Introduction

PATH, with funding from Conrad. N. Hilton, has been supporting the Ministry of Health in Mozambique to **integrate delivery of early child development (ECD) services into routine primary healthcare** since 2014. PATH began implementation in southern Maputo province from 2014 to 2019 and expanded to northern Nampula Province from 2018 to 2023.

Key implementation objectives included the promotion of:

1. **Developmental monitoring** during child consultations,
2. **Caregiver counselling** on playing and communicating with children, and
3. **Child-friendly health services** through improved interpersonal communication with caregivers and children and presence of play items.

To achieve these objectives, implemented activities included:

1. Introducing **child development indicators** in well-baby and sick-child registers,
2. **Revising guidelines and manuals** on newborn care, child health services, nutrition rehabilitation, and HIV treatment to include developmentally supportive interventions,
3. **Training and mentoring providers** on the delivery of ECD services, which includes developmental monitoring and individual counseling with pregnant women, caregivers, and children as part of maternal and child health services,
4. Developing and distributing **ECD job aids** to providers at health facilities, and
5. Training and mentoring health facility volunteers to facilitate "**playbox sessions**" in health facility waiting rooms, which include demonstration and practice of age-appropriate play and communication activities with the help of low-cost, homemade play materials.

When exploring how to sustainably support providers to deliver quality ECD services, PATH initially counted on district-level supervision. However, district-level supervision was often not regular or systematic enough to support providers, nor to improve services. PATH considered whether health facility directors could assume supervisory and mentoring roles for ECD, like those they already assumed for HIV/TB, malaria prevention, and immunization services.

Additionally, operational research conducted in Maputo in 2018 and a project evaluation by the Harvard School of Public Health in province in 2021[1] identified variability in the reach and quality of ECD services across health facilities, prompting PATH to consider how to revise project approach and activities for improved outcomes.

To this end, PATH conducted a human-centered design study in Nampula between October and November 2022 to better understand caregiver and health provider experiences with ECD counseling and to find out if there are opportunities to strengthen both frequency and quality of ECD counseling. As part of this study, PATH investigated the facilitators and barriers faced by providers and directors in delivering quality ECD services, to inform the development of future strategies.

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[1] Jeong J, Bliznashka L, Ahun MN, et al. A pilot to promote early child development within health systems in Mozambique: a qualitative evaluation. *Annals of the New York Academy of Sciences*. 2022 Mar;1509(1):161–183. https://doi.org/10.1111/nyas.14718

Methods

Aim and questions

The aim of this evaluation was to identify the facilitators and barriers experienced by health facility providers and their directors to optimal ECD service delivery in Mozambique.

The primary questions for this evaluation included:

1. What supports and motivates health facility providers to deliver quality ECD services?
2. What barriers do health facility providers face in delivering quality ECD services?
3. What would support and hinder health facility directors from supporting providers to deliver quality ECD services?

Participant selection

Purposive sampling was used to develop a list of potential key informants for interviews and focus group discussions (FGDs), using the following inclusion criteria:

1. A health facility provider who delivers well-baby and maternal health services (interview) or a health facility director (interview) in one of the four priority health facilities in Monapo, or
2. A health facility provider who delivers antenatal care, maternity, well-baby, and sick-child services (FGD) or a health facility director (interview) working in one of the three highest volume facilities in the planned project expansion district, Ribaue.

Data collection

After obtaining written informed consent, 30–45-minute interviews with key informants and 60-90 minute FGDs were conducted in Portuguese by a skilled facilitator using a semi-structured guide (Appendix A. Semi-structured interview guide, health facility director; Appendix B. Semi-structured interview guide, health facility provider; Appendix C. Focus group discussion guide, health facility providers). Interviews and FGDs were conducted in a private place in the health facility in the afternoon, after most health services had closed for the day. Key informants were asked about their workday and about what motivates and hinders them from providing quality maternal and child health services, including developmental monitoring and counselling. Informants were also asked about activities they participated in to improve the quality of services. All interviews and FGDs were audio recorded following participant consent; a notetaker also took detailed notes. Audio recordings were transcribed word-for-word into Microsoft Word and then translated to English using Word translation software.

Data analysis

An a priori codebook guided by the evaluation aim was applied to the qualitative interview and FGD data using ATLAS.ti (v8). Coding was an iterative process, with initial coding informing the development of a refined codebook and further refined until a final codebook was developed. Once coding was finalized, codes were grouped into themes and supported by exemplary quotations.

Ethical considerations

The human-centered design study received bioethics approval from the Mozambique Ministry of Health (#41CNBS2022). Interviews and FGDs were conducted after obtaining written informed consent from participants. Participants were offered a light lunch to compensate for their time.

Participant characteristics

A total of 37 participants, 7 health facility directors and 30 providers, participated in 16 interviews and 6 FGDs (Table 1).

Table 1. Participants by role and activity

Role	Interview	FGD	TOTAL
Directors	7	0	7
Providers	9	26	30

**5 providers participated in both interviews and FGDs*

Providers included three general nurses, who conduct sick-child consultations, 14 maternal and child health nurses, who provide antenatal and postnatal care as well as child-at-risk consultations, and eight preventive medicine technicians and three nutrition technicians who conduct healthy child consultations.

Results: Health facility directors' use of time and training

Health facility directors reported starting work at 7am (min-max: 5-7:20am) and ending at 3 or 3:30pm (3-6pm). Directors indicated that they spent between 25 to 75% (median: 50%) of their day on administrative and managerial activities such as supervision and inventory assessments, and between 30-75% (median: 50%) of their time on providing direct clinical care. The majority of interviewed directors (71%, 5 of 7) reported to spend half or more of their day providing direct clinical care (Figure 1).

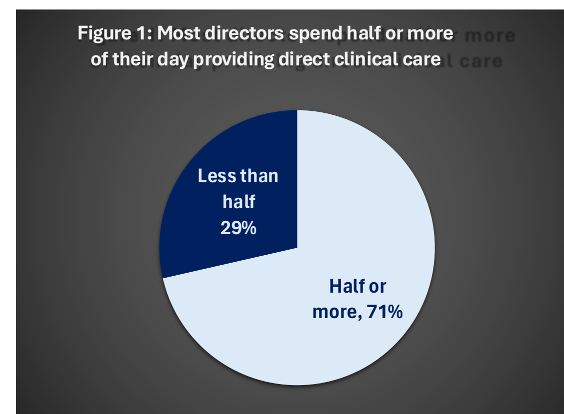


Figure 1: Most directors spend half or more of their day providing direct clinical care

Only one out of the seven directors reported to receive general training in quality improvement; five of seven received partner-supported quality improvement trainings in health-specific areas such as malaria and newborn and child health.[2] As a follow-up to the interviews, all seven directors were asked if they recevied a terms of reference when they were nominated to be director; all reported that they had not received a terms of reference, nor any management-related training at the time of their nomination.

Results: Facilitators and barriers for ECD service delivery

Most providers recommended that ECD counseling be delivered during all child services (i.e., well-child, sick-child, children at-risk) as well as during maternity services. A few providers indicated that well-child consultations were the most opportune time to deliver ECD counseling, compared to sick-child consultations and postpartum care, when caregivers were more worried and less able to pay attention.

[2] While implementers and participants of the PATH ECD project in Mozambique define "quality improvement" broadly to be about improving quality of services, the primary focus of project quality improvement activities has been about improving staff performance through improved supportive supervision, management, and interpersonal communication. Some partner-supported "quality improvement" trainings have also focused on this area, while others have followed more traditional principles of "quality improvement," focusing on improved system performance for better service delivery and health outcomes.

Two overarching themes, related to resources and behaviors, were identified as key facilitators and barriers for optimal ECD service delivery, by both providers and directors (Table 2).

Table 2. Key facilitators, barriers, and recommendations for optimal ECD service delivery

Facilitators	Barriers	Recommendations
Resource		
• ECD posters	• Material limitations • Staffing limitations	• More resources: ○ More posters ○ Materials in local language ○ Renumeration for health facility volunteers ○ Food aid for caregivers
Behavior		
• Being in service, helping people • Personal observation, ECD effectiveness	• Caregiver behavior • Criticism and lack of recognition	• More open, supportive feedback; shift to a learning culture

Resource facilitator: ECD posters

Figure 2. ECD poster

Providers repeatedly expressed how helpful the posters (Figure 2) were in providing quality ECD services. Providers explained that, with the posters, they did not have to memorize all of the ECD messages, including the developmental milestones. Additionally, posters served as a prompt to ensure that providers did not forget to cover key ECD messages. Posters have also allowed caregivers to visually see the messaging shared by providers.

“Interviewer: What helps you to provide good caregiver advise? Participant: It is the posters. I can forget and not memorize the milestones in my head. And me seeing the posters helps me guide in counselling. I don’t have problems because I can use the posters.” (Provider, Interview #7)

“I usually show these posters. I show the caregiver what is there for when they are that age. These posters, they help me a lot.” (Provider, Interview #9)

Resource barriers: Material and staffing limitations

Directors and providers echoed how challenging it was to deliver optimal maternal and child health services, including ECD services, in the context of limited materials and staffing.

“I feel I am not exploring the fullest what I learned in the training because there are no resources.” (Provider, Interview #6)

Providers highlighted that the lack of material inputs (Figure 3) hindered their ability to deliver quality care, including ECD services. Several directors and providers noted that stock-outs of drugs, vaccines, and medical supplies meant that they could not provide patients with the needed care. Lack of lighting, insufficiently addressed by using a phone's flashlight, was described to be a challenge in performing sutures after childbirth. Lack of transportation and fuel meant that providers could not go to out to distant communities to provide care.

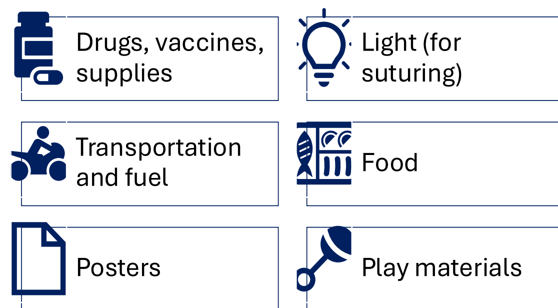


Figure 3. Limited resources hindered quality service

Not enough posters and play materials in the facility, as well as posters only in Portuguese were indicated to be barriers to providing quality ECD services. Providers explained that locally made play materials used in playbox sessions often get damaged or caregivers and children take them home.

Overwork and lack of staffing were also noted as barriers to providing quality services, which were exacerbated when providers did not speak the local language (e.g., Macua, Makonde). Providers emphasized the importance of being able to speak the local language, especially to deliver effective ECD counseling.

"Lack of staff affects the quality of services because a single person must do everything alone. This is discouraging." (Provider, FGD #6)

"We can't be there talking Portuguese. The mother will not understand." (Provider, Interview #6)

"There is a language barrier. I want to say this is a doll in Macua, but I can't. I say, 'doll, doll, doll,' but the caregiver doesn't understand." (Provider, FGD #1)

"The Macua I learned is not good. Sometimes the patient doesn't understand... When I have difficulty, I have the [health facility volunteer] interpret." (Provider, Interview #7)

A few providers also expressed the importance of offering renumeration or subsidies to health facility volunteers for facilitating playbox sessions to "motivate" them. One provider specified that even a small token, such as soap, would be appreciated by volunteers.

Alongside barriers faced in providing quality care due to resource limitations, providers also pointed to the lack of resources available to caregivers to implement certain ECD messages, especially regarding nutrition. One provider recommended that the program find a way to offer food aid to caregivers in need so that they could implement nutrition-related recommendations. This is critical, given clear evidence that investments in nutrition in the early years have a direct impact on child development.[3]

[3] *Black, M.M., Pérez-Escamilla, R., Rao, S.F. (2015) Integrating Nutrition and Child Development Interventions: Scientific Basis, Evidence of Impact, and Implementation Considerations. Advances in Nutrition, Volume 6, Issue 6,2015,Pages 852-859, https://doi.org/10.3945/an.115.010348.*

"There are situations in which the mother says there is no way to vary the food because she has nothing else, she only eats cassava porridge with moringa leaves because she does not have any support. We should have support from Social Action for food aid, offer a basic food basket to some mothers, especially those at high nutritional risk. Sometimes we give rich counselling, the mother listens, but there is no way to implement it due to a lack of resources." (Provider, Interview #6)

Resource-related recommendations

The following key resource-related recommendations were highlighted by providers and directors:

1. Offer renumeration or subsidies to health facility volunteers for facilitating playbox sessions.
2. Distribute more ECD posters to health facilities and offer posters and other ECD materials in local languages.
3. Link vulnerable families to food and agricultural support programs.

Though recommendations to address the lack of play materials were not suggested by participants, this is an issue that will need to be addressed to ensure the success and sustainability of playboxes. As such, implementers will need to look for sustainable solutions to increase play materials in waiting rooms, for example, through partnerships with local schools and health facility interns.

Behavioral facilitators: Service and ECD effectiveness

One of the most commonly expressed motivators for providers working in clinical practice related to "being in service" and "helping people." Providers repeatedly expressed how important and gratifying it was to care for others.

Relatedly, providers expressed how they enjoyed offering ECD counselling, feeling gratified when caregivers integrated what they had learned through ECD counselling, observing caregivers take better care of their children, and seeing the effectiveness of the care on the children's health and wellbeing. One provider described integrating ECD practices for their own child raising and directly seeing its effectiveness.

"Providing health services is what motivates me. I dream of a better Mozambique in terms of health." (Provider, Interview #6)

"It was my dream to take care of the mother and child to save lives and see happy families." (Provider, FGD #6)

"[ECD counselling] is very important because I am a witness to it myself. When I was being trained, I was pregnant, and I learned how to talk to the baby in my belly. So I've been talking, imitating what I learned, and evaluating my son. I see a difference with other children, he's very open-minded. I really believe that it is very important to stimulate the child, to let him play, to learn to communicate." (Provider, Interview #2)

"I feel satisfied when I see a child who is in a good state. I feel happy because I feel proud that I helped with the child's weight. I explained it to the mother, I advised the mother, the child is developing as they should be. I am the one who did it for the mother, and I feel happy to do it for the mother. The mother listened to my advice." (Provider, Interview #3)

"I felt very gratified and happy, especially the first time I had contact with ECD, the first talk I gave, I realized that the mothers gladly complied and promised to comply with the advice. I felt very happy... It is rewarding when the child achieves improvement. We find the child in poor health and achieve restoration, nutritional rehabilitation. It is very gratifying. When we feel the community is accepting the information that we give through the cooking demonstrations and when the mother follows the information that we give, it is very rewarding. The whole nutritional rehabilitation part is the thing I enjoy the most." (Provider, Interview #6)

Behavioral barrier: Caregiver behavior

Just as seeing caregivers integrate ECD practices and seeing positive outcomes for children is motivating for providers, seeing caregivers who miss appointments and do not change their practices is demotivating. One provider described how, when caregivers integrate ECD care, they feel "very good" and "confident" but when they work with caregivers who seem uninterested, they feel "sad", "embarrassed" and "insecure."

Across interviews and FGDs, providers described situations where pregnant women and caregivers would miss their appointments and how this hindered delivery of quality care; for example, not being able to assess the nutritional status of a child when the growth curve is missing multiple time points. One provider pointed to how economics plays a factor in caregivers' ability to implement nutritional recommendations.

"I feel sad when I explain to a mother, they should do this [nutritional advice], but the mother doesn't want to do it. But why doesn't she want to do it? ...they take [the harvest], and they sell it. There were a lot of peanuts this year, but if I ask any mother, they'll tell you they don't have any peanuts, because they have already sold them... when bean time comes, same thing. That is why malnutrition increases... mothers don't put things away to feed their children." (Provider, Interview #3)

Behavioral barrier: Criticism and lack of recognition

Providers repeatedly expressed the importance of positive reinforcement and recognition to motivate them to learn and grow but conveyed that it was more common for directors to criticize their work, which was demotivating and could affect the quality of their work.

"We rarely receive compliments. We know that compliments are important... if someone is waiting for you to fall to criticize you but whenever you do something well, they don't praise it, that demotivates you. Because you keep asking yourself, 'with everything that I do, is there nothing good that I do? Why do I always get criticisms and never get compliments?'" (Provider, FGD #1)

"[They say,] 'you didn't do this, you didn't register any births.' How am I going to be? I'm not going to be okay; I'm going to be very nervous. I don't work well when the person criticizes me." (Provider, Interview #1)

Behavioral barrier: Director-provider interactions

Related to the previous behavioral barrier, directors expressed that they did not enjoy the conflict they had with their colleagues due to their managerial and supervisory duties. One director shared

that changing provider behavior was the biggest challenge they faced. A couple directors explained that they preferred working in clinical care and do not enjoy aspects of their administrative responsibilities, which may partially explain the high percentage of directors who spend half or more of their day providing direct clinical care.

> *"I enjoy working in the clinical area. I don't like coordination activities where I have to problem solve conflicts." (Director, Interview #6)*
>
> *"Director: I like to spend time in visits more, because being there I can understand the evolution of the patients. Interviewer: What do you like least? Director: Organize the schedules, because at some point, there is a fight with colleagues." (Director, Interview #7)*

Behavioral recommendations

Providers emphasized one key behavior-related recommendation: to build director skills in celebrating successes and efforts and providing positive and supportive feedback to create a learning environment so that errors are not criticized but used as opportunities for learning.

Providers clearly communicated that they had a desire to receive feedback in order to correct mistakes and learn, but that they indicated a need to shift from a culture of "criticism," "scolding," and "yelling" to one where there is "open communication," "compliments," "praise," "consideration," and "recognition."

One provider acknowledged that their perception of the feedback from colleagues and directors impacted their experience of the feedback. That is, when providers themselves are open and receptive to receiving feedback, they would be more likely to learn and grow. If providers "already prepared myself that the colleague comes here to bother me, I won't understand anything" (Provider, FGD #1). Provider openness to feedback may be more likely if there is an overall culture of learning and providing and receiving positive feedback, rather than one where errors are reprimanded.

The importance of recognition and positive reinforcement was articulated by one director, who expressed a desire to materially recognize strong performance but because this was not feasible due to resource constraints, pointed to the importance of regularly vocalizing positive recognition.

> *"We would like, as a health facility, to recognize some providers that we think are in a good position of quality improvement, which are producing and improving the service. But the recognition in the health facility stops by saying: congratulations, colleague, you did that, you are to be congratulated. At some point, which is not so inviting for a professional. It is beautiful, a thank you from a leader. But there are those that don't appreciate it without some material recognition. As a health facility, we don't have that option. But in terms of moral, psychological support, we have it. We have said, you are to be congratulated for having done this, we witnessed your activities yesterday, you are to be congratulated." (Director, Interview #1)*

Behavioral theory of change: Positive cycle of a learning culture

A theory of change on the positive effects of a learning culture was developed based on the behavioral facilitators, barriers, and recommendations identified in this evaluation (Figure 4).

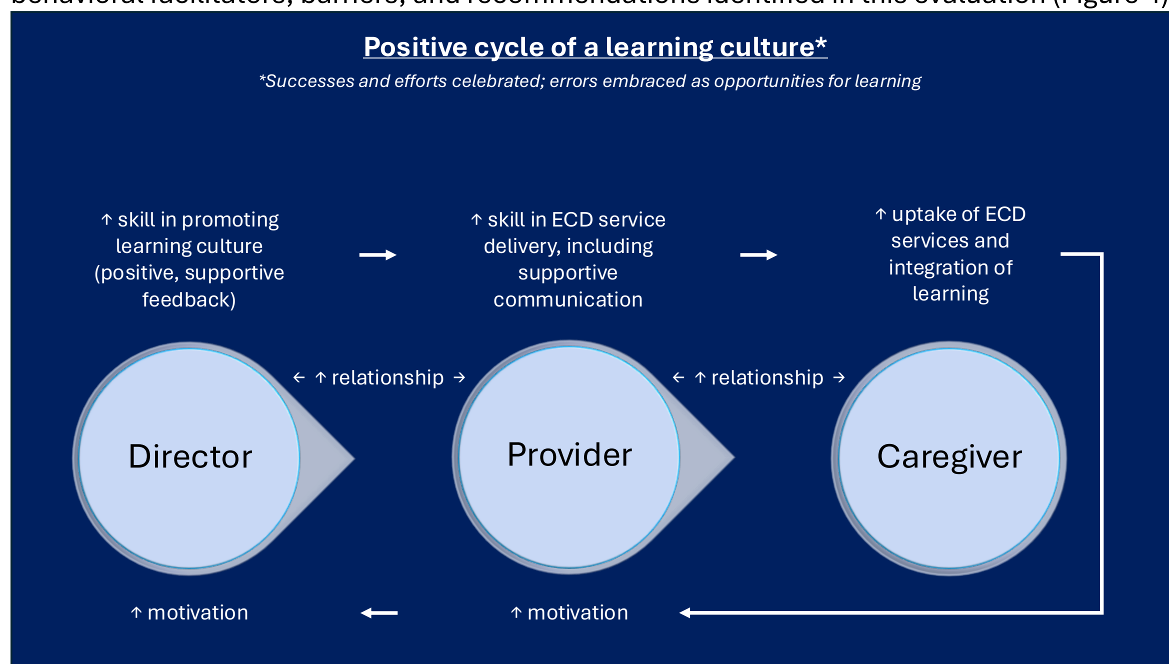


Figure 4. Theory of change on the effects of a learning culture on ECD counselling and practice

This figure illustrates that a learning culture, where successes and efforts are celebrated and errors are embraced as learning opportunities, could promote the identified behavioral facilitators while addressing the behavioral barriers. That is, if directors had the skills to promote a learning culture and consistently provided positive reinforcement and supportive feedback to providers, providers would be better supported to build their skills in ECD service delivery. This improved delivery would include the increased use of positive reinforcement and supportive communication with caregivers during ECD counseling. This shift is theorized to increase caregiver uptake of ECD services and support caregivers to apply and integrate learnings into practice. This change in caregiver practice would be a key motivator for providers to continue to provide quality ECD services and use supportive communication. The change in provider skill and motivation is theorized to also increase director motivation to promote a learning culture. The figure also illustrates that these improved skills and changes in practice would lead to improved relationships between directors and providers as well as providers and caregivers.

Relatedly, future work may explore:

1. Reasons directors spend more time on direct clinical care,
2. Approaches to support directors to increase time spent on administrative and management responsibilities, including supervision and mentoring of providers, and
3. The effect of skills training of directors, including whether training on “quality improvement”[4] would have an effect on the proportion of time directors spend on administrative and management responsibilities.

[4] As per footnote 2, project training on “quality improvement” would focus on improved staff performance through improved supportive supervision, management, and interpersonal communication.

Summary of recommendations

Based on the findings from this evaluation, PATH recommends the following for future implementation:

(1) Develop and test a feasible package of ECD services for each maternal and child health touchpoint.
(2) Offer feasible incentives to health facility volunteers engaged in ECD talks and playbox sessions (e.g., subsidized participation in campaigns and mobile brigades).
(3) Distribute more ECD posters to health facilities and offer posters and other ECD materials in local languages.
(4) Explore collaborations with local schools and health facility interns to ensure sufficient supply of play materials.
(5) Link vulnerable families to food and agricultural support programs.
(6) Build director skills in celebrating successes and efforts and providing positive and supportive feedback to create a learning environment so that errors are not criticized but used as opportunities for learning.
(7) Explore approaches to support directors to perform their administrative and managerial responsibilities.

Findings from this evaluation provided important context as PATH and key stakeholders co-created, tested, and validated ECD monitoring and counseling solutions for key maternal and child health touchpoints in 2023 (Recommendation 1). These solutions also addressed issues related to incentivizing health facility volunteers and production of play materials (Recommendations 2 and 4).

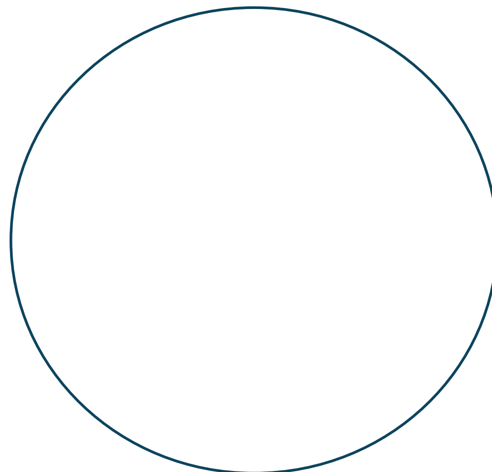
Regarding the need for a positive learning environment at the health facility (Recommendation 6), PATH intends to support government efforts in developing and testing health facility director training and coaching tools. Initial ideas for such tools have already been co-created with directors themselves. These include "Director's agenda," a tool meant to better structure director's time, including setting aside time for provider mentoring, and "Smile," an approach to start daily morning staff meetings and daily sector visits with focus on successes and positive practices.

Appendix A. Semi-structured interview guide, health facility director

Parte 1. Questões de aquecimento

Entrevistador: Obrigado por reservar este tempo para conversar comigo hoje.

1. Que funções desempenha neste centro de saúde?
2. Há quanto tempo trabalha neste centro de saúde? _____________ E quanto tempo trabalha como director clinico? _____________
3. Antes de trabalhar neste centro de saúde, onde é que estava colocado, e que funções desempenhava lá?
4. Normalmente, a que horas sai de casa para vir trabalhar? _________E a que horas costuma chegar ao centro de saúde? ___________
5. Normalmente, a que horas sai do trabalho/centro de saúde? ______E a que horas costuma chegar a casa? ______
6. O director vem de Monapo ou de um outro distrito /província?
7. Com quem é que vive aqui em casa (no distrito)? Caso houver crianças, quantos anos tem as crianças?
8. Conte-me como tem sido um dia de trabalho normal para si? Por exemplo, quando chega ao centro de saúde, qual é a primeira coisa que faz? E depois? A seguir a isso...? E depois... até que sai?
9. Essa rotina de trabalho é geralmente sempre a mesma, ou tem dias com uma rotina diferente? Caso SIM, o que acontece naqueles dias “diferentes”?
10. Quais são as suas 5 principais tarefas, como director clínico?
11. Destas tarefas, quais são aquelas que mais ocupam o seu tempo, durante uma semana normal? *(No círculo, ajude a marcar as frações / percentagens do tempo que dedica às suas principais actividades.)*



Parte 2. Motivação

12. O que você mais gosta de fazer no seu trabalho? Porquê?
13. E o que menos gosta de fazer? Porquê?
14. O que é que lhe motiva, no seu trabalho?
15. E há algo que lhe desanima ou que as vezes lhe deixa frustrado, no trabalho que faz?
    SIM / NÃO
    a. Se SIM, o que é e porquê?

Parte 3. Successos e desafios

16. O que considera que são os seus principais sucessos até agora, na função que ocupa actualmente na unidade sanitária? Há algo de que está particularmente orgulhoso? SIM / NÃO
    a. Se SIM, pode partilhar?
        i. Como conseguiu alcançar isso?
17. E quais é que acha que são os principais desafios para si, neste centro de saúde?

Parte 4. Actividades de melhoria de qualidade

18. Em termos de **melhoria de qualidade dos serviços** no seu centro de saúde, quais são as suas prioridades? O que exatamente gostaria de melhorar em primeiro lugar? Listar por ordem de prioridade:
19. Sabemos que, em regra geral, os serviços de saúde são tão bons quanto os recursos humanos que os provêm. Na sua experiência, **o que é que motiva** os provedores de serviços de saúde a darem o seu melhor?

a. Como implementa alguns desses aspectos para motivação, aqui na sua unidade sanitária?

20. Qual é **o seu papel**, **na melhoria de qualidade**? O que é que você faz, concretamente?
    (Sonde: se lidera encontros técnicos com a equipa clínica do centro de saúde [ex. ocorrências, sessões clínicas], se faz tutoria clinica, se faz supervisão, se faz formação em
    Pode explicar **com que frequência** e **como é que você faz**, cada dessas actividades? Vamos começar por…

  Usa alguma ferramenta? SIM/ NÃO Caso SIM, qual:

21. Na sua opinião, essas tarefas fazem parte dos seus termos de referência, como director clínico? SIM / NÃO / NÃO SEI
22. Conheça alguns documentos do MISAU, que falam sobre acções de melhoria de qualidade na US? SIM / NÃO
    a. Caso SIM, quais?
23. Há sectores da unidade sanitária, que costumam beneficiar mais que outros, das acções de melhoria de qualidade? SIM / NÃO
    a. Se SIM, quais? E porquê?
24. Como é que conjuga a tarefa de assegurar melhoria de qualidade com as suas outras responsabilidades?
25. Acha que deveria haver outra pessoa a nível da unidade sanitária a zelar pela melhoria de qualidade (ou talvez pelas algumas das tarefas)? SIM/ NÃO
    a. Se SIM, quem? E porquê é que essa pessoa seria uma boa aposta?
26. Recebeu alguma formação, em tarefas de melhoria de qualidade? SIM / NÃO
    a. Caso SIM, pode contar que tipo de formação recebeu, e de quem?
    b. O que foi mais util que aprendeu naquela formação, algo que está a usar até agora?
27. Recebe algum apoio ou incentivo para realizar as actividades de melhoria de qualidade? SIM / NÃO
    a. Se SIM, pode contar quê incentivo, e de onde vem?
    b. Se NÃO, será que seria importante, ter algum incentivo? De que tipo?
    c. Como é que isso lhe iria ajudar a conseguir realizar estas actividades?
28. Que barreiras enfrenta, na realização de actividades de melhoria de qualidade?
    a. Na sua opinião, o que poderia ser feito para ultrapassar essas barreiras?
29. E que sucessos já tinha, ao tentar melhorar a qualidade de serviços? (Caso já houver)

Appendix B. Semi-structured interview guide, healthcare provider

Parte 1. Questões de aquecimento

Entrevistador: Obrigado por reservar este tempo para conversar comigo hoje.

1. Há quanto tempo trabalha neste centro de saúde? ____ E neste sector?___________
2. Normalmente, a que horas sai de casa para vir trabalhar? ___________E a que horas costuma chegar ao centro de saúde? ___________
3. Normalmente, a que horas sai do centro de saúde? ______________E a que horas costuma chegar a casa? ______________
4. O provedor vem de Monapo ou de um outro distrito /província?
5. Com quem é que vive aqui em casa (no distrito)? Caso houver crianças, quantos anos tem as crianças?
6. Conte-me como é um dia de trabalho normal para si? Por exemplo, quando chega ao centro de saúde, qual é a primeira coisa que faz? E depois? A seguir a isso...? E depois... até que sai?
7. Há dias em que a sua rotina de trabalho muda? SIM / NÃO
    a. Se SIM, quando e o que é que muda?

Parte 2. Motivação

8. O que mais gosta no seu trabalho neste sector?
9. E o que menos gosta? Porquê?
10. O que é que lhe motiva no seu trabalho?
11. Há algo que lhe desanima ou que as vezes lhe deixa frustrado no trabalho que faz? SIM / NÃO
    a. Se SIM, o que é e porquê?

Parte 3. Aconselhamento nas consultas

12. Por dia, quantas consultas faz em média no seu sector?
    Sonde: *Num dia calmo* __________
    Num dia de enchente __________
13. Quanto tempo, em média, dura uma consulta? __________
    a. Esse tempo muda quando é um dia de enchente ou um dia calmo?
        i. Se SIM, em que medida? ____________________________________
14. Na sua rotina de trabalho, costuma fazer aconselhamento durante as suas consultas? SIM/NÃO
    a. Caso SIM, sobre que temas tem falado?
    b. Há alguns temas com que está mais confortável em aconselhar que outros? SIM/ NÃO Caso SIM, em quais temas sinta se mais confortável? Porquê?
15. O que é, para si, um aconselhamento **de qualidade**?
16. Qual tem sido a sua abordagem neste sector: aconselhar cada cuidador que vem à consulta ou priorizar alguns cuidadores? Porquê?
    a. Se aconselha somente alguns cuidadores, como é decide a quem aconselhar?
17. O aconselhamento que faz, é igual ou diferente para cada cuidador? Porquê?
18. Já alguma vez aconselhou um cuidador sobre como brincar e conversar com a sua criança? SIM / NÃO
    a. Se SIM, pode contar como fez? (Imagine que eu sou um cuidador)
        i. Como se sentiu, ao fazer esse aconselhamento? Porquê?
        E como é que acha que a o cuidador se sentiu? Porquê é que acha isso?

19. O que lhe ajuda a fazer um bom aconselhamento ao cuidador, no seu sector?
20. E há alguma coisa que faz com que seja difícil dar um bom aconselhamento ao cuidador? SIM/NÃO
    a. Se SIM, o quê?
    b. Na sua opinião, o que lhe ajudaria a ultrapassar essas dificuldades? Mesmo que não tenha uma solução imediata, queria que pensasse profundamente acerca disto e me desse uma proposta.
21. Você tem como saber, se os cuidadores seguem os conselhos que você deu, em casa? SIM / NÃO
    a. Caso SIM, como é que consegue saber isso?
22. Há algo que você faz na consulta, para aumentar chance que os cuidadores sigam os seus conselhos em casa? SIM / NÃO
    a. Caso SIM, o que é que faz?
23. Que outro apoio acha que é necessário, para garantir que os cuidadores realmente adoptem as práticas que você aconselhou, em casa?

Parte 4. Melhoria de qualidade

2. Todos nós precisamos de apoio para podermos fazer o melhor trabalho possível. Nos últimos 3 meses, recebeu algum apoio na realização das suas tarefas? SIM / NÃO
    a. Se SIM, que tipo de apoio recebeu? (AT, supervisão, formação etc.)
    b. Quem é que lhe deu esse apoio?
    c. Qual foi a área que mais apoio recebeu?
       (Exemplo: HIV, saúde materna; saúde infantil, DPI, nutrição, outro.)
    d. Pode me explicar um pouco como foi dado esse apoio? Passo por passo.
    e. Acha que esse apoio foi útil para melhorar o seu trabalho? SIM/NÃO. Se SIM, como é que foi útil?
    f. Sentiu que algo que podia ser melhorado na forma como foi dado este apoio?

Appendix C. Focus group discussion guide, healthcare providers

Parte 1. Questões de aquecimento

- Queria começar por pedir que me dissessem qual a vossa categoria profissional e em que sector da unidade sanitária trabalham. Gostaria de ouvir de cada um de vós.
  (Registar na tabela em baixo.)
- Há quanto tempo trabalham na saúde? Mais uma vez, seria importante ouvir de cada um de vós.
  (Registar na tabela em baixo, seguindo a mesma sequência dos provedores na tabela.)
- Durante esse tempo, sempre trabalharam nessa área ou sector da unidade sanitária? Para aqueles que não, em que outras áreas ou sectores já trabalharam? *(Registar na tabela, adicionando na 3ª coluna, caso precisar.)*

Parte 2. Motivação

1. O que é que mais vos motiva no vosso trabalho?
2. E há algo que vos desanima ou que as vezes vos deixa frustrados, no trabalho que fazem?

Parte 3. Aconselhamento nas consultas

3. O que é, para si, um aconselhamento **de qualidade**?
4. Qual tem sido a sua abordagem neste sector: aconselhar cada cuidador que vem à consulta ou priorizar alguns cuidadores? Porquê?
   a. Se aconselha somente alguns cuidadores, como é decide a quem aconselhar?
5. O que lhe ajuda a fazer um bom aconselhamento ao cuidador, no seu sector?

Parte 4. Melhoria de qualidade através de tutoria etc.

6. Todos nós precisamos de apoio para podermos fazer o melhor trabalho possível. Nos últimos 3 meses, receberam algum apoio na realização das suas tarefas?
   SIM (N):______/ NÃO (N):______
   a. Os que receberam, que tipo de apoio receberam?
   (*Sonde: tutoria clínica, supervisão, formação em trabalho, outro. Lliste todos, se mais que um*)
7. E*scolhe um tipo de apoio de cada vez e pergunte:*
   a. Quem é que lhes deu esse apoio?
      (*Sonde: uma única pessoa, uma equipa integrada constituída por...?)*
   b. Qual foi a área que mais apoio recebeu?
      (Sonde: HIV, saúde materna; saúde infantil, DPI, nutrição, outro.)
   c. Podem me explicar um pouco como foi dado esse apoio? Passo por passo.
      (Sonde: houve uma observação da consulta, houve uma sessão de discussão clínica, foi feita uma formação com base numa constatação de supervisão anterior, a pessoa fez os procedimentos da consulta junto com o provedor, etc.)
   d. Acham que esse apoio foi útil para melhorar o seu trabalho? SIM/NÃO. Se SIM, como é que foi útil? *(Sonde, mudou alguma coisa antes e depois de receber o apoio?)*
   e. Sentiram que algo que podia ser melhorado na forma como foi dado este apoio?
      (Sonde: o apoio devia ser mais frequente / a metodologia usada poderia ser diferente/ a comunicação não foi positiva / devia focar mais em outra área, outro).
8. Normalmente, tem feito encontros de equipa no seu centro de saúde? SIM / NÃO
   (Sonde: ocorrências, sessões clínicas, dicussão/auditoria de dados, discussão de casos, etc.
   a. Se SIM, que tipo de encontros são realizados?
      Liste cada tipo de encontro mencionado, e pergunte sobre sua frequência, participantes e passos tipicos.

9. Qual desses encontros considera mais útil para si e para o seu trabalho? Porquê?

Parte 4. Melhoria de qualidade na US – papel de directos e colegas

10. Na sua óptica, a nível da unidade sanitária, quem tem / deveria ter o papel de melhorar a qualidade dos serviços, particularmente serviços de saúde materno-infantil? Porquê? (*Sonde: director da US, director clínico, enfermeira chefe, outro clínico ou colega)*
11. Qual é/deveria ser o papel dessa pessoa na garantia/melhoria de qualidade?
12. E o que acha sobre a ideia de algum apoio técnico ser oferecido por um colega seu, que é seu par, ou você oferecer apoio ao/s colega/s?
    a. Já teve uma experiência relevante que poderia partilhar connosco?
    b. O que acha que funcionou/poderia funcionar bem, no apoio de pares?
    c. O que acha que não funcionou/não iria funcionar bem, no apoio de pares?