Summary Report on the COPE Approach to Safe Abortion Services in Nepal

BACKGROUND

The COPE (client-oriented, provider-efficient) approach originated as a quality improvement process for family planning services and was developed by Engender Health, which has been developing and refining the COPE technique and tools since 1988.

COPE is a client-centered approach to performance assessment that helps health-care staff to improve the quality of services provided by their facility and makes services more responsive to the clients' needs. Since COPE involves self-assessment, it promotes a sense of ownership among staff. When all levels of staff assess their own services, rather than undergoing an external evaluation, they feel personally responsible for correcting any identified issues with regard to quality or effectiveness. COPE also enables staff to explore opportunities to develop and implement action plans to improve services and fosters a sense of accountability and commitment to carry out these action plans. It also promotes teamwork and cooperation among all levels of staff. COPE utilizes self-assessment checklists and other tools to address the provision of quality comprehensive abortion care. By using the tools together, supervisors and staff become accustomed to working as a team.

Studies have indicated that COPE has been successfully implemented in several countries around the world.[1] Since 2013, Ipas Nepal has been implementing this approach in its intervention health facilities across 15 districts, but the effectiveness of COPE in the Nepalese context is yet to be evaluated. The overall purpose of this study was to assess service availability, service site readiness, providers' support,

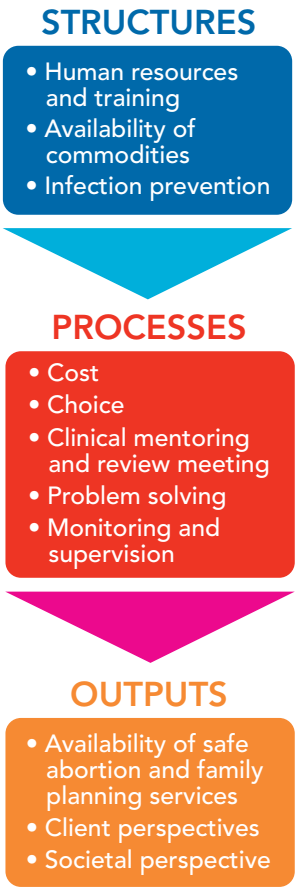
[1] Dohlie, M., Mielke E., Bwire T., Adriance D., Mumba F. COPE, a Model for Building Community Partnerships That Improve Care in East Africa. *Journal for Heatlhcare Quality,* 2000;22(5):34–39.

logistic supply, monitoring and Health Facility Operation Management Committee (HFOMC) support among COPE implemented and non-implemented health facilities. The results of this study will inform any future scaling-up of the approach in Ipas intervention districts and beyond.

METHODOLOGY

This was a comparative study using a blended qualitative and quantitative approach. Two districts were selected for the study. One district, where Ipas has been supporting COPE embedded within a package of technical support to Safe Abortion Service(SAS), served as the intervention district. Another district, where Ipas previously provided technical support but now the district is providing service on its own, was selected as the comparison district. For this assessment, client exit interviews (CEIs), Safe Abortion Service (SAS) record review, site assessments and COPE meeting record review provided quantitative information. Focus group discussions (FGDs), in-depth interviews (IDIs) and COPE meeting observation provided qualitative information.

Figure 1. Quality of care components covered



Twenty health facilities were purposively selected for the study, 11 from the intervention district and nine from the comparison district. Site assessments and SAS record reviews were conducted at both intervention and comparison study health facilities to assess service provision and the availability of human resources and commodities to provide SAS and contraception. A total of 19 focus-group discussions were conducted in the intervention district (10) and comparison district (9) with Health Facility In-charges (excluding hospital medical superintendents), service providers (at least one from each study facility) and HFOMC members to explore the extent of monitoring, supervision including recording in logbook, clinical mentoring and sustainability of the COPE process. Additionally, in the intervention district, seven COPE meeting records reviews and two COPE meeting observations were conducted to explore the effectiveness of COPE meetings and implementation of COPE action plans. Finally, 66 client exit interviews were conducted with women who received medical abortion (MA) services during the study period in the intervention district to assess their views regarding societal perspectives on abortion.

Qualitative data were analyzed manually using a content analysis. Quantitative data from the CEIs and SAS record review were entered in EpiData 3.1 and analyzed using SPSS 16. Frequency, percentage and mean scores were presented for intervention and comparison facilities in order to compare the descriptive findings. The Donabedian model, which conceptualizes three dimensions of quality-structure, process and outcome, was used to analyze the results. Figure 1 presents a summary of how quality of care was assessed.

FINDINGS

Structures

Human resources and training

Almost all intervention health facilities had two or more service providers trained in MA, implant and IUCD, but in the comparison district, most health facilities had only a single service provider and some health facilities had no trained service providers at all. IDI participants in intervention health facilities reported that regular review and refresher trainings were organized for service providers, but participants in comparison facilities said that there were no review and refresher trainings.

Availability of commodities

All medicines (combi-packed mifepristone/misoprostol and ibuprofen) were supplied from the District Public Health Office (DPHO) in intervention sites. Study participants in intervention sites expressed that Health Facilities had maintained a stock of supplies in the last three months. Supplies were requested at DPHO in time to maintain authorized stock level. All the medicines, contraceptives, MA drugs and MVA sets were received from the government system; Ipas had a supportive role in strengthening the existing system. Drugs at HFs were stored properly. COPE meeting review records showed that all intervention health facilities had sufficient numbers of thermometers, MA drugs, HMIS forms and MVA aspirators at service sites unlike comparison sites where MA drugs, examination lights, client personal profile forms, IUCD insertion and removal sets, implant insertion and removal sets were found to be insufficient (Table 1).

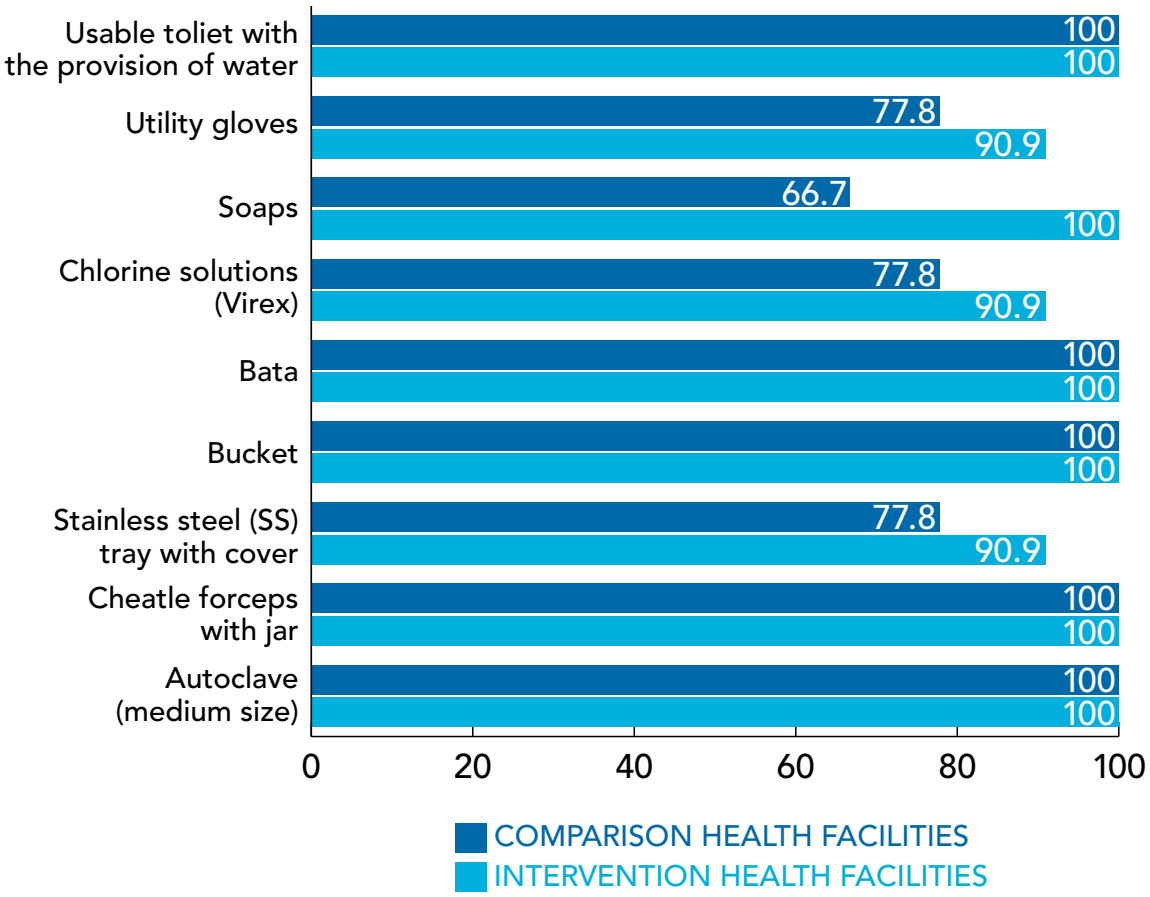
Table 1: Availability of materials in service rooms at intervention (n=11) and comparison (n=9) sites

Adequacy of materials in service room	Intervention Site		Comparison Site	
	Number	%	Number	%
Examination table with Rexene and footsteps and hand support	11	100.0	9	100.0
Speculum, (1 small and 2 middle size)	11	100.0	9	100.0
Thermometer	11	100.0	7	77.8
MA drugs (combipack)	10	90.9	6	66.7
Light (for examination)	9	81.8	8	88.9
Ibuprofen tab	11	100.0	9	100.0
Misoprostol tab	11	100.0	8	88.9
Client Person Profile forms (CPP)	10	90.9	8	88.9
HMIS 3.7	11	100.0	7	77.8
IUCD insertion and removal set	9	81.8	6	66.7
IUCD commodities (IUCD-380A)	9	81.8	8	88.9
Implant insertion and removal set	10	90.9	6	66.7
Implant commodities	9	81.8	7	77.8
Other contraceptives (Pills, condom, depo)	10	90.9	9	100.0
Water with tap and functioning water outlet pipe	11	100.0	8	88.9
Examination gloves	11	100.0	9	100.0
MVA Aspirator with Cannula 4, 5,6,7,8.	11	100.0	3	33.3

Infection prevention

Intervention health facilities had higher achievement of all infection prevention management criteria compared to comparison health facilities. Comprehensive approach (minimum requirement) and the practice of IP protocol and sanitation were maintained at intervention sites. It was found through site observation that all facilities in both the intervention and comparison districts had sufficient numbers of autoclaves, cheatle forceps, buckets, 'Bata', soap and usable toilets with the provision of water. However, the comparison district had fewer health facilities with a sufficient number of stainless steel trays with cover, Virex and utility gloves compared to the intervention district. (See Figure 2.)

Figure 2. Availability of adequate materials for infection prevention



Processes

Cost

Service cost is also a determinant of the utilization of SAS and FP services. Study participants in both intervention and comparison districts reported that the service charge for MA services was Rs. 500, and all services related to family planning were free of cost. Poor clients were provided free MA services in intervention sites but most of the comparison sites did not provide free services to those who were not able to pay.

Choice

Service choice, for both abortion care and a contraceptive method, is one of the indicators of quality service. After the implementation of COPE, clients in the implementation district reported having access to better service choices than in the

comparison district. Clients were given choices among the available options on SAS and contraceptives. Benefits and harms of available services were explained to help them to make an informed decision. In a case of unavailability of second-trimester services at HFs, providers referred such cases to higher-level facilities, usually to Koshi Zonal Hospital.

Clinical mentoring and review meetings

At intervention sites, the FGD participants mentioned that the clinical mentor contacts them regularly; Ipas also follows up and provides support on programmatic issues. Participants felt that review meetings for MA and FP service providers were scheduled in a timely fashion.

Problem solving

Most of the participants of intervention sites recognized COPE as a problem-solving approach at the local level. Following COPE implementation, a meeting was organized every three months. In such meetings, problems were discussed among the COPE members (includes in-charge, service providers, HFOMC member, Youth, FCHV, community leaders), action plans were prepared, task divisions were assigned, local resources were explored, and follow-up plans were prepared and implemented. In regards to the COPE action plan, in one-year duration, 1,929 plans were prepared. Out of these, 70 percent (1,347) were completed; around 20 percent (387) were ongoing while the remaining 10 percent (195) were not started. Regarding the type of action plan, nearly one-third of plans (32 percent) were related to the provision of quality SAS, followed by plans related to equipment and supply (19 percent), provision of IEC/BCC services in the community (19 percent) and provision of contraceptive service (15 percent). Clinical issues were only mentioned in 5 percent of the plans. In comparison sites, the problem solving was process was not conducted in an efficient way. There was a practice of discussing problems during HFoMC meetings, however, no systematic approach was followed for problem solving.

Monitoring and supervision

Study respondents of intervention sites described monitoring for quality services as a regular activity in the district. Integrated supervision was also done from DPHO. Ipas monitored frequently and provided guidance to providers for quality improvement. In most of the comparison sites, respondents expressed that monitoring and supervision were regular and systematic for SAS while Ipas worked in the district. However, after Ipas left the district, no separate monitoring for SAS was done by DPHO. Integrated monitoring was in place, but it was not functioning well.

Recording and reporting

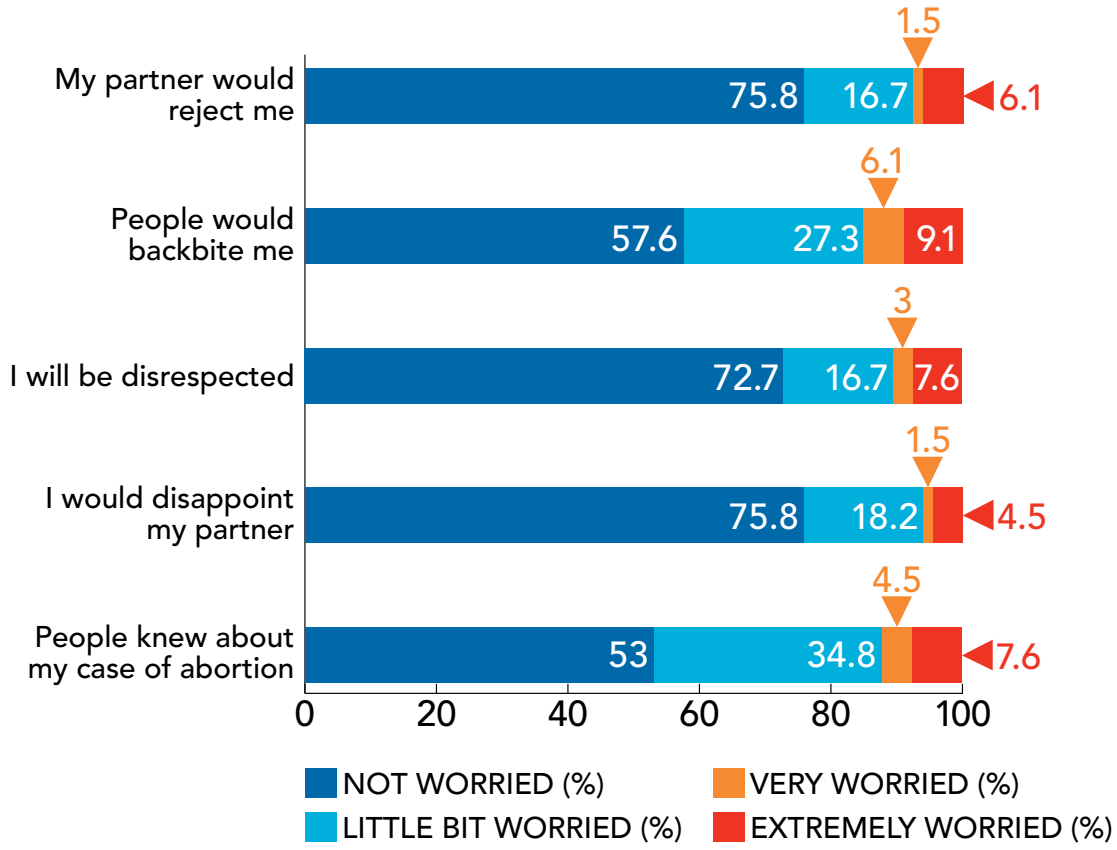
Study participants in both intervention and comparison sites mentioned that they had a system of managing and maintaining service records. However, the record keeping was more effective in intervention sites as compared to comparison sites. There was a separate room, cupboards and tables with a lock system to keep the registers safe and private. Personal details of clients using safe abortion service were recorded in a separate register and reported to DPHO every month. Some of the service providers in comparison sites faced a shortage of HMIS forms. They realized that their recording and reporting system was more effective when Ipas supported them.

Outputs

Clients' Perspectives

SAS clients in intervention sites were asked if they were worried about people in their community knowing about their utilization of SAS. Responses were classified into four categories: 'not worried', 'little worried', 'very worried' and 'extremely worried'. It was found that nearly half (53 percent) of the respondents were not worried that people in her community may know about her abortion. About 13 percent were found either very worried (5 percent) or extremely worried (8 percent). Additionally, when asked if their partner would be disappointed in their decision to utilize SAS,76 percent of respondents had no worry about this while 5 percent were extremely worried that their partner would be disappointed.

Figure 3: Clients' views on societal perception toward safe abortion (n=66)



Perception of society toward women who have had an abortion

Regarding societal perception of women who have had an abortion, 44 percent of respondents said society thought of them as a bad person. Likewise, 42 percent replied that society thought abortion was a sin. Nearly 14 percent of study participants responded that society hates women having abortions, while 10 percent said society considers them as unfaithful to their partner (see Table 4).

Table 2: Perception of society towards women who did abortion* (n=66)

Perception of society towards women who did abortion	Number	%
Sinful activity	28	42.4
Rejection by partner or husband	11	16.7
Not allowed to go to holy places	6	9.1
Hate from society	9	13.6
Selfish woman	16	24.2
Not faithful to partner	7	10.6
Not a good woman	29	43.9

*multiple response

Availability of safe abortion and family planning services

Almost all the health facilities in the intervention district were providing MA services, and some were providing MVA services. All the intervention health facilities had availability of five contraceptive methods (condoms, pills, depo, IUCD and implants) throughout the year. In the comparison district, the majority of the health facilities were providing MA and few were providing MVA services. Likewise, family planning services were not as comprehensive as in intervention district.

Sustainability and ownership

PHN and DPHO of intervention district seemed satisfied and mentioned that COPE was very effective for quality SAS, fulfilling minimum requirements through local initiation. They clearly mentioned that health facility staff including HFOMC members, youth representatives and FCHVs conducted regular meetings, discussed problems and identified solutions through planning and actions. They added that COPE facilitated collective actions to solve the problem. They opined that by preparing action plans, generating local support, coordinating and making the decision at local level, the use of COPE helped to increase client's satisfaction. It helped to enhance ownership and sustainability of improvements made to the system. Overall, participants agreed that the COPE approach needs to be continued.

"COPE approach helps in many things...last time we decided on the importance of involving youth group in a meeting. We also achieved the availability of materials required with the help of this approach.

IDI Respondent, intervention site

Ownership for continuation of COPE

Once staff are empowered, they become more responsible and accountable to their duties. The most important skills service providers at intervention facilities developed were information sharing, coordination, teamwork and decision-making. They were solving their problems by themselves, which signals the increase in ownership which ensures sustainability. They felt that the COPE approach could be sustained if the support of Ipas could be continued for few more years.

"We are developing our capacity for planning and implementing…. We will continue the COPE process but we need support from DPHO and Ipas, so that we can lead ourselves at the local level in future."

IDI, HFOMC, Intervention site

CONCLUSION AND RECOMMENDATION

COPE is associated with improvements in the regular availability of SAS service for infection prevention commodities, informed choice of abortion methods, use of local resources and sense of community ownership for the service continuation. It is one of the effective approaches to improve quality of care at HFs. It was encouraging to note that 90 percent of COPE action plans were either completed or at the implementation stage. However, societal perception of abortion is still not positive and clients were more worried about societal stigma than interpersonal stigma from family. It is recommended that COPE meetings be held regularly, that supply chains be improved, and that there be an additional focus on community sensitization activities to dismantle communities' negative perception towards abortion.

LIMITATION

The assessment in the intervention district was carried out in current Ipas intervention sites whereas there is no intervention in the comparison district. As a result, the observed differences could also be influenced by other components of the Ipas intervention (e.g., providing training and support for sites/providers) in addition to the COPE approach.

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