



TECHNICAL BRIEF

June 2005

COPE® FOR MATERNAL HEALTH SERVICES: EXPERIENCES FROM THE FIELD

INTRODUCTION

All women need high-quality services during pregnancy, childbirth, and the postpartum period to safeguard their health and prevent death and disability. However, many women in developing countries, especially those who are poor, undereducated, or live in rural areas, do not receive basic maternity care.

In an effort to increase the proportion of women who receive high-quality maternal health services, Family Care International is implementing a multi-faceted project, the Skilled Care Initiative (SCI), in three countries in sub-Saharan Africa with funding from the Bill & Melinda Gates Foundation (see box, right). A key focus of the SCI approach is to improve the quality and accessibility of maternity care offered in health facilities. As part of this strategy, FCI is implementing an innovative quality-improvement process called COPE® for Maternal Health Services.

This technical brief describes the COPE® for Maternal Health Services methodology; the process of implementing COPE® in the SCI project districts and some of the key challenges encountered; and its adaptation for use in mid-level health facilities.

SAVING WOMEN'S LIVES: THE SKILLED CARE INITIATIVE (SCI)

The Skilled Care Initiative aims to ensure that all women have access to high-quality, skilled care so that pregnancy-related problems can be detected and treated before they become fatal. The Initiative is working in selected districts in Burkina Faso, Kenya, and Tanzania to:

- **strengthen** government commitment and policies to increase skilled care during childbirth,
- **improve** provider performance through training and supervisory support for midwives and other skilled health professionals,
- **provide** essential equipment and supplies along with inputs to strengthen routine maintenance and resupply,
- **reinforce** linkages for referral, and
- **increase** utilisation of services by supporting behaviour change interventions in the community.

COPE® FOR MATERNAL HEALTH SERVICES

COPE® (Client-Oriented, Provider-Efficient) is a quality-improvement approach that was originally developed for improving family planning services, and has been adapted for a range of reproductive health services. Through a participatory and team-oriented approach, COPE® aims to empower health workers to improve quality of care in their own facility, often through simple and inexpensive changes they can make themselves. As part of the SCI project, the maternal health version of COPE® was developed by EngenderHealth and field-tested in selected SCI districts (see next section).

A standard set of methods and tools are used to facilitate the introduction of Maternity COPE® at health facilities. These include:

- **Self-assessment guides** focussed on a set of eight clients' rights and three providers' needs.¹ These questionnaires enable health personnel to appraise the quality of each element of maternal

¹ The original set of tools developed by EngenderHealth included seven clients' rights (e.g., Rights to Information; Access to Services; Informed Choice; Safe Services; Privacy and Confidentiality; Dignity, Comfort and Expression of Opinion; and Continuity of Care) and three providers' needs (Facilitative Supervision and Management; Information, Training, and Development; and Supplies, Equipment, and Infrastructure). FCI developed an additional assessment guide focussed on clients' rights to Compassionate, Caring Treatment.

health care (e.g., antenatal care, labour and delivery care, emergency obstetric care, and postpartum care).

- **Client exit interviews** to promote the exchange of information between health staff and clients about the quality of care offered in health facilities.
- **Client flow analysis** to assess clients' waiting times and the amount of time spent with providers.
- **Obstetric records review** to assess how well clients' records have been completed.
- **Action plan** to summarise the problems identified and to identify their root causes and specific actions to address them.

Similar to the original COPE® methodology, Maternity COPE® is a tool designed for ongoing, regular use so that health providers are engaged in a continuous process of assessing and improving the quality of care at their facility.

IMPLEMENTING MATERNITY COPE® IN SCI PROJECT DISTRICT HOSPITALS

As part of the SCI package of interventions to improve the quality and availability of maternal health care, FCI has field-tested and introduced Maternity COPE® at selected health facilities in Burkina Faso, Kenya, and Tanzania.² This section describes the process for implementing COPE® at the hospital level, the types of problems in maternity care that were identified, the solutions proposed, and some of the key challenges/constraints encountered.

In each district, experienced facilitators familiar with COPE® tools first introduced Maternity COPE® to FCI staff and district health management teams. Following this initial introduction, COPE® sessions were carried out over three to four days at each district hospital in the project sites. Staff from each of the key departments involved in providing maternal health care (e.g., the maternity, MCH/FP, gynaecology ward, and operating theatre), as well as support departments (pharmacy, laboratory, maintenance, accounting, and administration) participated in the sessions.

Through an introductory session using a variety of adult learning methods, the COPE® philosophy and quality appraisal tools were introduced to hospital administrators and participating staff. Thereafter, staff were divided into small working groups (four to five individuals each) comprised of representatives of various departments. Each team was assigned one to two self-assessment tools, which guided them in investigating the quality of maternal health care through the lens of different clients' rights and providers' needs. On subsequent days, staff carried out client exit interviews and conducted the obstetric records review and client flow analysis.³ On the last day of the session, each team developed an action plan, which outlined a range of problems and possible solutions, specified timelines, and designated a person responsible for the implementation of each solution. The action plans were presented to the other teams for input and feedback.

As described in the table in the insert, the COPE® action plans highlighted a range of clinical, managerial, and logistical issues, and their solutions. To encourage follow-up action, COPE® participants nominated a COPE® facilitator and committee members to coordinate activities and to take the lead in organising follow-up COPE® sessions at the facility.

At hospital sites where COPE® was introduced, the sessions were well-received by staff and generated a range of insights into gaps in quality of care. COPE® worked very well at a university teaching hospital in Burkina Faso where it was introduced; the approach was judged to be effective and motivating by participating staff, elicited good levels of staff participation, and resulted in a number of concrete improvements, both in maternity care and general services.

In Kenya, however, successful implementation of COPE® in district hospitals was hampered by the scarcity of maternity personnel and the way maternal health services are organised. Maternal health services are delivered by multiple departments of a hospital—e.g., the MCH unit, maternity ward (including labour and delivery and postpartum areas), gynaecology ward, and operating theatre—as opposed to a single department. Although the COPE® approach is designed to be conducted on-site during normal working hours (which

² Maternity COPE® was introduced in selected sites beginning in 2002 in Burkina Faso and in 2003 in Kenya. In Tanzania, COPE® is being introduced in 2005.

³ In Burkina Faso, the client flow analysis was deferred.

SELECTION OF PROBLEMS IDENTIFIED AND SOLUTIONS GENERATED THROUGH COPE®

PROBLEM	SOLUTIONS
CLINICAL	
Gaps in counselling for antenatal clients (Burkina Faso)	Exit interviews indicated that providers do not discuss key antenatal messages (e.g., pregnancy danger signs); after a training/update, providers began incorporating this information in their antenatal counselling.
Unnecessary vaginal exams (Burkina Faso)	A lack of information and training among providers resulted in too many vaginal exams being performed. A short training/update for providers was proposed to address this problem.
Vital signs not taken (Kenya)	Providers did not consider taking vital signs an essential activity; it was recommended that all midwives be trained on the importance of taking and recording vital signs.
MANAGERIAL	
Frequent stock-outs of drugs (Burkina Faso, Kenya)	In Burkina Faso, drug stock-outs were related to poor inventory management; once the pharmacist/chemist was trained in how to maintain inventories, the problem was resolved. In Kenya, stock-outs were the result of the unavailability of supplies at the central warehouse. The proposed solution focussed on better management of hospital orders.
Long client wait times (Kenya)	A shortage of staff was the main cause of long wait times, and the teams proposed that staff schedules be reorganised to better serve clients.
LOGISTICAL	
No signs showing where services are available (Kenya, Burkina Faso)	In Burkina Faso, clear signs were placed in prominent locations. In Kenya, signs were not available in local languages, and it was agreed that sign posts with relevant information in the local language be placed in the hospital.
Lack of privacy (Burkina Faso)	During counselling sessions with clients, providers kept doors open; doors are now closed to maintain privacy and confidentiality.

enables staff to participate while also attending to their routine duties), it proved logistically difficult to involve staff from departments in a group exercise while they were also responsible for attending to clients in their respective wards. In addition, due to severe staffing shortages, there are usually only a few providers working in a department or ward during any given shift. This made it possible for only one or two representatives from each department to participate in the COPE® exercise. A critical mass of maternity staff was not able to participate—a constraint that limited the impact of the exercise. Staffing shortages also constrained COPE® follow-up in Kenya because the COPE® committees consisted of staff from different departments who worked on different shifts and found it difficult to meet regularly and to coordinate follow-up exercises.

ADAPTING COPE® FOR HEALTH CENTRES AND OTHER MID-LEVEL FACILITIES

FCI field-tests indicated that the Maternity COPE® tools in their standard format were not entirely suited for use in mid- and lower-level facilities, such as sub-district hospitals and health centres. At this level of the health system, the total number of staff in each facility is considerably fewer. There are generally not enough staff members available to form several small working groups for the COPE® self-assessment exercise, making it very difficult to go through all the questionnaires in one session. This limits the extent to which the exercise can cover all aspects of maternity care and can compromise the collective identification of problems and solutions that is a hallmark of the COPE® methodology.

In response to this challenge, COPE® organizers in Burkina Faso and Kenya each independently modified the COPE® process, opting for slightly different approaches. In Burkina Faso, the facilitators decided not to use all the COPE® self-assessment guides during the first COPE® exercise. They selected about half the guides, focussing on those that which facilitators and staff agreed were most critical, such as clients' rights to access and safe services. The remaining guides were reviewed in a subsequent COPE® exercise. This strategy was felt to work well because the site could review the problems and solutions from the first COPE® at the same time as it identified new problems and solutions (based on the rest of the guides) during the second exercise. In the third and subsequent COPE® exercises, the site staff found that they were able to complete all the guides, since a number of problems had already been solved and therefore they could progress more rapidly through the questions.

In Kenya, the COPE® guides themselves were modified—pared down and re-focussed on the specific maternal health services provided at mid-level facilities. The number of questions in each self-assessment guide was reduced to approximately 10 to 20 questions, and duplicative questions were eliminated since all staff would be involved in reviewing each guide (as opposed to dividing up the guides among different working groups). Other COPE® tools such as the obstetric records review, the client flow analysis, and action plan remained unchanged. Field-testing of the simplified COPE® tools has been conducted at three sites in Kenya; the abbreviated self-assessment guides were reviewed by the entire staff in a one-day meeting, followed by sessions on subsequent days for review of the other tools. The simplified version of Maternity COPE® was well-received by staff, and a range of problems and simple solutions were identified (e.g., changes to the facility set-up and staffing schedule to ease congestion, on-site training and updates on specific skills, etc.). At the same time, however, COPE® highlighted many systems management and infrastructure problems (e.g., inadequate supplies, incorrectly constructed sluices for wash-water drainage from labour ward floors, etc.) that staff were not able to easily address on their own; many of these required long-term involvement and commitment, and were brought to the attention of higher-level officials for follow-up.



Staff of Yourga health centre in Burkina Faso review progress on their COPE® action plan.

MOVING FORWARD WITH COPE®

Based on SCI field experiences in Kenya and Burkina Faso, COPE® for Maternal Health Services has shown to be a promising quality improvement approach because of its focus on both clients' and providers' perspectives, as well as its emphasis on self-appraisal, teamwork, and all-staff participation. The experience has underscored the fact that maternal health providers are well-positioned to identify critical quality of care problems at their facility and to suggest strategies for addressing them. However, as noted above, several challenges and constraints were encountered in the introduction of Maternity COPE® at both hospital and health centre levels, which yielded some key observations and lessons learned for future work:

COPE® FROM A USER'S PERSPECTIVE

"We completed our fourth COPE® the day before yesterday. COPE® has been very useful. We keep finding new problems to solve. Clients were complaining of mosquitoes in the postpartum area and said they wanted sheets on the beds. Now that we have put sheets and mosquito nets, the new mothers are happy. Through the client interviews we see that antenatal clients have noticed the positive changes, too."

—Health centre staff member, Burkina Faso

- **Involvement of health administration in Maternity COPE® is essential for its continued use at health facilities.** The participation of administrators and district managers in the COPE® exercise, as recommended in the COPE® guidelines, fosters ownership, builds support, and secures buy-in for improving the quality of services. Conversely, scepticism or reluctance on the part of district managers can dampen the enthusiasm of facility-based staff who initially reacted very positively to the way COPE® helped them solve problems. In Burkina Faso, for example, a lack of involvement on the part of the district team suggested that their understanding of the approach was still sketchy and led SCI staff to organise a second COPE® orientation session.
- **COPE® should be tailored for the specific departments involved in maternal health care at the hospital level and the services being offered at mid-level facilities.** In Kenya, due to the practical and logistical challenges involved in securing the participation of enough maternal health care providers from key departments at the hospital level, it is strategic to carry out departmental COPE® exercises so that the majority of maternal health care providers in each ward or department can contribute to the exercise. At mid-level health facilities, it is important to focus the self-assessment tools on the specific services available and to avoid duplication between the guides.
- **Including community health committees in COPE® can help mobilise funds for improvements at health facilities.** Composed of community members and health staff, the committees can provide a mechanism for implementing the solutions identified through COPE®. Their participation also strengthens the links between the health facility and surrounding community, promoting shared problem-solving and mutual accountability. In Burkina Faso, the involvement of community health management committees (known in French as *Comités de Gestion* or *CoGests*) in COPE® exercises helped infuse a client/community perspective into discussions.
- **Prioritising of identified problems can yield more concrete and actionable solutions.** The action plans often result in a long list of quality-related issues, and staff can feel overwhelmed in trying to identify their root causes and possible solutions. Prioritising the problems that were most feasible to address made the process easier and more manageable.
- **Regular follow-up is needed to ensure that COPE® becomes self-sustaining and continues to improve the quality of services offered.** After the initial introductory exercises have been completed, it is usually necessary to provide some continued support, initially to help site staff develop confidence in facilitating COPE® and later to assist staff in addressing logistical or technical constraints to sustaining the process. Some resource or training inputs to support problem resolution, even if modest, are also a source of motivation for site staff to continue using COPE®.

