%) and off-site trainings (76%). This was corroborated by providers' reports about attendance at inservice trainings, with 80% reporting



that they had been to an inservice training since completing their preservice education (i.e., basic training). At 9 facilities, all providers (4 facilities) or most providers (5 facilities) had been to inservice trainings in the last 3½ years—that is 61% of providers in total. Approximately 67% of providers had received training in FP during their preservice education program. At only 2 facilities (both government facilities), the majority of providers had not been exposed to FP in their preservice education programs.

In contrast to provider reports, 91% of supervisors said that providers were primarily updated through on-site trainings (“on-site training” was defined by supervisors as continuing education, formal meetings, and informal discussions and demonstrations). According to supervisors (85%), formal off-site training was the second way that providers’ knowledge and skills were kept current. While off-site training was reported as an incentive for performance, other considerations went into making decisions about who attended updates and clinical training. Many of the supervisors reported that the decisions about who attends trainings were based on who needed what knowledge, formal assessment, interest shown, and who had deficient skills. The inclusion of informal knowledge transfer mechanisms may account for the greater emphasis supervisors placed on on-site training.

## **Enabled**

### ***Infrastructure, Equipment, and Supplies***

High-performing facilities were generally well stocked with key equipment and supplies. Supervisors, providers, clients, and community members cited the availability of supplies as one of the top reasons why high-performing facilities exceeded expectations and as one of the facilities’ greatest strengths. Providers also mentioned equipment and supplies as one of the main reasons their facilities maintained high performance over time. One community focus group member said:

*"[The high performing facility] has the most facilities and is the best." (Male, age 15–24)*

Availability of supplies was considered to be adequate if the facility had no stockouts of bleach, the four key (most frequently used) FP methods (combined oral contraceptives [COCs] and progestin-only contraceptives [POCs], condoms, and injectables), and had plastic buckets or containers for decontamination and sharps-disposal containers available. These criteria were met by 11 of the 13 facilities. The other 2 facilities reported stockouts of one or more FP methods in the previous 6 months.

All the RH facilities possessed an adequate inventory of supplies to support appropriate IP practices. There had been no stockouts of bleach during the previous 6 months and other supplies, such as plastic buckets or containers for decontamination and sharps-disposal containers, were on hand at all facilities.

With respect to the availability of contraceptives, none of the high-performing RH facilities had experienced stockouts of condoms, injectables, or Norplant® implants (if they offered Norplant) during the previous 6 months. Only 1 of the 13 facilities had experienced a stockout of POCs, and only 2 of the 13 facilities had experienced a stockout of intrauterine devices (IUDs) or COCs in the last 6 months.



Basic infrastructure at healthcare facilities visited was considered to be adequate if the facility was equipped with all of the following: a sheltered waiting area, private examination area, laboratory, pharmacy, toilet, storage area for drugs, electricity source, and supply of potable water. All but 2 facilities had these eight elements. Of those facilities that did not have all eight elements, 1 health center lacked a source of electricity, and 1 regional hospital did not have a storage area for drugs or a toilet in the RH area.

### **Management Systems and Leadership**

This performance factor encompasses supervision and communication systems as well as community committee or board involvement. Providers consistently mentioned a strong leader and/or standardized operating systems as the greatest strengths of their site and as one of the reasons that their site was able to achieve and maintain high performance over time.

All providers interviewed felt that the supervisor (or person in charge) was somewhat important to very important in the management of the facility. They were said to exhibit leadership qualities such as innovative problem-solving abilities, openness and transparency, willingness to delegate authority, and equal treatment of staff. When providers were asked about the characteristics of their supervisor (or person in charge), "supportive" was cited as the most common quality (n=24); followed by "hard working/assists with work" (n=11); "coach" (n=8); and "competent/knowledgeable" (n=6). At facilities where there appeared to be no outstanding on-site leader who acted as an innovator, standardized operating systems—such as business plans with targets, performance monitoring, and reporting procedures—were in place, having been created and implemented through the leadership of a strong central office.

Adequate communication was defined as having regular meetings (at least monthly) and systems for communicating information about changes in policies/procedures and performance of the facility. Communication at 10 of the 13 high-performing facilities was found to be adequate. According to both providers (80%) and supervisors (91%), regular staff meetings were the primary way by which providers at all facilities stayed informed about changes in policies and procedures. Furthermore, 89% of providers reported that they attended staff meetings on a regular basis, and 80% reported attending staff meetings at least once a month. One provider commented:

*"One goal we are working [toward] is pleasing clients. We discuss individual problems and weaknesses, and get on-the-job training in monthly meetings."*

At 3 facilities (2 government, 1 nongovernmental organization [NGO]), however, one or two providers reported that they did not attend regular staff meetings. Also, at 1 of these facilities, a supervisor reported that s/he did not review with staff how well the facility was performing. All providers said that they felt comfortable asking questions and offering suggestions at staff meetings.

Those in supervisory positions were able to create an open environment for communication, and staff felt comfortable expressing their thoughts and sharing their ideas. All providers said that they felt comfortable asking questions and offering suggestions at staff meetings. In total, 98% of providers felt that the supervisor (or person in charge) was open to staff suggestions and was willing to act upon those suggestions, as were other on-site supervisors and managers. In the private facilities, supervision was a component of the centralized system under which they worked. These facilities had other centralized systems, including business planning,



performance monitoring, and logistics management, in addition to norms for on-site management, such as communication among staff.

At all of the facilities, supervision was reportedly taking place on a regular basis. Supervision was considered to be adequate if there was an on-site supervisor actively overseeing FP/RH service delivery and the site had received an external supervision visit in the last year. In total, 10 of the 13 facilities met these criteria. Providers at every facility stated that there was someone acting as their on-site supervisor. The primary responsibility of the on-site supervisor was to discuss problems; the secondary responsibility was to provide performance feedback. Supervisors' responses to the same question regarding their responsibilities concurred, indicating a discussion of problems as their primary role. The majority of supervisors at 10 of the 13 facilities stated that they had received at least one supervision visit from a central office (MOH, NGO, CHAK, or other) during the past year. (Supervisors from 2 facilities said this was not applicable to their facilities.) Although most supervisors said that these external supervisors did provide guidance in helping to improve the facilities' performance, the visits were infrequent and could not be considered a consistent source of management assistance. Supervisors reported many different techniques for increasing the quality of care at their facility such as:

- ◆ Discussing monthly reports (e.g., FP statistics) with staff
- ◆ Sharing new skills learned in training
- ◆ Continually visiting the ward and helping out when needed
- ◆ Working with patients and observing the care given
- ◆ Making all equipment and supplies available
- ◆ Applying a spirit of teamwork through participating with staff in service provision
- ◆ Instituting open communication and transparency
- ◆ Trying to know staff weaknesses and strengths and working accordingly
- ◆ Asking each department to determine its targets and objectives and then meeting monthly with the department to discuss progress, and share and solve problems
- ◆ Delegating duties and responsibilities to other staff, making them accountable for their work

In addition to on-site supervisors, another regular management mechanism found at the high-performing facilities was the presence of a board or management committee with community representatives who participated in managing the facility. Both providers and supervisors from 9 of the 13 facilities stated that their facility had some sort of community involvement in management, ranging from a management or health center committee to a board of governors. This was found to be more common among government and faith-based facilities than private, parastatal, and NGO facilities.

Following are providers' examples of how the committees or boards had helped the facilities:

*"[It] sets standards for performance. Budget is done by this board—the Hospital Board of Governors."*

*"[We have a] board of governors with some members from the community. They formulate policies, work out budgets for the institution, hire and fire staff, and make decisions on staff development."*

*"Set the fees that patients pay. They use this money to buy supplies—cotton, syringes, etc."*



## Job Expectations

Although job expectations were often derived from interactions with the on-site supervisor or a review of the duty roster, these expectations were generated by written job descriptions, input from colleagues, and other means.

## Motivated

### Motivation

When asked about their level of motivation, the staff at 12 of the 13 facilities reported that they were motivated; similarly, supervisors at all facilities reported that staff were motivated. Most supervisors (97%) felt staff to be fairly to very motivated. At only 1 facility a supervisor said that the staff were not very motivated. Similarly, 87% of providers reported that they were fairly to very motivated to do their jobs. Only five providers at 3 facilities reported a lack of motivation. When asked if there were any rewards or *incentives* for doing a good job, 65% of providers replied yes (the majority replied yes at all but 3 facilities, which were government facilities), while 82% actually gave examples from their facilities. Certain incentives and rewards (such as tea breaks with tea supplied, training opportunities, medical benefits for employees, and time off) reportedly provided staff with the greatest motivation. Four supervisors and five providers also reported that verbal expressions of thanks, either one-on-one or at a meeting, were a form of incentive used. Raises and promotions were mentioned by four providers and five supervisors, most of them from NGO/private facilities or faith-based facilities, rather than government facilities.

### Team Problem-Solving Examples

- There was often no emergency transport available to district hospitals for clients in need of emergency services. In response, the staff assisted clients in arranging local transportation, providing cost sharing funds for those who could not afford to pay.
- A lack of water caused a decline in the number of births at a facility because clients were asked to bring their own water. The facility contracted with a person to bring water from a borehole and paid for it with cost-sharing funds. The roof catchment was repaired, which also provided some of the water needed.
- A facility did not receive its supplies from headquarters and had a stockout for about 4 months. In response, the facility borrowed contraceptives from the district hospital and other facilities nearby.
- The introduction of a fee for FP and antenatal client services reduced attendance at the clinic. The response from the facility was to create a method for giving discounts for inpatient and outpatient care (i.e., a sliding scale) and attendance returned.
- The facility referred emergency patients too late to a higher-level facility. In an attempt to resolve the problem, they asked other similar facilities how they dealt with referrals and implemented solutions gathered from neighboring facilities.
- Despite the budget indicating that there was adequate money, there was a continual shortage of funds. The facility instituted a policy of searching staff as they left the facility, and by reducing theft (or pilferage), revenues increased by 40%.
- There was a decline in attendance when charges for services were instituted. In response, the facility began community outreach visits where services were provided at a lower cost and clients were encouraged to seek services.
- To meet their clients' need for HIV/AIDS counseling services, the staff were sent for training. In addition, HIV-positive individuals were invited to meet and speak with the providers to sensitize the providers to the issues facing HIV patients.

*Teamwork* was cited by both supervisors and providers as one of the top three reasons why their site performed well and exceeded expectations, and was a characteristic found among all the facilities. All providers stated that staff members help one another with job responsibilities and that staff work together as a team to complete their tasks, creating a motivating and



enjoyable work environment. All of the supervisors interviewed felt that staff worked as a team, sharing work responsibilities; 97% of supervisors stated that staff worked together to identify and solve performance problems.

As reported by staff and their supervisors, there were occasional threats and disruptions to service delivery that had to be overcome through teamwork and group problem solving. In some cases this was facilitated with the use of tools from COPE® (client-oriented, provider-efficient services) (AVSC International 1995). Staff and supervisors accepted the reality of their situation, were prepared to improvise as needed, and were able to devise creative ways to maintain the provision of high-quality services over time (see text box on previous page). These findings attest to the resilient nature of these high-performing facilities.

Because teamwork emerged as such an important but ill-defined individual element of performance in Phase 1 of this study, the concept was explored through multiple open-ended questions in Phase 2. The following themes emerged from providers' comments on teamwork:

- ◆ Working toward common professional and religious goals and objectives promotes teamwork
- ◆ Good leadership promotes teamwork
- ◆ Staff respect for each other and willingness to help each other demonstrate teamwork
- ◆ Staff feeling responsible for the provision of high-quality services demonstrates teamwork
- ◆ There is open communication among staff and supervisors that fosters teamwork

Providers offered the following explanations for why they work well together as a team:

*Professional and/or faith-based goals, values, and organizational culture:*

*“Our aim is giving quality care to clients. Everybody is committed to her or his job. One can't do it alone; we need each other to help. If we have some [who are] weak, we try to pull up the weak ones—though most are strong.”*

*“Staff loves their work. They are there to serve the client. They have set norms. One of them is ‘patience first.’ The staff is there to help any time they can. The staff decided on this together [not written, but decided when they were talking together].”*

*“Being a private organization, we need to provide quality service. This service will ensure clients benefit and will come again. In the long run, we benefit.”*

*“The spirit of the hospital helps them to work together as a team. The motto of the hospital is to glorify people to God.”*

*“Unity; we are one. We have a central goal, which is to serve the patients. This requires cooperation. [Also, teamwork is] due to the matron who is always pitching in to help.”*

*Leadership:*

*“[The supervisor (or person in charge)] facilitates this [teamwork] and encourages staff.”*

*Mutual respect and equality:*

*“Discuss things openly [and] don't say things behind each other's back. [We] have respect for each other. We're always willing to learn from each other.”*



*“The general feeling [is] that each member of staff can make an input in the performance of the institution and, as such, each one of us is important.”*

*“We work together. We join hands without discrimination.”*

*Sense of personal responsibility:*

*“Insist on proper handing over [of tasks] and continuity of services. Everyone feels responsible. There is a matron’s report at end of every 12 hours and a clear idea of duties. Matron takes part in duties to see what we’re doing—clear delineation of job.”*

*“Most of the staff are conscious of their duties and cannot sit when another one is working.”*

*“The staff have a commitment to see the facility is running well and clients are satisfied.”*

*“They share duties/work because they feel that it is their responsibility and clients are to be served without delaying them.”*

*Open communication:*

*“The leader is also open to ideas and suggestions.”*

*“During the [staff] meeting, there is emphasis on working as a team for each department.”*

*“When I give my ideas, they are discussed and this gives me encouragement to have ideas on how to work better. In that way, I feel we work as a team.”*

*One supervisor added:*

*“We are all nurses. Nobody is above the rest. We are all here. We have unity. If positive, we share. If negative, we share.”*

### **Client and Community Focus**

The extent to which a client and community focus was present at the facilities was assessed by examining several subfactors: access to services, community outreach activities, counseling and interpersonal communication, and client satisfaction.

Access to FP/RH services was considered adequate if key services were offered at least 5 days a week for the full day, the services were affordable to clients, and client waiting time was reasonable. Availability of key services, including FP, male and child health, antenatal care, and care for sexually transmitted infections and HIV/AIDS, was judged to be adequate if the facilities offered the services at least 5 days a week (Monday through Friday) for the full day. In total, 3 facilities did not meet this criterion: 1 offered services both at their main facility and a satellite location, where services were available only 3 days a week. The other 2 facilities did not offer HIV/AIDS services at all. A community member who had visited one of the high-performing facilities reported that services were available to men as well:

*“X organization is known for FP and maternity services and generally providing good services for women, but it is expensive. Men are served too; some commented men get STD counseling and education.” (Female, age 25-34)*



Services at the high-performing facilities were felt to be affordable by most clients (84%), and this was true across all facilities, with a range of 60–100% of clients describing services as affordable. However, perceptions among the community, both males and females and users and non-users of the high-performing facilities, were that the high-performing facilities tended to be more expensive, especially the NGO facilities. To generalize among all community groups, cost often appeared to drive the decision about where to seek care. This was stated clearly in all the focus groups from one of the two facility catchment areas, as Clinic Y is seen as a high-quality facility that one would choose to go to if one had the money. This also came out in the discussion in the other facility catchment area, although not as strongly because of an increased number of facilities that entered into the discussion and the fact that one of the high-performing facilities discussed was a government provincial hospital with relatively low fees.

Several statements related to financial barriers convey why some people choose to go a facility other than a high-performing NGO-affiliated facility:

*“At Clinic X, diagnosis is cheap. They find the disease and prescribe the necessary drugs. At Clinic Y, apart from the good service, they are very expensive. They need money.” (Male, age 25–49)*

*“There is hardly any cost at Clinic X and therefore most people opt to go there. Those who have money go to Clinic Y.” (Female, age 15–24)*

On the other hand, one of the high performing facilities, a public provincial hospital, offered credit to clients:

*“I had not money at the time and Clinic Z offered credit facilities.” (Male, age 15–24)*

Community members further noted that, with the exception of the high-performing facilities, there were staff corruption problems at facilities they had visited.

*“In the hospital you have to make a deal with the doctors on the side so that they can attend to their patients.” (Male, age 25–49)*

*“The doctor just needs something to put into her/his stomach and everything is fine.” (Male, age 25–49)*

Most clients (82%) also reported that the time they waited to receive services was reasonable: 56% reported waiting less than 15 minutes to be seen; 74% reported waiting 30 minutes or less; 14% reported waiting 31–60 minutes; and 11% waited more than 1 hour. Among clients who waited more than 30 minutes, a little more than half felt that this was not reasonable. At least one client at all of the 13 facilities reported waiting less than 15 minutes for services, and only 7 of the 13 facilities had a client who reported waiting more than 1 hour for services.

Several community members shared this sentiment:

*“We would choose to go to Clinic Y because the reception there is very good. Health providers are welcoming and give immediate services, whereas at Clinic X it can take up to 6 hours to be attended to.” (Female, age 15–24)*

*“In Clinic Y, the service is fast and there are no delays, while at Clinic X they keep you for long hours before being served. You know people go to Clinic X just due to lack of money.”*



*Clinic Y knows how to handle people. You don't get the same experience at Clinic X.”  
(Female, age 25–49)*

Supervisors (85%) reported that the high-performing facilities conducted community outreach activities. Among the MOH and faith-based facilities, paid staff visits to communities were reported to account for more than 60% of outreach activities. However, clients did not confirm this level of activity; 43% of clients surveyed believed that their facility did not conduct community outreach activities, while 26% said that they did not know if the facility conducted any outreach activities. At only 1 facility, no clients reported that the facility conducted community outreach. At 8 facilities, five or more clients said that that facility conducted community outreach. Most clients surveyed (85%) had not participated in any community outreach activities.

A community member in the catchment area of one of the high-performing facilities said:

*“They make off-site [outside of the hospital] maternity visits.” (Male, age 15-24)*

Most clients (83%) reported having received counseling during their visit, and most (86%) felt that they received the right amount of information. The majority of clients at only 1 facility reported that they received too little information. The quality of counseling and interpersonal communication with clients was assessed using a number of measures. Most clients (86%) felt that they had sufficient privacy during their visit and that no one could see or hear their interaction with the provider. At only 1 facility, a government health center, overall privacy was inadequate, with close to half (47%) of clients reporting that privacy was insufficient. With the exception of 1 facility (another government health center), clients also generally felt comfortable (84%) asking the provider questions and telling her/him their concerns and worries (86%).

A community member commented that the attitudes of providers at the high-performing site in her area were more welcoming and less judgmental:

*“In Clinic X, when one goes for childbirth, one is asked embarrassing questions if one is unmarried. Places like Clinic Y don't ask such questions or pry into one's private life, but just give treatment or whatever service one wants.” (Female, age 15–24)*

In previous studies, meeting expectations was found to be associated with client satisfaction with the services received. Clients were asked if there were any information, services, or supplies they wanted but did not receive at the high-performing facility they visited. Approximately 84% said no—they had received what they wanted. An overwhelming majority of clients (98%) also asserted that they would return to the facility again for services and would encourage a friend or relative to come to the facility (99%). With respect to their overall level of satisfaction with the services they received during their visit, most clients were very satisfied (74%), while 24% were satisfied, and only 2% were somewhat or very unsatisfied, with little variation by facility.

### **Performance Feedback**

Although related to client and community focus, performance feedback encompasses multiple performers and feedback systems. But client feedback was the only element under this factor found to be common across facilities. At least one provider and one supervisor at every facility said that they gathered client feedback about the services offered at their facility through formal



channels (e.g., exit interviews, suggestion boxes, community survey) or informal and/or indirect channels (e.g., client comments during their visit, client comments during health education talks, community-based distribution [CBD] reports, health committee feedback from the community). Some providers described changes made at their facilities based on client suggestions. Only 13% of clients, however, said that they had ever been asked to provide their opinions about the services at the high-performing site they had visited, but more than half (56%) thought that the staff at the facility listened to clients' suggestions and took action. At all but 3 of the facilities (1 government hospital and 2 government health centers), one or more clients reported having been asked to provide feedback on services at some point in time. At the 2 health centers, most clients did not believe that staff listened to clients' suggestions.

Supervisors and providers did not agree on the most common medium of providing feedback on provider performance. The majority of supervisors (72%) believed that they provided performance feedback by both written and oral means, while only 25% of providers agreed with this perception. Providers (52%) reported that verbal feedback was the most common way that their on-site supervisor provided feedback. Five providers from 4 facilities reported that they received no performance feedback at all. Supervisors further felt that service statistics were the primary means of identifying performance problems, while providers felt that staff feedback was the way that performance problems were most frequently identified.

### **Socio-Demographic Characteristics of the Respondents**

Among the 13 facilities selected for this study, 5 were affiliated with the MOH, 5 were of private affiliation (private affiliation includes NGOs and parastatals), and 3 were faith-based (affiliated with religious missions or church groups). There were 5 facilities located in urban settings, 5 in rural settings, and 2 in peri-urban settings. Most of the facilities were hospitals (n=8), 5 were healthcare centers, 1 was a clinic, and 1 was a nursing home. All of the faith-based facilities were located in rural settings and all were hospitals. The NGO/parastatal facilities were located primarily in urban and peri-urban settings, and most were hospitals. The MOH facilities were evenly distributed across location and facility type.

The majority of interview respondents were female; more than 80% of supervisor and provider respondents were female. More than 40% of supervisors were nurses or midwives, and more than 62% of providers were enrolled nurses. The majority of RH site staff were located in urban settings and worked in a hospital environment (see **Table 4**).



**Table 4. Characteristics of Supervisor and Provider Respondents**

Characteristic	Supervisors (n=34)		Providers (n=45)	
	Number	Percentage	Number	Percentage
<b>Gender</b>				
Male	9	26.5	5	11.1
Female	25	70.6	35	77.8
Not recorded	1	2.9	5	11.1
<b>Qualifications</b>				
Nurse	9	26.5	28	62.2
Midwife	1	2.9	4	8.9
Nurse/Midwife	14	41.2	7	15.6
Clinical Officer	3	8.8	1	2.2
Doctor	4	11.8	3	6.7
Other	3	8.8	2	4.4
<b>Location</b>				
Urban	16	47.1	22	48.9
Peri-urban	5	14.7	7	15.6
Rural	13	38.2	16	35.6
<b>Level</b>				
Health Center <sup>a</sup>	10	29.4	17	37.8
Hospital	24	70.6	28	62.2

<sup>a</sup> "Health Center" includes clinics and nursing homes.

The majority of client respondents were also female. In total, 50% of client respondents had completed a primary school education; another 45% had completed secondary or post-secondary levels of education. More than 85% of client respondents were married and the average age was 26.5 years. A majority of client respondents frequented urban RH facilities located in hospital environments (see **Table 5**).



**Table 5. Characteristics of Client Exit Interview Respondents (n=223)**

Characteristic	Clients	
	Number	Percent
<b>Gender</b>		
Male	4	1.8
Female	213	95.5
Missing	6	2.7
<b>Education</b>		
None	8	3.6
Primary	113	50.7
Secondary	88	39.4
Post-Secondary	14	6.3
<b>Age (Mean Age = 26.5)</b>		
14–19	29	13.0
20–24	66	29.6
25–29	64	28.7
30–34	38	17.0
35–39	14	6.3
40–44	8	3.6
45–49	2	0.9
50–56	1	0.5
Missing	1	0.4
<b>Location of Facility Visited</b>		
Urban	100	44.8
Peri-urban	41	18.4
Rural	82	36.8
<b>Level of Facility Visited</b>		
Health Center/Clinic <sup>a</sup>	89	39.9
Hospital	134	60.1

<sup>a</sup> “Health Center/Clinic” includes clinics and nursing homes.

Focus group participants were more evenly distributed by gender than interview respondents—40.5% of the group was males (see **Table 6**).

**Table 6. Focus Group Demographics by Group and Location**

Location Demographic	Length of Meeting	Number per Group	Mean Age (in Years)	Age Range (in Years)
<b>Female Users 15–24</b>				
Kakamega	1h 20m	8	20.7	18–24
Muranga	2h 20m	7	19	17–24
<b>Female Users 25–34</b>				
Kakamega	1h 45m	7	27.5	25–34
Muranga	1h 22m	8	27.3	25–32
<b>Female Users 35–49</b>				
Kakamega	1h 15m	7	39.4	37–44
Muranga	1h 43m	7	40.1	35–49
<b>Male Users 15–24</b>				
Kakamega	1h 45m	8	22.1	20–24
Muranga	1h 20m	8	22.5	18–26
<b>Male Users 25–49</b>				
Kakamega	1h 42m	8	30.2	25–40
Muranga	1h 14m	6	34.6	27–45

## DISCUSSION AND IMPLICATIONS

This study identified many important characteristics and strategies of high-performing RH service delivery facilities in Kenya that enable them to consistently exceed performance expectations. Findings suggest that selected factors hypothesized by the PI model to influence individual and organizational performance are relevant to understanding the performance of exemplary reproductive healthcare facilities in a low-resource setting (such as Kenya). Five performance factors were found to be common across the Kenyan high-performing facilities: 1) knowledge and skills; 2) infrastructure, equipment, and supplies; 3) leadership and management systems; 4) motivation; and 5) client and community focus. Staff knowledge and skills were found to be adequate through reported IP practices and exposure to training. Crucial infrastructure, equipment, and supplies were available, including IP supplies, major RH services, basic infrastructure, and four key contraceptives (COCs, POCs, condoms, and injectables).

The strength of the leadership and management systems factor among NGO clinics was demonstrated through the rigorous oversight and leadership provided by central offices to the clinics with respect to performance and financial monitoring. All facilities demonstrated an open environment and the presence of mechanisms that foster regular communication and supervision, namely regular staff meetings. Teamwork was an especially important part of the culture at the exemplar facilities, with staff reporting that they held common values and that there was a sense of equality among all staff. This “set of common values” in many cases tied directly in to an unexpected result of the power of religion or a common faith among staff members. Having a connection between the quality of services delivered and the providers’ commonly-held religious values proved repeatedly to be an essential factor in working as a team and as a motivating factor to perform. Providers also placed heavy emphasis on the importance of having common professional goals to help meet the needs of the clients. Teamwork served to increase staff motivation at high-performing facilities, as did small incentives such as tea breaks for staff with the tea supplied by the facility, and access to free medical care for staff and their families. Facilities further exhibited a focus on clients and community through community outreach activities, counseling and interpersonal communication between staff and clients, acceptable waiting times, and affordable services.

Within the management systems and leadership factor, this study found a distinction between an on-site leader (i.e., an innovator who creates new ways of doing things and is held up as a role model and an on-site manager/supervisor (i.e., an implementer who ensures that standardized management systems and procedures are properly followed). Government-affiliated and faith-based facilities, which lacked strong central oversight and leadership, tended to have on-site leaders (innovative facility in-charges or managers/supervisors) who promoted high performance. NGO-affiliated facilities had effective on-site managers/supervisors who oversaw the implementation of standardized management systems, including ambitious cost-recovery systems to help ensure that service quality and financial performance expectations were met. Good leaders instituted regular and effective communication mechanisms, and understood how to organize and supervise staff, how to lead problem-solving efforts, and when to delegate responsibilities. Good managers were conscientious in ensuring that procedures were observed.

Two performance factors were unexpectedly found to have little relevance in this study—performance feedback and job expectations. Performance feedback in the facilities included in this study appeared to be largely based on informal feedback rather than Western-style employee appraisal systems; therefore, this factor may not have been adequately captured by



the indicators used in this study. As a result, its importance may be underestimated. If we extend performance feedback to include feedback from client to provider (rather than just supervisor to provider), the relevance is somewhat stronger, with many facilities using different means to obtain and respond to client feedback on the services offered. Client feedback obtained was also typically addressed on a regular basis, thus helping to ensure that services continually shifted to meet community needs. For the performance factors, however, it is felt that inappropriate measures were used. Research from business and industry as well as anecdotal evidence in developing countries has shown that having clear job expectations is usually the most important performance factor for increasing an individual's ability and motivation to perform. When individuals are clear about what to do, they are more likely to perform to a given standard. Future studies may be needed to revise measures and survey questions related to these factors to better capture how providers and supervisors understood expected levels of performance by providers.

In addition to sharing a number of performance factors, the high-performing facilities studied exhibited organizational resiliency. These facilities had mechanisms in place to help them achieve their goals and, at the same time, effectively innovate and adapt to rapid and turbulent changes—all key elements of organizational resiliency. For example, many of the high-performing facilities included in the study held regular staff meetings to discuss problems affecting the delivery of high-quality health services and identify creative solutions to those problems. Staff were able to offer many examples of performance barriers that were removed through this internal process of problem diagnosis and resolution. In examining Coutu's (2002) synthesis of the literature on resilience, we can conclude that the high-performing facilities described in this study exhibit all three of the resilience characteristics she defines—a staunch acceptance of reality, a deep belief often buttressed by strongly held values, and an uncanny ability to improvise.

With a few notable exceptions, differences between high-performing facilities by external affiliation were minimal. Faith-based and government facilities appeared to be more vulnerable to supply interruptions. Among private/parastatal facilities, none of the facilities had experienced an inventory stockout of oral contraceptives or IUDs, while 1 MOH and 1 faith-based facility had experienced stockouts of COCs. Only 1 of the MOH facilities had experienced a stockout of POCs in the last 6 months; 2 of the faith-based facilities had run out of their supply of IUDs. In contrast to some of the MOH facilities, both private/parastatal and faith-based facilities were fully equipped with toilets, drug storage areas, electricity, a radio or telephone, and a flashlight or lamp. This finding may be partly explained by the fact that all faith-based facilities and the majority of private/parastatal facilities were hospitals. Compared to providers at other facilities, providers at government and faith-based facilities more frequently believed that their knowledge and skills were insufficient for performing their job duties.

Another difference by facility affiliation was related to community linkages. One-third of private/parastatal facilities did not engage in community outreach activities, while more than 90% of MOH and 100% of faith-based facilities conducted community outreach activities, according to supervisors. Community involvement in management varied slightly according to the external affiliation of the facility. Both providers and supervisors interviewed said that MOH and faith-based facilities were more likely to involve the community in management of facility operations than private/parastatal facilities. Of providers and supervisors employed at private/parastatal facilities, 58% claimed that their facility was not associated with a community management committee.



A study such as this presents many interesting ideas that encourage further examination. The study was designed to discuss not only the “characteristics” of high-performing sites, but also the behaviors or strategies employed by those affiliated with the sites in hopes of replicating such strategies in the future. This presented a challenge in reporting. Many “actions” or “behaviors” can be categorized under multiple performance factors, suggesting linkages between common factors. For example, the measurement of staff knowledge and skills relevant to IP, and their ability to maintain site cleanliness, are affected by the availability of supplies and equipment for decontamination and sterilization. The quality of IP may also be affected by the quality and frequency of on-site supervisor rounds or “spot checks.” The degree of financial autonomy, and the financial mechanisms in place to permit the disbursement of funds, also may contribute to a high-performing site’s ability to purchase IP and other needed supplies, such as contraceptives. In addition, all of the facilities in this study maintained open work environments where staff felt comfortable sharing their ideas and fostered teamwork among staff. The fact that the staff participate in the operation of the site may encourage them to be more active in monitoring services and notifying the administration quickly of any problems encountered.

It is difficult to separate many of the factors into clear “determinants of performance,” especially when looking at specific behaviors. When a supervisor provides feedback to the provider, this can be classified as an example of good supervision or management, performance feedback, or as a motivating factor. When staff meetings provide opportunities to discuss new trainings attended, new information, results of client feedback, and problem-solving opportunities, that one action—the staff meeting—has provided feedback, leadership, expectations, and motivation for the staff members. When the facility had autonomous use of cost-recovery funds, the behavior itself is documented in this study. How the facilities decided as teams to utilize money was presented in the findings (e.g., using cost-sharing for incentives such as tea breaks or to improve emergency transport). However, the ability to keep and use that money (rather than returning it to the MOH) is an important policy issue and how that was determined was not clear.

Separating all of the characteristics into clear and replicable strategies and behaviors was difficult. Although all of these sites were characterized by common values—motivated and empowered staff, teamwork, and an openness and honesty between supervisors and providers—how these characteristics were developed was not always apparent. Sometimes they seemed to be the result of good leaders; however, strong leadership was not common among all sites. Three commonalities the sites shared were: the development of strategies to ensure that supplies were always available, the establishment and regular use of mechanisms for communication, and the instillation of a sense of equality and teamwork in staff. This knowledge can help managers introduce ways to improve communication, teamwork, and performance support systems.

This study showed that five of the seven performance factors essential to effective individual and organizational performance, as well as all the attributes associated with organizational resiliency, contribute to the high performance of healthcare facilities in Kenya, a low-resource setting. In fact, the presence of organizational resiliency characteristics appeared to enable many of the high-performing facilities to maintain their high performance over time.

To improve the quality and efficiency of healthcare delivery facilities in a sustainable way, study results suggest that interventions may require assisting on-site supervisors/managers and providers to effectively manage change by strengthening innovative decision-making and problem-solving approaches. Findings from this study will now be used to shape and prioritize interventions aimed at improving the performance of average and low-performing healthcare facilities.





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