phcpi PRIMARY HEALTH CARE PERFORMANCE INITIATIVE

IMPROVEMENT STRATEGIES MODEL:

AVAILABILITY OF EFFECTIVE PRIMARY HEALTH CARE SERVICES: PATIENT-PROVIDER RESPECT AND TRUST

Led by: Bill & Melinda Gates foundation, The World Bank IBRD • IDA | World Bank Group, World Health Organization

In partnership with: Ariadne Labs, Results for Development

CORE PRINCIPLES OF AVAILABILITY OF EFFECTIVE PRIMARY HEALTH CARE SERVICES

The subdomain Availability of Effective PHC Services includes the presence of competent, motivated health workers at a health facility or in a community when patients seek care. Effective PHC also requires that providers and their patients build participatory relationships and a foundation of trust and respect. Health worker motivation is critical as it is associated with technical and experiential quality as well as effectiveness. Finally, effective PHC also requires safe practices routinely followed in the delivery of care.

PROVIDER AVAILABILITY

Availability is defined as the presence of a trained provider at a facility or in the community when expected and providing the services as defined by his or her job description. Availability is important because, while there are often shortages in human resources, deployed providers are frequently inappropriately absent or, when present, are not actively delivering health care because they are engaged in other duties.

PROVIDER COMPETENCE

Provider competence entails having and demonstrating the “knowledge, skills, abilities, and traits” to successfully and effectively delivery high-quality services.(1) Competency can be built during pre-service education as well as in-service education and is not limited to technical knowledge. A competent provider must also have strong empathy and communication skills, and these are considered important components of “experiential quality”, from the patient perspective.

PROVIDER MOTIVATION

“Motivation in the work context can be defined as an individual’s degree of willingness to exert and maintain an effort towards organizational goals.”(2) Motivation captures intrinsic and extrinsic characteristics that affect the behavior and performance of providers in a health system. Intrinsic motivation is the feeling of accomplishment driven by organizational goals and the impact of one’s work on patients and communities. Alternatively, extrinsic motivation is driven by monetary or non-monetary individual or environmental incentives.(2) Within motivation, the literature has a particular focus on degree of provider autonomy, degree of remunerative motivation, supportive supervision, options for professional development, and level of burnout.

PATIENT-PROVIDER RESPECT AND TRUST

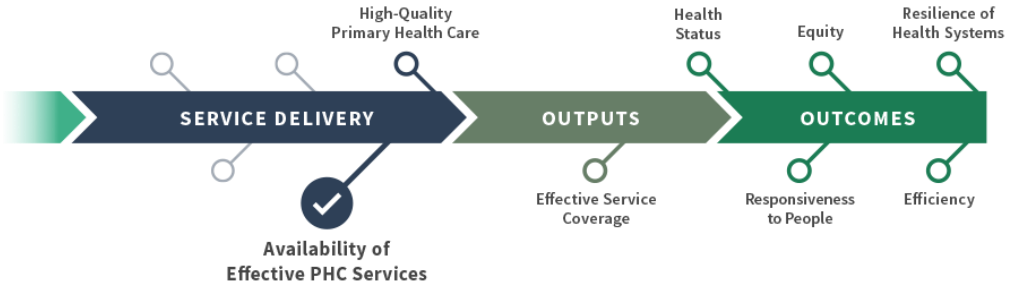
Patient-provider respect and trust refers to a relationship between patients and providers that ismutually respectful and trusting. Respect and trust between providers and patients can improve communication and provider motivation and contribute to the formation of continuous relationships over time.

SAFETY

“Patient safety is the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum.”(3)

WHAT COULD YOUR COUNTRY ACHIEVE BY FOCUSING ON AVAILABILITY OF EFFECTIVE PHC SERVICES?

Improvements in availability of effective PHC services can lead to improvements in the following areas:



AVAILABILITY OF EFFECTIVE PHC SERVICES: WHAT ARE THE FIRST STEPS?

STEP 1: ENSURE AN ADEQUATE SUPPLY OF HEALTH WORKERS

An adequate supply of human resources for health on a national and subnational level is a foundation for implementing interventions intended to improve availability of effective PHC services. Training, recruiting, and deploying an appropriately sized and adequately trained workforce is discussed in greater detail in the Workforce module (forthcoming). However, an adequate supply of competent providers is only a first step towards achieving high-quality, available, and effective services.(4)

STEP 2: ENSURE THAT TRAINED AND COMPETENT PHC PROVIDERS ARE AVAILABLE TO PATIENTS

The presence of an appropriate number of providers is of limited benefit if providers are absent from their planned shifts or if service delivery is structured in such a way that patients are unable to access a skilled provider at convenient times. Patients can only receive high-quality care from competent providers if those providers are present in facilities or communities and trained in the relevant care. If provider absenteeism is driven by facility-level factors such as inadequate supervision, poor remuneration, a sense of ineffectiveness due to poor training or inadequate supplies, or a lack of professional development, improving provider motivation may concurrently address provider availability.

Even with the availability of large numbers of health workers, inadequately trained and skilled providers will likely not contribute to improving either individual or population-level health outcomes. Frontline primary care service delivery is a highly complex task, requiring the ability to diagnose and manage a wide range of possible illnesses in undifferentiated patients presenting at the first contact point with the health system. Additionally, providers health workers require appropriate and comprehensive training in prevention and promotion to engage with individuals and commnities to promote health and wellbeng and address risk factors. Competency at these tasks requires substantial experience and training that often goes beyond typical academic degree-based educational programs, requiring post-graduate experience

and supervision. It is this comprehensive set of skills effectively applied in community settings that are likely to be responsible, at least in part, for overall improvements in morbidity and mortality.

STEP 3: ENSURE RESPECT AND SAFE PRACTICES THROUGHOUT

There are some overlaps between provider competence and patient-provider respect and trust. Experiential quality of care – measured from the patient perspective – may influence patient choice and utilization of primary care facilities. Competence and safety have similar overlaps – a system staffed with a workforce without the necessary clinical competency will most certainly perform poorly on safety. Safety includes not only provider knowledge in safe diagnostic, prescribing, and procedural practices, but also accessibility to the necessary supplies and equipment for a provider to perform his or her job.

PATIENT-PROVIDER RESPECT AND TRUST

Patient-provider respect and trust refers to a relationship between patients and providers that is mutually respectful and trusting. Respect and trust between providers and patients can improve communication and provider motivation and contribute to the formation of continuous relationships over time.

WHAT SHOULD I KNOW BEFORE BEGINNING IMPLEMENTATION?

Respect and trust in a health setting should be reciprocated between patients and providers. While sometimes overlooked, patient respect for providers is a critical part of experiential quality of care and is often influenced by patient perceptions of provider attitudes, competence, and caring behaviors.(5) In fact, an evaluation of the Brazilian primary health care system found that facility infrastructure and resources – while important for coordination and access – were not associated with higher reports of respect for cultural practices.(6) Respect is also related to timeliness and fair treatment. Providers can demonstrate respect for patient time if patients are seen quickly with adequate consultation times and do not face discrimination.

When patients feel they are respected by providers and they trust providers' judgment, they may be more likely to seek care when needed, enabling them to develop continuous, lasting relationships with providers. Alternatively, if patients do not feel respected by providers, they may be deterred from seeking care, exacerbating poor health outcomes.(7) This is particularly detrimental in low and middle-income settings where providers may be scarce and patients do not necessarily have the ability to switch providers at will.(8)

The suggestions below are grouped into three different considerations and relate to both provider trust and respect of patients as well as patient respect and trust of providers: 1) Communication and engagement, 2) facility-level interventions for providers, and 3) Disrespect and abuse literature. We have found that there is a significant gap in the literature in terms of interventions to promote respectful care. Instead, most interventions and strategies focus on the prevention of disrespectful care which – although an important start – is not sufficient to ensure that patients have access to respectful and trusting care.(9)

COMMUNICATION AND ENGAGEMENT

Frequent and high-quality communication and engagement between patients and providers can contribute to mutual respect and trust. A synthesis of relevant research on provider accountability found that government-facilitated community involvement in health care had a positive impact on provider behavior across low-income settings.(10) Engaging communities in health care early and often can help align expectations between patients and providers and help providers identify the needs of their population. Engaging with the communities to identify what services are most relevant and being adaptive to community needs is discussed in the local priority setting module and is a strategy for building trusting relationships between communities and the health system. Community engagement and approval has also been discussed as a strategy for improving provider motivation; providers who feel supported by the communities they serve may feel more intrinsic motivation.(11,12) This is particularly important when providers are working in areas that are unfamiliar to them; engagement with the community can help providers understand local values, cultural practices, or taboos that influence how they communicate with patients.

Minimizing language barriers is an important foundation for strong communication, engagement, and trust between patients and providers. Particularly in areas with diverse dialects, patients must be able to access providers with whom they can communicate complexly. For instance, there are often significant health disparities between indigenous and non-indigenous populations globally, with indigenous groups experiencing greater barriers to care and worse health outcomes. Language has historically been a barrier to care for these populations.(13) In order to provide respectful care to these groups, it is important for providers to be conversant in indigenous languages. In addition to language, it is important for providers to understand socio-cultural practices that may influence the way that patients seek and perceive health care and for providers to work with communities to ensure that these practices are respected and prioritized

Relatedly, some countries have addressed provider shortages through international recruitment of providers. The implications of such practices are discussed briefly in the provider availability module. However, one important consideration is international providers' language skills. For instance, in the 1990s Brazil recruited physicians from Cuba as a component of the *Mais Medicos* program with the goal of bolstering their health workforce. However, the majority of service users had difficulties understanding Cuban doctors.(14) While language barriers do not necessarily imply that there is an absence of respect and trust between providers, they can certainly make it challenging to foster deep relationships that are often characterized by strong communication.

Patient and Family Advisory Councils (PFACs) are a community engagement strategy that can improve patient-provider respect and trust by establishing and recognizing community members as key contributors to the health systems. In PFACs, community members meet with providers to discuss quality improvement and facility interventions to improve patient care. The following step can be taken to establish and sustain PFACs:

- Establish the PFAC team within the facility – The providers in the PFAC should be champions for community engagement in the health system. Roles and responsibilities for the providers within the PFAC include: a leader to manage the PFAC, a logistics coordinator, a community recruitment coordinator, and a scribe.
- Define the mission, vision, and goals of the PFAC – These components will eventually be discussed and formed by the community members as well, but it may be helpful to establish the baseline mission, vision, and goals between provider members to ensure alignment.
- Meeting logistics – the providers should consider how and when PFAC meetings are held. Some important considerations to ensure inclusion include transportation, reimbursement, and child or elder care.
- Identify patient and family advisors & recruitment – The PFAC team should next consider how they want to select community members. It is important to include patients who have some familiarity with the practice and are willing to contribute their feedback. Providers can be asked for suggestions. The best methods for contacting potential members will depend on context but may include: email, patient portals, regular mail, notices in newspapers, or through community-based organizations.
- Invitations and first meeting – Identify and consolidate materials to orient patients to the goals of the group. During the first meeting, important topics include: introductions, discussion and feedback on the mission, vision, and goals, establishing topics or agendas for the next few meetings.
- Ensure sustainability – some suggestions for ensuring that PFACs are sustainable include: allocating staff time and resources to PFACs, sharing information on feedback from the PFAC and how it was incorporated with communities, recognize and actively appreciate the contributions

of community members to these groups, ensure that patient members are diverse and represent all segments of the population.(15)

More detailed information on PFACs, as well as sample resources for roles and responsibilities and discussion questions can be found here.

FACILITY-LEVEL INTERVENTIONS

Provider respect for patients may have many root causes, some of which relate to provider motivation and workload. Providers who are more motivated, particularly intrinsically, may be more likely to respect and trust their patients. Conversely, providers who are overworked, experiencing burnout, or are not well supported with infrastructure and other inputs may be less likely to engage respectfully with their patients.(8) Therefore, efforts to improve provider motivation may, by extension, improve respectful care and begin through facility-level interventions.

The Transparency for Development Project – a partnership between the Ash Center for Democratic Governance and Innovation at the Harvard Kennedy School and Results for Development – is studying how local transparency interventions can improve health outcomes.(8) Early analyses in Indonesia and Tanzania found that many community members were dissatisfied with providers' attitudes and bedside manner. The researchers used qualitative methods to explore why providers treated patients disrespectfully and identified the following reasons:

- Provider frustration with patients' lack of care seeking behavior
- Limited supplies, medicines, and equipment
- Limited health staff
- Limited facility space

While frustration with systems and inputs may sometimes drive providers to interact with patients in a curt or non-respectful manner, it is of course important to note that lack of necessary infrastructure or capacity does not grant providers permission to do so. It is never acceptable to engage in disrespectful care. However, in order to help enable providers to develop respectful and trusting relationships with their patients, facility managers should monitor inputs to ensure that providers are supported in their duties.

Another important consideration for patient-provider respect and trust is respect for patients' time by minimizing wait times and ensuring that patients do not feel rushed during consultations. Interventions designed to shorten wait times, such as group visits and appointments are discussed in the timeliness module. In addition to respecting patients' time, providers can prioritize respect of patients during consultation by ensuring privacy and confidentiality.

Patient charters are a facility-level strategy for strengthening accountability for respect between patients and providers. Charters detail the responsibilities of providers to protect patients' human rights. If a national patient charter does not exist, it should be developed, and charters should be displayed prominently in facilities for the greatest accountability.(16) Charters can help patients identify and dispute disrespectful care. Charters are also useful because they often display the cost of services and provide financial transparency to patients.(17) However, the presence of a charter does not ensure that its principles will be upheld or that they are necessarily relevant, particularly if they are not adapted to the local level. Patients should be engaged in the development of charters to ensure that they reflect their expectations and needs, and both patients and providers should be expected to engage in conversations about respectful care. This can take place during active outreach to communities to discuss patient rights.

Finally, at the facility level, respectful care should be integrated into provider performance measurement and monitoring, and facility-level systems should be in place for patients to voice concerns or complaints about non-respectful care. These may be as simple as complaint lines or boxes or may entail community advisory boards. Additional methods for ensuring consistent communication with communities are addressed within the Community Engagement module.

DISRESPECT AND ABUSE LITERATURE

A substantial amount of the literature on provider respect for patients focuses on maternal disrespect and abuse, which is the extreme absence of provider respect and trust for patients. Disrespect and abuse is defined as "interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified."(18)
Explanations for disrespect and abuse often include facility-level factors such as under-equipped health facilities, overwhelmed or underpaid workers, and lack of supervision. However, sometimes disrespectful care can be engrained in the health system and passed from trainers to trainees and is not a result of inadequate inputs.(19)

Recently, there has been growing attention to interventions and strategies to improve respectful maternity care. Social accountability mechanisms – as discussed in the "community and engagement" section above – can help minimize disrespect and abuse, including through reduced informal payments, more polite treatment, shorter waiting times, and reduced absenteeism.(9) Social accountability can be pursued through the inclusion of patient representatives in quality improvement collaboratives, patient and family advisory committees, or clinic or hospital governance committees. Another common strategy for social accountability is citizen monitoring of quality of care. In this model, citizens assess certain aspects of the facility, such as wait times, appropriate number of beds, and physical or verbal abuse. Similar strategies include social audits and community report cards. These strategies have been facilitated by increased use of information and communication technology which has made reporting faster and more efficient. For instance, the platform U-report developed by UNICEF allows community members to report problems in their communities or facilities to hold providers and facility managers accountable for disrespectful or inappropriate care. More information on U-report and a similar platform – mTrac – can be found on their respective websites. Other interventions to reduce disrespect and abuse in maternity care – including a more robust discussion of social accountability – can be found in this evidence review from the Maternal Health Task Force. A few of these interventions and their application in Tanzania are discussed in greater detail in "What others have done".

What it is
What others have done
How to get started
How to succeed

WHAT HAS BEEN DONE ELSEWHERE TO IMPROVE PATIENT-PROVIDER RESPECT AND TRUST?

As described in What It Is, a substantial amount of the literature related to respect and trust focuses on the prevention of non-respectful or even abusive care at the facility level rather than fostering respectful interpersonal care. The cases here describe a few such programs and interventions.

DISRESPECT AND ABUSE IN CHILDBIRTH - TANZANIA

The *Staha* study ("respect" in Swahili) was implemented in two districts in the Tanga region of Tanzania starting in 2011 with the goal of reducing disrespect and abuse during childbirth through a two-part intervention.(20) Community members and health system stakeholders designed the intervention by consulting baseline data on disrespect and abuse in the districts. Through this process, implementers decided upon two interventions: 1) an adapted client service charter on norms and standards for mutual respect and respectful care to display in facilities, and 2) a quality improvement process for identifying drivers of disrespect and implementing targeted facility-level changes. Examples of interventions that were identified through the second intervention include: a private admissions area, curtains for exams, transparent systems for supply stock outs, and customer satisfaction exit interviews. The suite of interventions was assessed through self-reported disrespectful care. The odds of disrespectful and abusive care were reduced by 66%, with process indicators suggesting that that intervention contributed to these changes. Additionally, these effects were found to be sustained even a year after facilitation by *Staha* concluded. A number of resources from the *Staha* project including but not limited to baseline and end line surveys, in-depth interview guides, and focus group discussion guides can be found on the Averting Maternal Death and Disability website.

Another project in Tanzania implemented two different interventions in a large referral hospital in the city of Dar es Salaam.(21) Like the *Staha* study, this project conducted a baseline study and a multi-stakeholder participatory intervention selection process to identify relevant interventions for the setting. The two interventions selected were Open Birth Days and a Respectful Maternity Care Workshop. Open Birth Days were designed to improve patient knowledge of and preparation for birth. This was intended to fill a gap in knowledge identified by both patients and providers. Additionally, patients engaged in a discussion about patient rights and received a copy of the Universal Rights of Childbearing Women. The Respectful Maternity Care Workshop provided training on respectful care to providers, using an adapted version of the World Health Organization's Health Workers for Change curriculum. (21) After the six-session workshop, providers worked together to develop action plans to improve the issues they identified. Although the evaluation of this program was unable to assess the impact on disrespect and abuse, both interventions were received positively by patients and providers. Additionally, providers had increased knowledge, ability to empathize, and improved job satisfaction, and patients felt that they had more positive interactions with providers. Both this project and the *Staha* study demonstrate the effectiveness of participatory planning to identify and execute interventions related to disrespect and abuse. Although both of these projects are not specific to primary health care, the strategies and lessons learned from these projects can be easily translated to any health care setting.

CITIZEN MONITORING - PERU

The Participatory Voices Project was implemented in Peru between 2008 and 2011 to introduce community monitoring as a tool to improve quality of health services. While the project did not focus specifically on the interpersonal relationship between patients and providers, it aimed to: 1) strengthen capacities of civil society networks, 2) identify and connected key actors in the rights-based approach to

What it is
What others have done
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How to succeed

heath, 3) build partnerships between NGOs, international cooperation agencies, grassroots social organizations, civil society networks, and international actors; and 4) encourage political advocacy and provide technical assistance to an array of actors to improve responsiveness of the health system to marginalized populations.(22)

The project was planned with flexibility for local adaptation, and there were four general steps for implementation: 1) activity planning by the technical supporting team, 2) public announcement, selection, and capacity building of the members of the monitoring committees, 3) implementation of field activities, and 4) monitoring of commitments and evaluation. Related to steps 2 and 3, in each province, a group of individuals were identified to carry out the community monitoring activities. Trainings were conducted to teach individuals about some of the following concepts: human rights, health care rights, democracy and citizenship, sexual and reproductive health and rights, and organization and operation of health care services. Implementation differed but generally included visits to facilities for citizen monitoring, meetings for participatory analysis of findings, and discussion with authorities on commitments for improving services.(22) Observations of the program found that a number of respectful care practices were encouraged and fostered such as a greater promotion of culturally appropriate practices and increased attention to the right to health by authorities. Additional information on the Participatory Voices Project can be found on the CARE International website.

CITIZEN/FACILITY CHARTERS – KENYA & NEPAL

Citizen charters are a facility-level intervention that can increase accountability and empower patients to advocate for their rights. In Kenya, service charters are expected to be displayed in all health facilities. In addition to patient rights, they are also expected to include information on available services, corresponding costs, facility hours, and names and contact information of health facility committee members. Additionally, all information should include local language translations.(17) An evaluation of health facility charters in the Kericho District found that implementation of these charters differed substantially; none of the facilities met all of the requirements. In this district, the majority (66%) of patients surveyed were aware of the charters, 84% of these had read the information, and 83% of those who read them found it useful. The financial information was most useful to patients; the listed costs of services made patients feel that the facility was more transparent, helped them plan their finances, and gave them an opportunity to dispute charges that they thought were unfair. However, they did not feel that the charters made providers more responsive to their concerns. Some attributed this challenge to social expectations and norms that prevented them from openly discussing issues they encountered at the health facility. While this case highlights the financial utility of charters, it did not fulfil all of its expected purposes related to respectful care, and implementation was a challenge.

In Nepal, PHC facilities adopted facility charters in the early 2000s. Compared to Kenya, an evaluation of the implementation of charters in the Dang district in Nepal found far less awareness of charters. Only 15% of patients were aware of charters and two-thirds of these had read them.(23) Some participants noted that the charter made them aware of the services that were provided, but like Kenya few felt that it enabled them to dispute care that did not align with the charter. Some implementation challenges that were identified through the evaluation of these charters included lack of consultation with the community on the purpose and content of the charter, inadequate training on the charters within facilities, lack of punitive or corrective action when the charter is not followed, and an absence of ownership of the charter and its principles from providers at the facility. Additionally, many patients in this region are illiterate, and no efforts were made to convey this information to them. Although service charters were more successful in Kenya, both cases demonstrate limited use in enabling social accountability. However, charters may be a useful starting point for identifying facility values and services, but they must be paired

with community engagement during development and implementation, provider ownership, and monitoring and sanctions for non-adherence.

WHAT QUESTIONS SHOULD BE CONSIDERED TO BEGIN IMPROVEMENTS?

The questions below may be a useful starting place for determining if patient-provider respect and trust is an appropriate area of focus for a given context and how one might begin to plan and enact reforms:

ARE COMMUNITY MEMBERS ASKED ABOUT THEIR EXPERIENCES WITH PROVIDER RESPECT AND TRUST?

Through community engagement, stakeholders can better understand the challenges related to respect and trust between patients and providers. Additionally, engagement with patients in communities can be a way for patients and providers to connect and understand one another outside of the context of a facility.

ARE THERE PROCESSES FOR EVALUATING RESPECTFUL CARE IN FACILITIES? ARE THERE ANY QUALITY IMPROVEMENT SYSTEMS IN PLACE TO IDENTIFY AND RESPOND TO CHALLENGES RELATED TO RESPECT AND TRUST AS WELL AS DISRESPECT AND ABUSE?

Respect and trust should be evaluated using a triangulation of data and sources, including direct observation and patient feedback mechanisms. It is important for facilities to have clear processes for understanding and addressing respectful care.

DO PROVIDERS FEEL THAT THEY ARE ADEQUATELY SUPPORTED TO PROVIDE RESPECTFUL CARE?

While lack of resources is never an excuse for providers to deliver disrespectful care, providers will be better supported to provide patient-centered and respectful care if they have appropriate workload, compensation, drugs and supplies, and support.

DOES THE FACILITY HAVE A CHARTER FOR RESPECTFUL CARE? IF SO, HOW WAS IT DEVELOPED AND HOW IS IT DISSEMINATED AND USED?

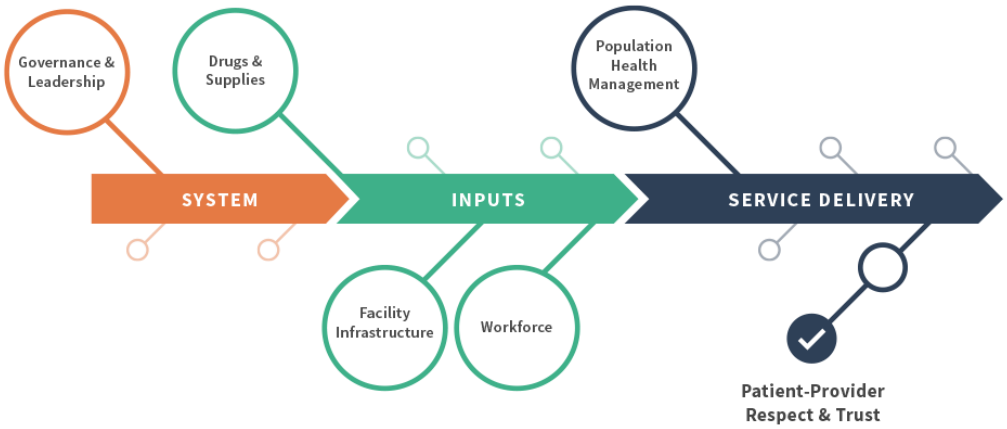
One example of a charter is the Universal Rights of Childbearing Women, developed by the White Ribbon Alliance. Patient charters should be designed with patients, adapted to the local contexts, and may be most effective when they are used as a foundation for patient engagement and provider education on patient rights. Patient charters in isolation cannot improve respect and trust, but can be used as a foundation for conversations.

IS PATIENT TIME RESPECTED? DO PATIENTS HAVE TO ENDURE LONG WAITING TIMES ONCE THEY ARE AT THE FACILITY?

Waiting time is an important aspect of patient-provider respect and trust. Patients' time should be respected and valued. As discussed in the timeliness module, some interventions that may improve waiting times include group visits, effective task shifting, use of information technology, and appointment systems.

WHAT ELEMENTS SHOULD BE IN PLACE TO SUPPORT EFFECTIVE IMPROVEMENTS?

In order for interventions aimed at improving provider availability to be most successful, the following elements of the PHCPI Conceptual Framework should be in place or pursued simultaneously:



C4.C PROVIDER MOTIVATION

Although provider motivation - both intrinsic and extrinsic – is not necessary for patient and provider respect and trust, it may facilitate these positive interpersonal interactions. Additionally, both provider motivation and patient and provider respect and trust share many improvement strategies such as community engagement, social accountability, and facility-level quality improvement efforts.

A1.C & C1.B SOCIAL ACCOUNTABILITY & COMMUNITY ENGAGEMENT

Social accountability and community engagement can help facilitate strong patient and provider respect and trust. Social accountability strategies are discussed in greater detail in Implementation Considerations. It is important to understand how communities perceive provider respect and trust in order to inform intervention selection, and social accountability mechanisms are one strategy for monitoring performance and progress.

B4 & C4.A WORKFORCE & PROVIDER AVAILABILITY

In order to foster respect and trust between patients and providers, patients must be able to see providers for a sufficient amount of time. This requires a robust workforce that is well distributed and whose time is efficiently delegated to accommodate consultation demand.

B1 & B2 DRUGS & SUPPLIES & FACILITY INFRASTRUCTURE

Providers often cite inadequate inputs and support as a driver of non-respectful care.(8) While providers should deliver respectful care irrespective of available inputs, it is important to support providers with the supplies, tools, and infrastructure they need. This also demonstrates the importance of reflecting on root causes of facility-level challenges to appropriately select interventions.

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