313: ENABLING SERVICE PROVIDERS TO PUT IMCI STANDARDS INTO PRACTICE THROUGH COPE® (CLIENT-ORIENTED, PROVIDER-EFFICIENT SERVICES)

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Objective:
To evaluate changes in provider performance and client satisfaction in child health services following implementation of COPE®, as adapted for Integrated Management of Childhood Illness (IMCI) standards of care.

Methods:
COPE is a continuous quality improvement process that brings together all levels of staff in a health facility. Staff review self-assessment guides, review records, interview clients, measure client-flow, and develop action plans, focusing on local solutions to any problems identified. First developed for family planning clinics, the process has been applied in over 45 countries in the past 14 years, and adapted for use at sites providing a range of health services. In 1998 and 1999 EngenderHealth, UNICEF, and other partners adapted the COPE tools to reflect the standards for the Integrated Management of Childhood Illness (IMCI) approach. IMCI training was expected throughout the region concurrent with this intervention.
This quasi-experimental study was conducted in eight intervention and eight control sites providing child health services in Guinea and Kenya. A 1999 baseline survey of staffing levels, waiting times, prescribing practices, and children's illnesses confirmed that the intervention and control sites were similar in most respects. Over the next 15 months, four COPE exercises were conducted at each of the eight intervention sites, approximately every four to five months. Note that no specific IMCI training occurred during this period.
In 2001 a final evaluation was conducted in all sites including facility audits, 320 observations of client-provider interactions, interviews with 157 providers, and exit interviews with 320 adult caregivers who had come seeking care for a sick or well child. Focus groups were held with 88 staff from all intervention sites in both countries, to discuss the COPE process.

Results:
On almost every indicator of quality, intervention sites performed significantly better than control sites according to IMCI standards. In representative areas of provider performance – client-provider discussions, privacy and confidentiality, and diagnosis of sick children, sample data showed: 26.3% of intervention providers – vs. 8.8% of control providers discussed general health with caregivers; 81.3% had uninterrupted sessions, compared with 57.9%; 42.5% asked about child's fever, vs. 25%; and 63.8% vs. 38.3% took the child's temperature (All P values for preceding examples were $<.01$.) The only indicators not showing improved quality related to prescribing practices; inaccuracies were documented in both intervention and control sites. Intervention site clients were much more likely than control site clients to report understanding everything they were told (97.5% vs. 88.1%) and to report being "very satisfied" overall with the visit (69.8% vs. 48.4%). In intervention sites, 80% of repeat clients reported that services were better than they had been before, as compared with 26.9% of those in control sites. Providers underwent profound changes in how they viewed clients and colleagues, treating clients with increased respect and empathy, and markedly strengthening their sense of unity at work. The COPE process affected staff's sense of empowerment and accountability; "Before, most problems were someone else's responsibility. But now we see that we ourselves can solve most problems." Staff solved most problems they identified without outside assistance including issues related to infrastructure and equipment, human resources and service delivery. Organizational changes included reduced hierarchy and bureaucracy and more supportive supervision.

Conclusions:
COPE was associated with dramatically improved provider performance, higher client satisfaction and higher caregiver knowledge. Clear improvements in service quality are evident with a minimal intervention that involved only the provision of some trigger
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questions about quality and a structure for discussing problems and solutions. However, COPE is not a “magic bullet” . Training in discrete clinical areas could complement this process for optimal improvements in service quality.

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