COMPASS
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# Improving Provider Performance: Results from Guinea and Kenya

Health care providers improved their performance, and their clients were more satisfied with the care they received, when staff at child health clinics in Guinea and Kenya were empowered to take initiative through an intervention known as COPE®. COPE consists of a series of exercises designed to encourage providers to examine how they perform their daily tasks, to analyze their problems, and to develop their own solutions. In a comparison of eight sites that used COPE with eight control sites, staff at the intervention sites felt more positively about their work and provided higher quality child health services. Moreover, clients at the intervention sites were happier with the services they received and learned more about protecting and preserving their children's health. While past qualitative and quantitative evaluations and reviews have documented COPE's utility,[1] this was the first longitudinal evaluation of COPE contrasting experimental and control groups.


Photo: Wendy Stone

A nurse tracks a child's weight and height.

## How the Evaluation Was Done

Ensuring that health care services are of high quality is crucial if clients are to seek them out in the first place and if they are to complete the treatments that they receive.[2] Yet making health services both more client-centered and more efficient and effective—all keys to quality services—poses special challenges. In an era of limited resources and limitless needs, simple and inexpensive ways of improving the performance of the health care system are of the utmost importance.

COPE is a simple quality improvement approach that has been widely used in family planning and other health care settings (see box, page 2). In 1998 and 1999, EngenderHealth worked with a number of partners, including the United Nations Children's Fund and the U.S. Agency for International Development (Africa Bureau), to adapt COPE for use in improving child health services. Over a 15-month period in 1999 and 2000, local staff at eight child health sites in Guinea and Kenya participated in four exercises using the version of COPE adapted for child health, each spaced approximately four to five months apart.

Because of the importance of determining COPE's potential for improving provider performance, a longitudinal, quasi-experimental evaluation was conducted at the eight service sites in Guinea and Kenya, as well as at eight control sites that were matched by size, number of staff, and function. All of the Kenyan facilities were rural health centers in four districts in Western Province. In Guinea, larger sites in eight periurban districts were selected for the study.

A 1999 baseline survey that looked at such issues as staffing levels, waiting times, prescribing practices, and children's illnesses confirmed that the intervention and control sites were generally similar in most respects. During the course of the project, process data were obtained from COPE exercises and action plans, from routine site visits and informal discussions with staff, and from reviews of service-utilization records for the period 1998–2000.

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In April 2001, following the end of the project, the baseline survey was repeated, and focus groups and interviews were conducted with staff at the intervention clinics. In all, 77 staff in Kenya and 80 in Guinea were interviewed, and focus groups were held with 88 staff at intervention sites in the two countries.

Exit interviews were performed with 160 adult clients in each country who had come to the facility seeking care for a child. Additionally, in each country evaluators observed 160 client-provider interactions, noted what questions staff posed to the clients, what information was given, and what treatment was offered, and commented on aspects of the interaction, such as privacy and respect. The observers also rated providers' interpersonal skills in these interactions (for instance, how they greeted the client, whether they made eye contact, whether they smiled at the client, whether they were respectful and gentle, whether they behaved judgmentally, and whether they listened to the client, explained things, and tried to ensure that the client understood what he or she had been told).

## What the Evaluation Found

### *Service quality*

By the end of the project, observers noted marked improvements in service quality at the intervention sites as a consequence of using COPE. For instance, when reviewing examinations performed by providers, observers found that staff at intervention sites conducted more thorough assessments of children than did those at control sites (see table, above). The former were significantly more likely than the latter to check the child's neck for stiffness, to examine the child's abdomen, to check his or her hands for pallor, and to take the child's temperature. Seven intervention sites had established separate oral rehydration corners (where staff could teach parents how to rehydrate their children after diarrheal disease), compared with two control sites. In addition, staff at intervention sites were more likely than those at control sites to discuss with clients such issues as family planning (17% vs. 3%), child growth (26% vs. 16%), general health (26% vs. 9%), and nutrition (36% vs. 16%).

**Provider's actions in diagnosing illness in a sick child**

| What the provider did | Intervention sites | Control sites |
|---|---|---|
| Examined neck for stiffness | 45% | 19% |
| Examined abdomen | 73% | 58% |
| Checked hands for pallor | 26% | 4% |
| Took child's temperature | 64% | 38% |

The evaluators' observations of client-staff interactions following the COPE interventions showed that staff at intervention sites maintained auditory privacy in 61% of interactions, significantly more than staff at control sites (41%); likewise, intervention-site staff maintained visual privacy more often than did control-site staff (59% vs. 40%). Indeed, the evaluators judged that all eight intervention sites provided visual and auditory privacy for counseling, compared with just three control sites.

On every measure of interpersonal skills, the observers rated staff at the intervention sites higher than those at control sites. For instance, intervention-site staff were significantly more likely than control-site staff to have greeted the client well (64% vs. 14%), to have maintained eye contact (62% vs. 21%), and to have smiled when greeting the client (56% vs. 10%) (see chart, page 3).

Exit interviews with clients offered evaluators a chance to gauge clients' knowledge of and perceptions about the services they received. When asked what they had been told to do at home to help the child recover, clients who had visited intervention sites were significantly more likely than those who had been to control sites to say they had been told to continue to breastfeed the child (23% vs. 6%), to give the child more fluids (23% vs. 5%), and to bring the child back if there is no improvement (41% vs. 23%). Similarly, when asked how they would know if their child's condition was deteriorating, clients at intervention sites were more likely than clients

### What is COPE?

COPE® (client-oriented, provider-efficient services) is both a process and a set of tools. Developed by EngenderHealth and used in more than 45 countries over the past 14 years, COPE is designed to help health care staff at a service-delivery site continuously assess and improve the quality of their services. COPE consists of four tools: a set of self-assessment guides, a client interview guide, a client-flow analysis, and an action-planning tool. One unique aspect of COPE is its focus on self-assessment, guided by local staff themselves, as the first step toward service improvement. Another is that no interventions are predetermined, and no one knows beforehand what will happen or what may change as a result of COPE. While COPE was initially developed for use in family planning clinics, it has been adapted over time for use at sites providing reproductive, maternal, and child health services, as well as for use in communities as a whole to identify community health needs. Further information on COPE can be obtained by contacting info@engenderhealth.org.

at control sites to know to look for such problems as fever (70% vs. 46%), diarrhea (47% vs. 19%), and vomiting (35% vs. 22%).

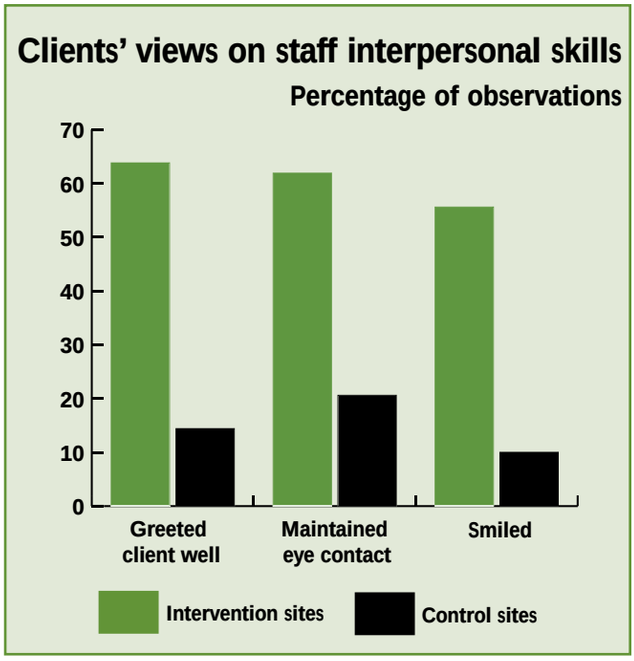
Clients visiting intervention sites were more likely to characterize waiting times as "not long" than were clients attending control sites (72% vs. 59%); the former also were more likely than the latter to report having heard health talks at the facility (49% vs. 14%). Besides finding staff to be knowledgeable and respectful and believing that they explained things well (see chart, page 4), clients at the intervention sites were also more likely than those at the control sites to report being "very satisfied" overall with their visit (70% vs. 48%).

Overall, clients at the intervention sites were more likely than those at the control sites to report thinking that services were offered at convenient times, that waiting times were acceptable, that services were safe, that staff treated clients with privacy, confidentiality, and respect, and that staff helped them access other services, both at that facility and elsewhere. Seventy percent of clients at the intervention sites gave services a "very good" rating, compared with only 39% at the control sites. Finally, 80% of clients at intervention sites said that services were better than before, compared with 27% of clients at control sites.

## *Problem-solving*

How did staff achieve these results? The majority of the improvements could be traced to staff's reviewing of COPE self-assessment guides (which are based on internationally accepted standards and guidelines) and asking themselves if staff were in compliance. Few other inputs were required. A key aspect of COPE is that it enables staff to identify problems and to try solving them by changing how they provide services. COPE's action-planning tool helps staff develop a realistic, time-bound plan for implementing the changes that they believe are needed and appropriate, such as by making small changes to work schedules, altering how records are organized, improving referral mechanisms, reexamining infection prevention protocols, or repairing equipment.

A review of the action plans developed during COPE exercises at the eight intervention sites indicated that across sites and in each country, staff identified remarkably similar problems. Further, the overwhelming majority of these problems (in such areas as infrastructure, equipment and supplies, human resources, and provider performance) were solved over the 15-month period. For example, infection prevention procedures were improved at all intervention sites in Guinea and Kenya (as a result of special training sessions organized by staff); in contrast, these did not change at the control sites. Staff at intervention sites also cleaned and organized facilities, made signs listing available services, resolved water-supply issues, dealt with pest infestations, and improved waste disposal, among others.



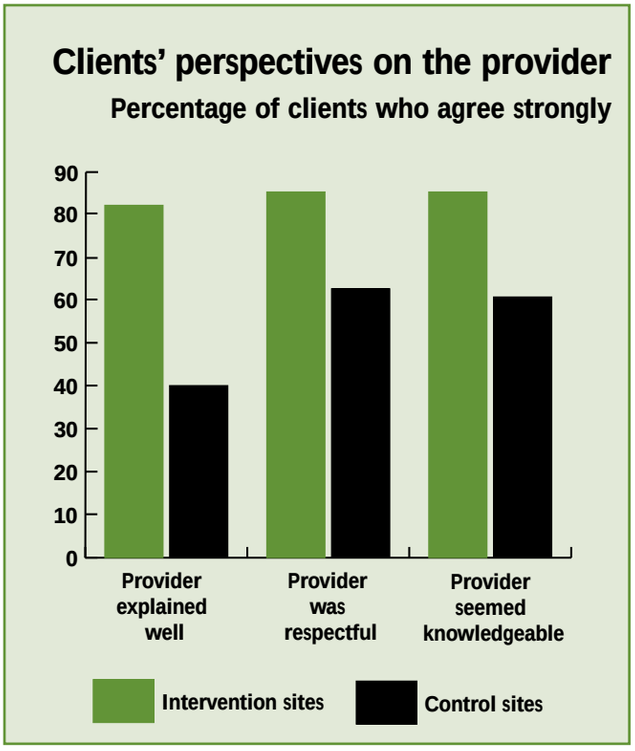

Staff at all intervention sites thought that an important quality problem was the failure to offer clients enough information. By the end of the COPE intervention, Kenyan staff reported progress on giving more health talks in the facility, on working with men in the community, on addressing nutrition issues, and on placing more emphasis on home care for the child. In Guinea, staff at most sites decided to provide the community with more information about such diseases as malaria and diarrhea and about immunization and family planning.

## *Providers' attitudes and behavior*

Promoting participation and teamwork are fundamental aspects of COPE. Focus groups and interviews in both countries suggested that the COPE exercises helped break down barriers in the workplace. For example, a Kenyan participant observed that "colleagues now volunteer to help those who are very busy, without being asked."

The process of interviewing clients enabled staff to reexamine their own behavior toward clients. Clients often revealed to clinic staff that providers were too harsh, that the time they spent with clients varied too much, that waits often were too long, and that privacy was more important to clients than staff seemed to believe. By the end of the study period, staff at the intervention sites were judged by the evaluators to have become more respectful of and more attentive to clients.

COPE's focus on helping staff identify and address management problems also had a clear impact on their per-




ceptions of the workplace. After 15 months of COPE exercises, staff members at intervention sites had significantly higher morale and were more satisfied with their jobs than were respondents at control sites. Staff at the intervention sites in both Guinea and Kenya also had much more positive feelings toward management than they had had in 1999, whereas staff at the control sites had become even more disillusioned and negative with the passage of time. For example, in Guinea, the proportion of staff who agreed strongly with the statement that "staff here have high morale" increased from 52% in 1999 to 77% in 2001 at the intervention sites, but fell from 48% to 18% at the control sites.

## What the Findings Suggest

The evaluation of COPE (in this instance, for child health services) confirms that the process can have a dramatic effect on the way people work and on the services they provide. Offering local health care providers a measure of support, encouraging them to talk about their problems, and empowering them to change the environment in which they work can create impressive improvements in the quality of health care services, leading to better services and happier clients.

Health care providers in developing countries struggle daily with problems arising from a poor infrastructure, a lack of funds and supplies, and bureaucratic barriers. The local use of a down-to-earth performance improvement tool such as COPE may help ameliorate some of the effects of these broader problems at individual facilities.

Yet enhancing the performance of health care providers is not just a local issue. One of the future challenges of promoting quality improvement globally will be adapting approaches that encourage local ownership of solutions and empowerment of providers so they can meet national and regional priorities.

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1. For example, Lynam, P., McNeil Rabinovitz, L., and Shobowale, M. 1993. Using self-assessment to improve the quality of family planning clinic services. *Studies in Family Planning* 24(4):252–260; Bradley, J. 1998. Using COPE to improve quality of care: The experience of the Family Planning Association of Kenya. *Quality/Calidad/Qualité* No. 9. New York: Population Council; and Dohlie, M.-B., et al. 2000. COPE, a model for building community partnerships that improve care in East Africa. *Journal for Healthcare Quality* 22(5):34–39.

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