

## **398: BRIDGING FACILITY-BASED QUALITY IMPROVEMENT WITH CONSUMER PARTICIPATION**

### **Authors:**

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### **Objective:**

To model a practical process for health staff, in low resource settings, to link facility-based assessment with consumer participation in order to define and improve the quality of services.

### **Methods:**

Building on COPE (Client-Oriented, Provider Efficient services) a practical, facility-based self-assessment process, and tools for quality improvement in low resource healthcare facilities, EngenderHealth developed Community COPE. This new model enables healthcare staff to apply participatory approaches with different consumer groups in the local community, in order to learn their needs and expectations of services, and create an ongoing dialogue between community members and facility staff, leading to specific improvements in facility-based care. Both COPE and Community COPE are based on a framework of clients' rights and providers' needs. To gauge client perspectives, COPE includes a client interview tool. However, interviews and satisfaction surveys suffer from shortcomings, such as courtesy bias, or inadequate focus or prioritization of issues (Cleary & Edgman-Levitan, 1997; Simmons & Elias, 1994). In addition, client interviews do not reach potential clients who do not come, or those who have stopped using the services, particularly important in addressing preventive health care. At the same time, participatory approaches encourage community members to advocate for their rights to quality healthcare, and to view themselves as consumers of services rather than as passive recipients of care.

Key steps include: (1) staff orientation on consumer participation in assessing and improving hospital services; (2) meetings between community leaders and hospital staff to gain support for consumer participation and feedback; (3) interviews and focus group discussions with subgroups in the hospital's catchment area; (4) analysis of issues raised and development of action plans; (5) inclusion of consumer representatives on QI committees; (6) increasing hospital staff attendance at community meetings. In the E. African case described, participants were men and women, ranging from adolescents to elders, and included local elected leaders, teachers, students, farmers, housewives, community workers, supervisors, traditional birth attendants and leaders of religious and women's groups.

### **Results:**

Key problems identified included access to services, poor client-provider interaction, cleanliness and privacy. Community members indicated that patients were waiting too long, particularly in the injection room and at the cashier's station. Staff was reassigned and supervisors visited these two stations more frequently to resolve these problems. Community members had to travel long distances for specialized services such as ear, nose and throat, or dental care. To respond, specialized training was arranged for one physician from the hospital in vision screening, diagnosis and treatment of eye infections and cataracts. In addition, the hospital plans to hire more part-time doctors in other specialty areas and also for its mobile services. Following an orientation on good customer service, in the most recent interviews and group discussions, community members noted that staff are now more friendly, welcoming and attend to clients more swiftly than before. There were complaints about rats in the mortuary. At the hospital's request, the district public health officer exterminated the rats. In addition, hospital staff cleared the grass around the mortuary, repaired holes and cracks in walls and installed lights inside the building. The long term plan is to build a new mortuary by 2006. At the second follow-up there were no complaints about the mortuary.

### **Conclusions:**

Consumers have specific ideas to improve health services and can reinforce staff's own efforts to improve quality. The participatory process increases consumers' own sense of ownership of health services. Consumers are effective advocates for health and health services when they are actively engaged in a quality improvement process. This model has applications, particularly in settings undergoing health-sector reform, e.g., for linking micro-insurance organizations to healthcare providers.