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COPE

Client-Oriented Provider-Efficient *Services*

A Process and Tools for
Quality Improvement
in Family Planning
and Other Reproductive
Health Services

AVSC International

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Foreword

Service providers working in hospitals and clinics are often seriously handicapped in giving high-quality care to clients who come for family planning and reproductive health services. This is true nearly everywhere, but especially in the resource-poor settings that we find in developing countries.

There frequently are too few staff given the demand for services. Money, resources, and supplies are inadequate. Facilities may be in disrepair. There are conflicting demands on time. Services are disorganized. Training programs may have inadequately prepared providers with the skills and knowledge they need. Typically, visits and help from supervisors or managers from headquarters are infrequent, brief, and focused more on inspection rather than facilitative problem-solving.

Yet, despite these many obstacles, local service providers continue to work and try to do the best they can with what they have. Therefore, AVSC developed COPE to be a low-technology technique that would help local service delivery teams help themselves. COPE provides a means for local teams to assess their own work in order to identify and find solutions to problems in their facility. COPE also helps providers become more aware of the wants and needs of their clients.

Of course, not all problems concerning the quality of services can or should be solved locally. Local teams will continue to require standards and guidelines, appropriate training, problem-solving supervision, and the material and financial resources that only their headquarters or national institution can provide.

COPE is but one intervention to be applied in a comprehensive quality-management system. Nevertheless, we have found that some of the biggest gains in improving the quality of services happen when local providers discover through COPE that they can work together as a team to solve many of their problems.

This handbook compiles and reflects the lessons AVSC and its counterparts from more than 20 countries have learned over the last decade in developing, applying and evaluating COPE. We expect that the techniques and tools described in this handbook will be adapted by each institution to its own needs and circumstances. COPE needs to be integrated with other interventions and techniques for improving quality.

As you apply, adapt, and integrate COPE, we hope you will share your lessons and improvements with us and others.

Terrence W. Jezowski
Acting President
AVSC International

Summer 1995

Acknowledgments

With the aid of a grant from Mrs. Jefferson Patterson and with support from the U.S. Agency for International Development, AVSC International has been developing and refining the COPE technique since 1988, continually feeding lessons learned about what works and what does not work back into the COPE process. This evolution continues as we and our colleagues find better ways to work in our joint efforts to improve the quality of services for clients.

By the end of 1994, COPE had been conducted in 20 countries and in more than 100 service-delivery sites. The lessons learned from this experience have been incorporated in this handbook. AVSC has also adapted and combined several quality resources in the development of COPE, most notably:

- Computerized Patient Flow Analysis of Local Family Planning Clinics (Graves et al. 1981)
- Fundamental Elements of the Quality of Care (Bruce 1989)
- Handbook of Indicators for Family Planning Program Evaluations (Bertrand et al. 1993)
- Quality of Care in Family Planning: Clients' Rights and Providers' Needs (Huezo and Diaz 1993)

We thank the staff of all the institutions and sites that have participated with us in the development of COPE. Special mention is due to the individuals, organizations, and institutions that pioneered the use of COPE. These include:

The Family Planning Association of Kenya
The Ministry of Health, Kenya
The Christian Health Association of Kenya
The University College Hospital, Ibadan, Nigeria
The Imo State Ministry of Health, Nigeria
Staff of AVSC International's Africa offices

A number of AVSC staff members contributed to the production of this handbook. Joseph Dwyer, director of AVSC's regional office in Nairobi, originated the idea of COPE and provided leadership in its evolution and implementation. Grace Wambwa, senior program officer in the Nairobi office, and Mofoluke Shobowale, senior program officer in AVSC's Nigeria office, helped with the initial development of COPE and its introduction in many Sub-Saharan African countries. Frances Way, of Planned Parenthood of Wisconsin, assisted in the adaptation of the Client-Flow Analysis tool.

The handbook was written primarily by Dr. Pamela Lynam, senior international advisor on quality, based on her extensive experience introducing and adapting COPE. Jan Bradley, evaluation and research officer based in Nairobi, was responsible for developing the tools in a format that focuses on client rights and provider needs. Karen Beattie, associate director of evaluation and research, reviewed and revised the handbook with comments and assistance from the following AVSC staff: Jan Bradley, Phyllis Butta, Charles Carignan, Nick Danforth, Sally Girvin, Pamela Beyer Harper, Jeanne Haws, Fatma Uz, Terrence Jezowski, Barbara Jones, Evelyn Landry, Amy Pollack, Mofoluke Shobowale, Grace Wambwa, David Wilkinson, and Cynthia Steele Verme.

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How to Use This Handbook

COPE was developed to help clinics and hospitals focus on improving the quality of their family planning services and to help them use their resources more efficiently. Although originally developed with an emphasis on improving sterilization services, COPE has grown over time to include services for temporary methods of contraception and other reproductive health services (for example, postabortion care, services for men, access to referrals for services not provided at the clinic or hospital, and services for reproductive tract infections, including sexually transmitted diseases such as HIV infection).

An experienced COPE facilitator usually helps a site perform its first COPE exercise. In the course of the first COPE exercise, this facilitator also trains a staff member to be the facilitator for future COPE exercises at the site. This handbook was developed as a resource for trained COPE facilitators and site facilitators. It contains all the elements needed to facilitate a complete COPE exercise.

This handbook contains information on the following:

- Initiating COPE and helping sites prepare for a COPE exercise
- Facilitating the COPE Introductory Meeting
- Using the four COPE tools (Self-Assessment Guides, Client Interviews, Client-Flow Analysis, and the Action Plan)
- Facilitating the Action Plan Meeting
- Conducting COPE follow-up

Sample letters, schedules, and completed samples of forms are included throughout the text. The appendixes include a blank copy of each form and guide used during the exercise. For sites that perform sterilization, an explanation of the Sterilization Record Review is also included as an appendix.

ADAPTING COPE

COPE is meant to be adapted to the specific needs of each hospital and clinic that conducts a COPE exercise. COPE is conducted *by* staff, *for* staff: because staff needs in each site are different, COPE will be different in every site. When adapting the COPE tools to a specific site, facilitators and site administrators should keep COPE's key principles in mind: self-assessment and the use of local action and existing resources to identify and resolve problems.

Facilitators should treat the information in this handbook as suggestions, not instructions. Facilitators should not feel obligated to use every part of this handbook at every exercise and should not feel that the exercise must be limited to the material in this handbook. The following examples show just a few of the ways a site may choose to adapt the materials in this handbook.

Adapting the Self-Assessment Guides

Participants need not fill out the guides or limit their discussions to the questions on the guides. The questions on the guides are designed to give participants an idea of the kind of issues they can explore during their discussions. Sites may use the guides as they are, adapt the guides for their site, or develop their own versions of the guides.

Facilitators should not feel obligated to use every guide at every COPE exercise: in fact, it may be more useful for sites to use guides only for the areas where problems were identified during a previous COPE exercise.

Adapting the Client-Interview Tool

Again, the Client-Interview Form included in this handbook is meant to serve as a guide to the questions participants might ask during interviews. Interviewers are not expected to fill out the form or use only the questions listed.

Sites may wish to make client interviewing a regular part of their services: that is, providers may decide to conduct client interviews at periodic intervals, instead of doing so only during COPE exercises.

Adapting Client-Flow Analysis (CFA)

CFA was designed to help measure waiting time and staff utilization for family planning services, but this tool can be adapted for use with almost any kind of service.

To track different types of services, staff need only change the kind of information collected and coded on the Client Register Form and the Client-Flow Chart. Sites may also decide to conduct CFA simultaneously in a number of departments in the clinic or hospital and compare the results.

SHARING COPE EXPERIENCES

AVSC has been refining the COPE technique for several years and has incorporated the comments and suggestions of clinics and hospitals that have performed COPE into this handbook. Please forward any problems, suggestions, and comments from your experiences with COPE to:

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What Is COPE?

COPE, which stands for client-oriented, provider-efficient services, is a technique hospitals and clinics can use to find out how to make their services more efficient and more responsive to client needs.

COPE was developed to help providers of family planning services become more aware of the needs of their clients and use the resources they have more efficiently. Over time, it has been adapted to include references to other reproductive health services, including services for reproductive tract infections (including sexually transmitted diseases such as HIV infection), postabortion care, and services for men.

COPE is a *process* and a *practical* set of tools for improving the quality of family planning services at a clinic or hospital. It is simple to use, easy to understand, and cost effective. COPE takes little time and few resources, and, most important, COPE has been shown to work (Lynam et al. 1993; Rabinowitz et al. 1994).

MEETING CLIENT NEEDS

Because family planning is a preventive, not a curative service, the degree to which services meet clients' needs will determine whether clients choose to use the services. Often, however, client needs go unmet. In many family planning clinics, clients may wait for several hours to see a staff member for only a few minutes. In others, staff may never get together to discuss their work or to iron out difficulties—and these difficulties can mushroom into larger problems that interfere with the smooth running of the service.

Both small and large problems can affect the quality of services at a site:

- Staff schedules may be poorly organized—for example, there may be only one nurse available at the busiest times of the day

- In sites that have no signs that direct clients to the family planning clinic, shy clients who are reluctant to ask the way may leave without having found the clinic
- Services for men may not be available
- There may be no privacy for clients who are discussing personal matters like reproductive health concerns
- Sites may have inadequate infection-prevention measures
- Pamphlets, posters, and other informational materials may be locked away in cupboards—while potential clients sit in waiting areas for hours with nothing to look at or read
- As the concept of reproductive health has developed, family planning staff have been expected to incorporate new activities (for example, screening for reproductive tract infections) into their daily routine, but they may lack the training or resources to do so

These are only a few examples of the many problems staff and clients may face in providing and receiving services. Yet in all these examples, the service providers themselves could make changes that would substantially improve the quality of services.

Service providers and clients are the experts on the quality of services at their clinic or hospital, but they often have little opportunity to express their opinions or to define what they think of as “quality” services. Service providers, with the help of clients, can identify problems and develop plans for improvement. Active involvement of both clients and providers increases the likelihood that the process of improving services will be continuous.

Quality Improvement: The COPE Approach

COPE employs the main principles of quality management, which focus on meeting and exceeding clients’ expectations and needs. COPE emphasizes identifying problems in the way things are done—that is, in the “process”—rather than assigning blame. A major element in quality management, and an underlying assumption of COPE, is that quality can always be improved and that improvement of quality should be ongoing.

The most important aspect of COPE is its emphasis on *self-assessment*. COPE gives staff a forum within which to assess the quality of the services they provide. It also asks them to consider quality of service from the perspective of the clients they serve. Through COPE, service providers identify problems with services, recommend solutions, and determine the persons who will be responsible for taking action by a specific date. That the process is done by clinic staff themselves helps them commit to rectifying problems and to planning for future improvements. COPE is empowering for staff: it reinforces staff

confidence in their ability to address their own problems, and it makes continuing to do so progressively easier.

Problem identification also allows site management to justify needed policy changes or resource allocations to a budgetary authority or to provide everyone with the extra incentive needed to get things moving. “Team building” is another COPE outcome. Because COPE provides a forum for discussion, staff have an opportunity to interact with others (including their supervisors and staff from other departments) with whom they have little opportunity to communicate under day-to-day clinic conditions. With a good facilitator leading the exercise, all levels of staff can be heard.

COPE COMPONENTS

The COPE process is made up of a number of components. The four COPE tools that make up the main body of a COPE exercise are:

- **Self-Assessment**, done primarily through the use of 10 Self-Assessment Guides (see Appendix A). The guides have been organized according to the rights of the client and needs of the provider necessary to ensure quality family planning services (see Figure 1-1). A description of the self-assessment process appears on page 4.1.
- **Client Interviews**, performed by staff with the aid of a Client-Interview Form (see Appendix C). A description of the client-interview process appears on page 5.1.
- **Client-Flow Analysis (CFA)**, a “low-tech” method of tracking clients through the family planning clinic from the time they enter until they leave. AVSC recommends that sites not perform CFA at the first COPE exercise. A description of CFA appears on page 6.1.
- **Action Plan**, prepared by the staff using the other three tools, which describes the problems staff have identified, recommended solutions, and the persons responsible for completing the actions before a specific date. A description of how to prepare the Action Plan appears on page 7.1.

Other parts of the COPE process are:

- **Introductory Meeting**, in which COPE is explained to participants
- **Action Plan Meeting**, in which staff incorporate findings into the Action Plan
- **Follow-up**, both follow-up of recommendations on the Action Plan and follow-up COPE exercises

FIGURE 1-1 Rights of the Client, Needs of the Provider

QUALITY SERVICES

Clients Have the Right to:

- Clear information
- Access to services
- Their choice of family planning method
- Safe services
- Privacy and confidentiality
- Dignity, comfort, and free expression of opinion
- Continuous supplies

Providers Have a Need for:

- Good supplies and working environment
- Good management and supervision
- Clear information and training

Adapted from "The Rights of the Client," a poster created by the International Planned Parenthood Federation, and Huezo and Diaz, 1993, "Quality of Care in Family Planning: Clients' Rights and Providers' Needs," *Advances in Contraception* 9:129-139.

The COPE tools are designed to be *flexible*: providers at each site should adapt the COPE tools to meet their particular needs. Little equipment is needed to do COPE—for the initial exercise, the most important thing needed is two or three days of the time of a facilitator who can visit the site, help the staff go through the COPE process, and train a staff member as a site facilitator who will continue to conduct COPE exercises at periodic intervals. Apart from the Introductory Meeting and Action Plan Meeting, the exercise takes place as staff do their normal work.

THE COPE FACILITATOR

COPE is carried out by the site's staff (clinic staff, surgical staff, nursing staff, administrators, counselors, receptionists, ancillary staff, etc.) with assistance from an experienced COPE facilitator. For the initial COPE exercise at a site, the facilitator is often someone from the site's headquarters organization or from a technical assistance agency who has experience in conducting COPE exercises.

The Site Facilitator

For the initial COPE exercise at a site, one objective is to train one or more staff members to be “site facilitators” who will manage and follow up COPE exercises. A trained site facilitator is essential to enable staff to continue to do COPE on their own.

Ideally, an external facilitator works with the site facilitator during the first COPE exercise at a site. The site facilitator leads the follow-up meeting for the first exercise, with support from the external facilitator. Thereafter, the site facilitator conducts COPE exercises and follow-up on his or her own, with varying degrees of support from headquarters or other staff.

Facilitating COPE Meetings

CREATING A COMFORTABLE ENVIRONMENT

Staff will be more likely to participate fully if they feel physically comfortable. To achieve this, the facilitator should:

- Come prepared with the materials and supplies needed (see Figure 2-4)
- Arrange the room in an informal style
- Make sure everyone can hear
- Establish rapport and let staff know that the facilitator is on their side
- Be kind and sensitive to staff
- Relax and be natural
- Try to make participants feel at ease
- Start the meeting on time
- Use training aids (such as flipchart paper, a blackboard, samples of methods, etc.) and make sure all participants can see visual aids
- Encourage group participation in the discussions. Walk around the room instead of staying at the front.

The following pages contain tips that will help facilitators encourage full participation from staff during COPE meetings. For special points about facilitating the Action Plan Meeting, see Figure 7-1, page 7.3.

Tips for Facilitating COPE Discussions

FACILITATING DISCUSSIONS

While working with staff during the COPE exercise, the facilitator should probe a little—for example, ask participants questions if they are having a hard time being specific about problems—but without directing them. The following suggestions may help the facilitator guide participants and help keep them focused without leading the discussion.

Probe by asking open-ended questions

Open-ended questions usually begin with “what,” “where,” or “how.” These types of questions may help encourage participation from the staff, because to answer them, participants will have to think and respond at some length—the questions cannot be answered by “yes” or “no.” Open-ended questions can be used to:

- *Start a discussion:* For example, “What do you think about infection-prevention practices in this clinic?”
- *Get a member of the team more involved:* For example, “What is your opinion about infection-prevention practices in the clinic, Nurse Obare?”
- *Bring a conversation back on track:* For example, “What other information do we need to solve this problem?”

Show empathy

The facilitator should show participants that he or she understands how they feel about a situation. This helps participants feel like part of the group and helps them share their feelings and ideas. Empathy statements can start with “I can understand that it must be difficult to...,” or “I understand this is a difficult problem for you...” Empathy statements can help to:

- *Acknowledge strong emotions:* For example, when someone is showing anger, the facilitator can begin a reply with “I can see that you’re upset...”
- *Encourage people to listen:* If the participants feel that the facilitator is genuinely recognizing their emotions, they are more likely to listen to what is said.

-
- *Relieve anxiety about discussing a problem publicly:* For example, the facilitator can say, “I can understand why it would be very difficult for you to do effective infection prevention if you don’t have the supplies.”
 - *Help someone express emotions:* For example, “It sounds as if you feel very strongly about this issue, and you have had problems dealing with this before.”

Rephrasing

Rephrasing (or paraphrasing) helps clarify what was said. It is a way of saying “This is what I understood you to mean—am I right?” A restatement of the speaker’s message can be introduced by phrases like: “So, in other words...,” “It sounds like...,” or “Let me make sure I’ve got this right...” Rephrasing can be used to:

- *Clarify what someone is saying:* For example, “It sounds as if you think we are spending too much time discussing infection prevention.”
- *Resolve conflicts between participants:* For example, “It sounds as if Dr. Ndete thinks that our infection-prevention procedures are adequate, and Nurse Obare thinks there is still some room for improvement.”
- *Get at deeper issues:* Some things are hard to speak about. By rephrasing, the facilitator can help participants talk about the real root cause of the problem by using statements like “So, in other words, there is more to this problem than meets the eye,” or “Can you think of any other reasons for this problem?”

Encourage ownership

The most important feature of COPE is its emphasis on *self-assessment*. COPE is not an outside assessment exercise—staff look at themselves and the services they offer, identify and analyze shortcomings and bottlenecks, and then decide for themselves what they need to do to rectify problems. The facilitator should emphasize this from the first, so that staff at the site do not feel that the facilitator is there to judge them.

The facilitator should make as few suggestions as possible—even if they seem obvious. Suggestions that come from the staff are more likely to be taken up by them.

continued

Tips *continued*

Show enthusiasm

The success of COPE depends on the enthusiasm of the staff. If the facilitator doesn't show enthusiasm, it will be difficult for staff to get excited about COPE.

Be positive

Facilitators should reinforce the positive. For example, "COPE is done in good sites such as this one, where staff have demonstrated that they are interested in the welfare of their clients." This helps to reassure staff members who may believe that the site has been singled out because it needs improvement.

Talk about strengths as well as problems

After staff have identified their problems, talk about their strengths also. People are often too modest to mention their positive qualities themselves. The exercise should end on an "up" note.

Be flexible

The COPE facilitator should always bear in mind that each site has different needs, strengths, and weaknesses. For example, some of the Self-Assessment Guides may be appropriate for some sites and not for others. Some sites may do a Client-Flow Analysis at the first COPE exercise, while most others will delay doing it until a future exercise. COPE tools should be adapted for individual site circumstances and needs; COPE will be a different experience every time it is done. Wherever possible, this should be discussed in advance with the site management.

Encourage participation

COPE is about participation. The facilitator is there to start things off, but the more staff participate, the better. The facilitator should try to establish rapport and encourage questions, interruptions, and lively discussion without letting participants argue in a hostile way.

Every speaker should be respected. A few participants should not dominate discussions: the facilitator should try to involve shy people and the staff who may not be used to participating in meetings where they are asked to express their ideas. Everyone's participation is important in COPE.

To make sure that the site facilitator will be comfortable facilitating future exercises, he or she should be encouraged to take on as much of the facilitation of the exercise as possible.

Give examples

It is important to give concrete examples of where COPE has been effective—people love to hear “true life stories” about how prominent institutions also have problems. *But do not name names of institutions or individuals.* It is very important that confidentiality be maintained and participants be reassured that their problems will not be a subject of discussion at another site’s COPE exercise.

A facilitator who does COPE at a number of sites may find it useful to keep a notebook of the kinds of problems staff have identified at different sites and the actions that were taken to resolve them. It’s best if this record does not use specific names or places—just the problems and the solutions found.

Keep the participants on track

The facilitator, although acting as a guide rather than a director, should maintain control. The facilitator’s primary job is to keep the discussion focused and to avoid repetition of issues wherever possible.

Preparing for a COPE Exercise

INITIATING COPE

COPE is initiated differently at different sites. Often, a clinic or hospital will contact a facilitator or an organization that performs COPE to request assistance in conducting an exercise. Alternatively, a ministry of health or the headquarters of a family planning organization may ask a trained COPE facilitator to identify a site that has an interest in improving the quality of services.

The facilitator should try to learn as much as possible about the services provided at the site before the exercise is performed and may wish to prepare some general information to be used during the exercise (for example, the number of people in the site, area, or country who use family planning or the government and institutional policies about family planning that may affect services).

Working with a Headquarters Organization

If the request for COPE comes from an organization, the COPE facilitator should plan to do the exercise along with a representative from the headquarters of the organization, as well as with the staff member from the site who will become the site facilitator. This has several advantages:

- The organization headquarters learns about COPE as a quality-improvement tool
- A trained COPE contact at headquarters can support the site facilitators
- The site's staff see the importance their headquarters gives to the exercise and to quality improvement

COMMUNICATING WITH THE SITE

Advance Visit to the Site

If possible, the COPE facilitator should make an advance visit to tour the site, to explain COPE to the management staff, and to discuss management's critical role in supporting COPE. If an advance visit is impossible, the facilitator and the management staff should meet on the first day of the exercise before the COPE Introductory Meeting.

Either during an advance visit or on the first day of the exercise, the facilitator should talk to as many as possible of the staff members who have direct client contact—not just senior staff members—to become acquainted with the services provided at the site and to encourage staff to participate in COPE. At this time the facilitator may wish to recommend that management involve additional staff in the exercise, including staff who are key to the smooth running of the site but were not included in an initial determination of COPE participants.

Scheduling COPE

During the advance visit (or, if an advance visit is not possible, through correspondence), the COPE facilitator, headquarters representative, and site managers should determine COPE participants and select two or three consecutive days on which to conduct COPE.

The first COPE exercise at a site is usually carried out over two days (see Figure 2-1). In most sites, it is better not to use the Client-Flow Analysis (CFA) in the initial COPE exercise. Staff should instead focus on the other components of self-assessment.*

Letters to the Site

Whether or not the COPE facilitator can make a preliminary visit to the site, the facilitator or headquarters organization should correspond with the site in advance to explain the COPE exercise and to request the attendance of various key members of staff (see sample letters, Figures 2-2 and 2-3). As many staff members as possible should participate in the exercise—including administrators and family planning service providers, as well as guards, doormen, receptionists, and cleaners. If the site is a hospital, representatives from other departments (for example, staff from maternal and child health, postpartum, gynecology, and

* CFA is usually introduced at the second COPE exercise, when staff assess where they stand with the first Action Plan. There are a number of reasons for not doing CFA at a first COPE exercise, including: so that staff can focus on the self-assessment process; so that staff are not overwhelmed with too many activities; and so that staff can determine whether waiting time and staff utilization are problems at the site. If CFA is included, COPE is conducted over three days (see Figure 6-2, page 6.5, for a sample schedule that includes CFA).

FIGURE 2-1 Sample Schedule for an Initial COPE Exercise

DAY 1

Morning—Initiating the exercise

Tour of facility/meet management and participants in COPE
COPE Introductory Meeting with key staff (approximately 1½ hours)

Afternoon—Client Interviews and Self-Assessment

(carried out during routine work hours at staff's convenience)
Conduct Client Interviews
Conduct Self-Assessment

DAY 2

Morning—Client Interviews and Self-Assessment

(carried out during routine work hours at staff's convenience)
Prepare Client-Interview Action Plan
Prepare Self-Assessment Action Plan

Afternoon—Action Plan

Hold Action Plan Meeting with same staff that met for the
Introductory Meeting (approximately 2 hours)
Schedule dates for follow-up meeting and next COPE exercise

male wards) should be included. All have a contribution to make towards improving the quality of family planning services. The important points to emphasize in communicating about COPE are:

- **Management's role.** In order for COPE to succeed, *management has a critical role* to play in supporting staff's involvement in COPE exercises and staff's responsibility for solving the problems identified.
- **Self-assessment.** COPE is a *self-assessment* process that can help management and staff improve the quality of services at their site. It is not an external process.
- **Problem identification.** COPE helps staff identify the barriers to quality in their site, as well as the ways those barriers can be overcome.
- **Staff involvement.** With COPE, *all* staff should think about how to improve efficiency and orient services towards client needs, while using available resources.

FIGURE 2-2 Sample Letter to Administrator

August 27, 1995

Dr. Esther Wakume
Family Planning Coordinator
Karibuni Clinic

Dear Dr. Wakume:

AVSC has developed a tool to assist sites with some management and quality of care issues. We call this initiative *COPE*, which stands for “client-oriented, provider-efficient” services. COPE contains four parts, which are explained in the handbook enclosed with this letter.

The first part of COPE is *Self-Assessment*. Using guides, staff can stand back for a while and take a look at their own services. Are these arranged with the client in mind? Are they as efficient as they might be? Are there bottlenecks or barriers to service? If the staff identify any of these as problems, they are asked to come up with their own recommendations for improvement.

The second part of COPE is *Client Interviews*. We ask staff to interview their own clients to find out more about services from a different perspective. Although it is difficult to get clients to be open about services, service providers have often found this part of COPE to be one of the most revealing.

The third part of the package is the *Client-Flow Analysis*. This is a method of tracking clients through the family planning services and looking at issues such as client waiting times and staff deployment. This is an optional exercise, and we may not introduce it at your site at this time.

The fourth part of COPE, the *Action Plan*, is developed from the first three. Staff look at problems they have identified and make recommendations for solving them.

COPE is a simple exercise. It is not an outside assessment or critical exercise—indeed, it is offered to sites like yours that show concern for quality of care for family planning clients and have a willingness to accept and try new ideas. COPE helps staff at all levels gain a good understanding of what makes *quality services* and can serve as a way to improve quality continuously over time. It has been enthusiastically received in the sites where it has already been introduced, and staff have become very excited about COPE’s possible applications.

I would like to conduct COPE with you and your staff on September 18. I look forward to seeing you and to working together with you on COPE. I shall write again with more details of the itinerary for my visit.

Sincerely,
Pamela Lynam
AVSC International

FIGURE 2-3 Sample Follow-Up Letter Detailing COPE Participants

September 7, 1995

Dr. Esther Wakume
Family Planning Coordinator
Karibuni Clinic

Dear Dr. Wakume:

Further to my letter of August 27, I am writing to you with more details.

I plan to arrive at your clinic on September 18 (please see attached COPE schedule). Could I ask for your assistance? For the COPE initiative to be a success, we need present at the initial meeting and at the final meeting the following staff members:

- Representatives from administration (this may be the head doctor, matron, the medical superintendent, the hospital administrator, the hospital secretary, etc.)
- Family planning coordinator
- Surgeon(s) who perform female sterilization or vasectomy
- Theater nurse(s)
- Staff members responsible for family planning records
- Family planning clinic staff, including doctors, nurses, counselors, and aides
- Receptionist
- Clinic ancillary staff representatives (supplies coordinator, cleaning staff, etc.)
- Representatives from the maternity ward, ob/gyn ward, male ward, pediatric ward, pharmacy or supplies department, and other departments such as physiotherapy, etc.
- Guard/doorman

Would you try to arrange this? We should emphasize to these staff members that we will not take up too much of their time. I look forward to seeing you on the 18th.

Sincerely,
Pamela Lynam
AVSC International

MATERIALS AND SUPPLIES

Facilitators should bring the supplies they will need to perform COPE to the site—facilitators should not assume that the site will have what they need. Figure 2-4 lists all the materials needed to conduct a COPE exercise.

FIGURE 2-4 Materials and Supplies Needed for COPE

HANDBOOKS

3 complete copies of the COPE handbook for the site to use in follow-up COPE exercises

COPE TOOLS

3–5 copies of each of the 10 Self-Assessment Guides

15 copies of the Client-Interview Form

1 copy of the Sterilization Record Review (for sites that provide sterilization services)

If Client-Flow Analysis will be performed:

100 copies of the Client Register Form

5 copies of the Client-Flow Chart

1 copy of the Client-Flow Chart Summary

OTHER SUPPLIES

Large sheets of paper (flipcharts or newsprint) for the Introductory Meeting, for recording information from COPE tools, and for the Action Plan Meeting (one complete flipchart pad should be sufficient)

Colored markers for recording the Action Plan. Facilitators should bring enough to share with participants.

Tape for putting up the large sheets of paper

If Client-Flow Analysis will be performed:

Ruler

Large sheets of graph paper (five sheets should be sufficient)

Calculator

Colored pens for graphing client flow

COPE Introductory Meeting

As suggested in the follow-up letter to the site administration (see Figure 2-3, page 2.5), representatives of all departments and all types of staff should be invited to the COPE Introductory Meeting.* The meeting is held on the morning of the first day of COPE and should take approximately one to one and a half hours.

PURPOSE OF THE INTRODUCTORY MEETING

The purposes of this meeting are:

- To encourage participants to discuss what *quality service* means and to discuss their commitment to quality improvement
- To introduce COPE and to explain how it can be used to improve quality
- To create awareness and “ownership” of the concept that, as the experts on quality in their site, site staff have the power to improve the quality of their services
- To explain how COPE works and to introduce the COPE tools (the forms used in performing COPE)
- To identify teams that will work together on the Self-Assessment Guides

* It is important not to have too many observers from a headquarters organization or from other organizations. The more outsiders there are, the more constrained staff may feel about sharing their problems openly.

- If Client-Flow Analysis is included, to identify individuals who will be responsible for preparing the graphs and charts, analyzing them, and presenting the findings for the Action Plan

MATERIALS AND SUPPLIES

The facilitator should bring all supplies needed to do COPE to this meeting (see Figure 2-4). The facilitator will explain the COPE instruments to participants and will distribute other supplies to the teams that will work on the different COPE tools. Facilitators may find it useful to prepare flipchart sheets in advance that show participants the key points that will be covered in the meeting.

CONDUCTING THE MEETING

The following outline lists suggested topics for the meeting. Facilitators should read the section “Tips for Facilitating COPE Discussions” (pages 1.6–1.9) for guidance on how to encourage staff to actively participate in the Introductory Meeting. Facilitators should not expect too much at the very first meeting—staff need to become comfortable with and accustomed to COPE before they can participate fully.

TOPIC 1

INTRODUCTIONS

The facilitator should introduce himself or herself (as well as any colleagues participating in the exercise). If possible, participants should introduce themselves and describe their responsibilities.

TOPIC 2

WHAT IS COPE?

The facilitator should explain that the COPE acronym stands for “client-oriented, provider-efficient,” and that COPE is intended to improve quality. The COPE process can be applied to other services besides family planning—it has even been suggested for use in running a garage. COPE gives service providers an opportunity to stand back, look at services for a few hours, put themselves in the shoes of a client, and think about services from the client’s perspective. COPE encourages service providers to ask their clients what they think about the services available to them and gives staff an opportunity to decide which problems they can resolve by using existing resources. COPE can also be helpful in identifying when outside help is needed to resolve a problem.

TOPIC 3

WHY IS COPE BEING DONE?

The facilitator should explain that COPE is being done because the management and the staff at the site have an interest in improving the quality of their services. COPE can help staff identify the problems at the site that need to be addressed and focus on dealing with problems constructively.

TOPIC 4

WHAT IS "QUALITY"?

The facilitator should ask participants to suggest a definition of *quality*. Questions like "What do you think clients have a right to expect?" or "If you were coming to this clinic for family planning services, what would you want to get?" or "How would you want staff to treat you?" are useful in helping participants articulate a response. The facilitator can ask participants to give verbal responses and can put them on a flipchart. Alternatively, the facilitator can ask participants to write definitions on index cards and tape the cards on the wall, grouping similar responses together.

Through the course of this discussion, the facilitator should emphasize the following to participants:

- *Quality service* is the sort of service staff members would want to receive or would want their spouses, their children, or their parents to receive
- Quality is about meeting clients' needs and allowing staff to work more efficiently
- Quality improvement requires *on-going attention*—it is not attained by a one-time meeting or by one training session, but should become a part of what staff are always doing

TOPIC 5

WHAT DO CLIENTS WANT AND NEED?

The facilitator should ask staff what they think their clients want or need from the family planning service. Staff usually raise items like "choice of methods" in their definition of quality. The facilitator should focus discussion on items raised by staff and cover as many of the "rights of the client" as possible (see Figure 1-1, page 1.4). The facilitator should look for opportunities for staff to discuss: whether the needs of all clients are being met, whether services are available and accessible to clients at all stages of their reproductive lives, and whether services are available for adolescents, postabortion clients, postpartum clients, and clients who need services relating to

reproductive tract infections (including sexually transmitted diseases like HIV infection).

TOPIC 6

WHAT DO SERVICE PROVIDERS NEED?

The facilitator should ask staff what practical things they think they need in order to meet the client needs they have identified. The facilitator should cover as many of the “needs of the provider” as possible (see Figure 1-1, page 1.4).

TOPIC 7

WHY DO COPE? WHY IMPROVE QUALITY?

COPE is a process and a set of tools that enable service providers to consider the quality of their services. The facilitator should stress the following points:

- There is potential for improvement in every organization and work situation.
- Problems generally occur because a system is not working efficiently. By reducing the amount of time and resources staff spend resolving the same problems again and again, the quality of services can be improved.
- COPE can help improve conditions at the site for both the clients *and* the service providers. When this happens, both client satisfaction and job satisfaction increase.
- Family planning is a priority for:
 1. The *individual*—for health and other reasons
 2. The *institution* or the country’s *ministry of health*—because part of their mission is to protect the health of the people they serve
 3. The *country* or the *government*—through government policies that promote maternal and child health or access to family planning services
- Family planning is a *preventive* health measure. If the services are *not* user-friendly (the facilitator should use concrete examples—lack of attention to clients, dirty equipment, very long waits, etc.), then clients may not return for services and will certainly not recommend them to their friends and neighbors. Each dissatisfied client will tell others about her or his experiences.

- At the end of the discussion, facilitators should relate suggestions made by staff to the “rights of the client” and “needs of the service provider” discussed above.

TOPIC 8

WHERE ELSE HAS COPE BEEN DONE?

The facilitator should explain that COPE has been performed in more than 20 countries and in more than 100 sites—from large national teaching hospitals to small service-delivery sites with just a few staff members. COPE has been introduced throughout Africa and in Asia, Latin America, the Near East, and North America.

TOPIC 9

HOW COPE WORKS

The facilitator should explain how the COPE tools are used:

- **Self-Assessment.** This is carried out by teams of staff during the course of their normal work. Through the Self-Assessment Guides, teams look at elements of quality based on clients’ rights and providers’ needs (see “Instructions to Participants,” pages 4.3–4.4)
- **Client Interviews.** These are carried out by staff during the course of their normal work. While explaining this tool, the facilitator may ask for volunteers to conduct client interviews (it is only necessary to interview a small number of clients during the exercise, so it may be adequate if, for example, five staff members volunteer to interview two clients each). The facilitator should ask to meet separately with these volunteers at the end of the Introductory Meeting (see “Selecting Interviewers,” page 5.2).
- **Client-Flow Analysis (CFA).** This is a method of tracking clients through the facility from the time they enter until they leave. CFA is not usually performed during the first COPE exercise at a site. If CFA is to be done, the facilitator should hold a separate meeting for all those who will participate in CFA and those who will be responsible for CFA charts and graphs (see “Selecting Participants,” page 6.4, and “Preparing Participants,” page 6.6).
- **Action Plan.** This is developed during the Action Plan Meeting to resolve some of the problems staff identify during the exercise.

During discussion of each of the COPE tools, the facilitator should familiarize participants with the instruments and supplies teams will use.

TOPIC 10

PROBLEM SOLVING THROUGH COPE

The facilitator should discuss COPE's approach to problem solving, focusing particular attention on the Self-Assessment Guides and the Action Plan. Facilitators should stress that the focus is on *work processes*, not the performance of individual units or people.

Self-Assessment Guides

The Self-Assessment Guides were developed to encourage service providers to brainstorm about the kinds of problems they experience at their site. The questions listed in the guides relate to common problems experienced in family planning programs, for example: poor or nonexistent linkage between services that inhibit referrals for family planning; clients' or health service providers' inadequate knowledge about family planning services; services providers' desire for updates on recent advances in contraceptive technology; constraints to counseling; and inadequate knowledge about infection-prevention procedures.

The guides are simply to aid in *recognizing problems* and thinking about *the cause of problems*. Staff are not expected to fill out the guides or answer every question. Teams should also discuss problems at the site that are not noted on the guides.

Action Plan

Writing up an Action Plan prompts service providers to think of *alternatives* for solving problems using existing resources. The plan also prompts participants to determine a staff member responsible for solving the problem by a specified date. The Action Plan Meeting allows staff to discuss the problems they have identified, to identify the causes of problems, and to agree to solutions. The meeting also gives staff an opportunity to *prioritize the actions* they will take to address the solutions they have identified, while taking into account the *available resources* at the site.

TOPIC 11

DETERMINING TEAMS

During the Introductory Meeting, the facilitator and participants should decide on the number and makeup of the teams for the Self-Assessment Guides and should determine which guide or guides different teams will work on. The number of teams and the number and type of staff members in each team will depend on circumstances at each site.

In large sites, organizing teams during the Introductory Meeting might take up a lot of time. In these sites, the facilitator and site managers may determine teams in advance of the exercise.

Depending on the size of the site and the number of guides that are to be used, some teams may need to work on more than one guide, and some staff may be assigned to more than one team. Each guide contains a suggestion as to the type of provider that should be included in the team for that guide (see Appendix A). Aside from these suggestions, the team makeup should be “multidisciplinary”—that is, each team should be made up of staff that perform different functions at the clinic rather than, for example, having a team of all doctors or all maintenance staff.

TOPIC 12

THE ACTION PLAN MEETING

The facilitator should make sure that the participants know about the Action Plan Meeting and should announce the following:

- That each team will be responsible for presenting the findings they gather using the COPE tools at the Action Plan Meeting
- That these findings will be discussed and used to develop an Action Plan for the site
- The time and place of the meeting

TOPIC 13

QUESTIONS

The facilitator should ask participants if they have any questions.

Self-Assessment

PURPOSE OF THE SELF-ASSESSMENT TOOL

Self-assessment is at the heart of COPE: in fact, every component of COPE helps staff answer the question, “What problems at this site prevent the services from being of better quality for the client and more efficient for the provider?”

The “Self-Assessment” tool of COPE is performed by teams of staff members who use 10 Self-Assessment Guides (and, in sites that offer sterilization services, the Sterilization Record Review) to take a thoughtful look at services at their site.

MATERIALS AND SUPPLIES

The following materials are needed for work with the Self-Assessment Guides and the Sterilization Record Review.

To perform the exercises:

- 3 to 5 copies of each Self-Assessment Guide (more copies may be needed for larger sites)
- 1 copy of the Sterilization Record Review (for sites that provide sterilization services)

To record findings:

- Flipchart paper
- Markers
- Tape

The Self-Assessment Guides

The Self-Assessment Guides are based on the rights of clients and needs of the provider presented in Figure 1–1, page 1.4. A copy of each guide appears in Appendix A. These guides are meant to apply to *all* clients (women, men, adolescents, etc.) and *all* reproductive health services (contraceptive services, services for reproductive tract infections, maternal and child health services, postabortion care, etc.). The following is a synopsis of each guide:

1. *Clients' Right to Information.* Addressed to staff who are involved in giving information to clients, this guide concerns the availability of information through informational activities, counseling, and client-education materials.
2. *Clients' Right to Access.* This guide helps staff determine whether there are barriers (physical or otherwise) that hamper clients' access to services.
3. *Clients' Right to Choice.* This guide concerns clients' right to choose an appropriate method of contraception. This guide also addresses issues of informed consent relating to permanent contraception.
4. *Clients' Right to Safety.* Using this guide, which is particularly important for sites that perform sterilization services, staff address safety issues (particularly screening, infection prevention, and reporting of complications).

At sites where sterilization procedures are performed, a *Sterilization Record Review* is performed as a supplement to the safety guide. To perform this review, one of the team members examines a sample of clients' sterilization records to ensure completeness and to determine whether clients are making unnecessary visits (see Appendix B).

5. *Clients' Right to Privacy and Confidentiality.* This guide relates to issues concerning clients' right to privacy and confidentiality during service delivery—particularly during counseling and physical examination.
6. *Clients' Right to Dignity, Opinion, and Comfort.* Through this guide, staff consider issues that relate to the way staff talk to and treat clients during service delivery, as well as to clients' physical comfort at the site.
7. *Clients' Right to Continuity.* This guide focuses on the need for clients to have continuity of service and addresses the question of whether facilities have efficient systems for ensuring continuity of care.
8. *Service Providers' Need for Good Supplies and Site Infrastructure.* This guide addresses the question of whether staff have the tools and working environment needed to provide high-quality services.

9. *Staff Need for Good Management and Supervision.* This guide helps staff determine whether the site fosters a supportive working environment.
10. *Staff Need for Information, Training, and Development.* Using this guide, staff look at whether providers are well informed and well trained.

USING THE SELF-ASSESSMENT GUIDES

The guides are used by teams of staff members. The number of teams and the number of participants in each team depend on the number of guides the site would like to address and the number of participants available at the site (see “Determining Teams,” page 3.6).

Once site managers are familiar with COPE (after the first COPE exercise at a site), they may choose to focus on only a specific guide or set of guides—or may choose to think of their own questions and not use the guides at all.

STEP 1

INSTRUCTIONS TO PARTICIPANTS

The facilitator should hand out the Self-Assessment Guides while discussing them at the Introductory Meeting—this generally makes the atmosphere more relaxed as staff start to look at the guides, ask questions about them, and discuss them with their colleagues.

While introducing the guides, the facilitator should be sure to make the following points:

- **This is not a test.** The guides will not be collected: *they are for the use of the participants only.*
- **Participants are not expected to respond to every question.** Participants should only address the items on the guides that seem important to quality of services at the site. The guides suggest potential problems, but some of the points listed may not be relevant to every site. The guides are intended to start staff members thinking about their services in an in-depth and concrete way.
- **Some important points may not be included in the guides.** Participants should add their own questions in the blank spaces on each guide to ensure that all items important to service delivery at the site are included.

- **This is an exercise done *by staff, for staff*.** The role of the facilitator is to lead staff through the process, not to criticize the site.
- **Participants should be honest about problems at the site.** This exercise is not intended to judge *individuals*, but rather to analyze whether *systems* work and to determine ways to improve these systems.
- **Participants should get input from colleagues.** It is important for teams to solicit comments from staff or departments not represented in the group.
- **Participants should be as specific and concrete as possible.** When identifying problems or making recommendations, participants should try not to use vague language. “Lack of...” statements are often not helpful because they do not address what lies behind the “lack.” Often it is helpful to ask “Why is this a problem?” in order to find the cause of the “lack.”

STEP 2

WORKING ON THE GUIDES

During the Introductory Meeting, the facilitator will give participants the schedule for the COPE exercise. Although two days are usually set aside for teams to work on the guides, this work should not take staff away from their normal duties during the two-day period: participants should think about the questions on the guides during their normal work day. Active work on the guides is done when the teams meet (teams may decide to meet during breaks, at a scheduled meeting during the workday, or before or after work).

Staff working as a team for a guide should determine when to meet to review the guide and discuss the problems they identify. For example, one team may decide to work individually on the guides throughout the course of their workday and then meet together over coffee, tea, or meal breaks. Another team may decide to first have a brief meeting to begin discussion of the guides, then break to think about the issues discussed, and finally meet again to agree on findings.

The facilitator should arrange to drop in on each team while they are meeting to see whether team members have any questions about what they are supposed to be doing and to help ensure that problems and solutions are specific. For example, for a team to decide that one problem is “poor quality services” is not enough. Staff must ask themselves what they mean by “poor quality”—for example, are resources scarce for a particular activity? If so, which resources? Why?

STEP 3

RECORDING FINDINGS

Participants should prepare the problems and solutions they identify for the Action Plan Meeting. When identifying problems and solutions, participants should use the following format in preparation for the Action Plan: *problem, recommendation, by whom, by when*. To illustrate, the facilitator can put up a flipchart and go through a simple problem and show how it could be written out (see Figure 4-1).

FIGURE 4-1 Sample Problem and Solution Identified for the Action Plan

<i>PROBLEM</i>	<i>RECOMMENDATION</i>	<i>BY WHOM</i>	<i>BY WHEN</i>
<i>No heavy-duty gloves</i>	<i>Buy gloves with petty cash</i>	<i>Sarah Jotto</i>	<i>October 3</i>

Client Interviews

PURPOSE OF CLIENT INTERVIEWS

The Client-Interview tool is designed to help encourage service providers to routinely ask clients what they think about the quality of services at the site. While using the Client-Interview tool, participants should remember that *clients* include all men, women, adolescents, etc., who come to the site for reproductive health services (including contraception, postabortion care, maternal and child health, and treatment of reproductive tract infections). Client Interviews help the site find out

- What clients know about the services offered
- What clients think about the services offered
- Clients' suggestions for improving services

MATERIALS AND SUPPLIES

The following materials are needed for performing client interviews.

To perform the interviews:

15 copies of the Client-Interview Form

To record findings:

Flipchart paper

Markers

Tape

CONDUCTING CLIENT INTERVIEWS

A large sample of clients is not necessary. About 10–15 interviews with clients is adequate for each COPE exercise. Volunteers might agree to interview two to three clients each—making sure that they do not interview the same client more than once. Staff should be encouraged to ask clients about services informally as a regular part of their activities after the COPE exercise is complete.

If participants find that this tool is a useful way to find out what clients think about the site, they may want to repeat the Client-Interview process periodically—perhaps every two or three months—to find out if there are any changes in clients' perceptions of services or to address different issues that affect clients.

STEP 1

SELECTING INTERVIEWERS

Getting clients to open up and really say what they think about services at the site may be difficult. Clients may want to please the interviewer—especially if the interviewer is the person from whom they hope to get the service that they have come for. Interviewers should be friendly and approachable so clients will be more likely to open up to them. Interviewers should be sure to let clients know that the site sincerely wants to improve services.

During the Introductory Meeting, the facilitator should ask for volunteers who will act as client interviewers (see “Client Interviews,” page 3.5).

STEP 2

APPROACHING CLIENTS FOR INTERVIEWS

Interviews should be as informal as possible. Although interviewers might decide to sit in the waiting room with a group of clients and start to chat with them—individual interviews should be conducted in private.

Instead of simply asking questions from the Client-Interview Form, interviewers should start by asking clients about themselves and their families. Then, after introducing himself or herself, the interviewer should tell the client that an exercise to improve services is being performed at the clinic and that, to perform the exercise, staff need to know what clients really think about services. The interviewer should then ask if the client has any suggestions for improving the clinic. Some interviewers may choose to interview clients just before they leave the clinic, *after* they have received services. Figure 5-1 presents some suggestions for conducting successful client interviews.

FIGURE 5-1 Tips for Client Interviewers

Introduce yourself to the client. Explain that the purpose of the interview is to learn how clients feel about services offered at the facility and to get the client's suggestions on how services might be improved. Stress that the interview is confidential and that the client's name will not be used.

- Ask open-ended questions
- Don't become defensive
- Accept any criticism, instead of explaining it away
- Follow up on general comments
- Ask for specifics, where possible
- Thank the client for his or her help

STEP 3

USING THE CLIENT-INTERVIEW FORM

Interviewers do not have to stick to the format and questions on the Client-Interview Form (see Figure 5-2 for a sample Client-Interview Form). The form is simply a guide to get an interview underway. Interviewers might use the form to make a few notes about the client's responses to question or important points the client raises, but the forms do not have to be filled out or handed in to anyone. The purpose of the interviews is to get ideas from the *clients*. In some sites, the staff have been surprised to learn new things about their clinic from the clients.

If a client mentions a problem with the services, the interviewer should ask the client for recommendations for a solution and should make a note of it for the Action Plan Meeting. The interviewer should also think about how to deal with problems clients identify.

STEP 4

RECORDING CLIENT INTERVIEWS

Each interviewer should record problems identified by clients in preparation for the Action Plan Meeting. Interviewers should use flipchart paper to record these findings using the format: *problem, recommendation, by whom, by when* (see Figure 4-1, page 4.5, for a sample problem recorded in this format).

Interviewers should not record only problems: the facilitator should encourage staff to report the positive things clients say during interviews, as well as the interviewers' thoughts about how it felt to interview clients.

FIGURE 5-2 Sample Client-Interview Form

CLIENT-INTERVIEW FORM

SITE: _____

DATE: _____

Directions: Introduce yourself to the client. Explain that the purpose of the interview is to learn how clients feel about services offered at the facility and to get the client's suggestions on how services might be improved. Stress that the interview is confidential and that the client's name will not be used. Adapt the questions listed here to your facility and the client you are interviewing. Record any additional information the client volunteers. Thank the client for her or his assistance.

1. Why did you come to the clinic today?
2. Did you get what you came for? If not, why not?
3. Have you been given information about family planning? yes no

If yes: What methods did you hear about?

If no: Would you have liked to get family planning information?

4. If you came for family planning, did you get the method you wanted?
 yes no

If yes: What instructions were you given about your method?
Do you have any more questions about your method?

If no: Why not?

5. What do you like best about this clinic?
6. What do you like least about this clinic?
7. What suggestions do you have to help us improve services at this clinic?
8. Is there anything else you would like to tell us?

Interviewer comments:

Client-Flow Analysis

Client-Flow Analysis (CFA)* can be used where waiting time or staff utilization has been identified as a problem during a previous COPE exercise. As a general rule, it is best not to perform CFA the first time a site does COPE.

There are a number of reasons for not doing CFA during a site's first COPE exercise. The most important of these is not to overwhelm staff with too many activities during a first COPE exercise: staff should instead focus on COPE's self-assessment process as a whole. Because the results of CFA are concrete and visual, staff may focus too much attention on this aspect of COPE, rather than considering it as just one element of self-assessment. If waiting time or staff utilization is identified as a problem at the site, CFA can be performed at a follow-up COPE exercise.

This chapter describes the basic steps needed to conduct CFA and suggests staff members who should be involved in performing this tool. However, some adaption of this material may be needed to suit CFA to the needs of individual clinics or hospitals. For example, in some facilities, clients may receive family planning counseling as one part of a visit for child-welfare or prenatal services. In these facilities, it may be important to involve child-welfare or prenatal staff in the CFA data-collection process. Before conducting a COPE exercise that includes CFA, the facilitator and site administrators should adapt the CFA tool.

PURPOSE OF CLIENT-FLOW ANALYSIS

The CFA tool presented in COPE is designed for use in analyzing a health care facility's family planning services. However, the CFA forms can be adapted for use in analyzing almost *any* type of service that involves a client and a provider. By changing the data

* COPE's CFA tool was adapted from a computerized patient-flow analysis developed by the Family Planning Evaluation Division, U.S. Centers for Disease Control and Prevention (Graves et al. 1981).

collected on the CFA forms to reflect the type of services offered, staff in any department can analyze client waiting time and staff utilization. For example, by recording gender and charting clients by this information, staff can examine differences in waiting and contact time for women and men.

CFA describes client flow and staff utilization in a clinic. To perform CFA, regular clinic staff use charts and graphs of data collected in any one clinic session to help identify potential improvements. The CFA graphs and charts permit rapid evaluation of client flow: they visually demonstrate how client and staff time are used. Like other COPE tools, CFA reveals some of the strengths and weaknesses in clinic operations. It is simple to conduct, interpret, and use, and it can be carried out as often as needed.

FIGURE 6-1 What CFA Can Do

CFA Can	CFA Cannot
Identify bottlenecks	Provide the best solution for the bottleneck
Identify lapses in client contact time	Explain what staff were doing during that time
Identify missed contacts	Explain why contacts were missed
Identify unscheduled client contacts	Tell why extra contacts were made
Provide personnel cost estimates	Tell whether personnel costs are reasonable
Measure client waiting time	Tell whether these waits are reasonable
Measure client time spent at each contact	Judge quality of care at each contact
Demonstrate the effect of changes in clinic operations on client flow	Judge whether the effect is a desired one

Once the findings have been charted, staff can sit together and analyze the results. Staff may look at the flow of all clients during the session, or they may analyze what happened with particular clients. When they identify problems with client flow, participants can discuss proposed solutions and add them to the Action Plan.

The benefits of CFA may include *a reduction of staff and client waiting time* (and frustration) in the clinic, a better distribution of workload for each staff member during the

work day, and a reduction of personnel costs. By demonstrating ways to increase efficiency, CFA may also show ways that the clinic can serve more clients.

What to Expect from CFA

Although CFA is a good tool for analyzing clinic efficiency, it is no substitute for the judgment and expertise of those who work in the clinic. It should always be used in conjunction with what is known about the clinic operation by those who know it best: *the staff*.

CFA can help identify shortfalls, but the staff themselves must seek explanations for any unusual occurrences identified in the analysis (see Figure 6-1). CFA only *identifies* potential problems. The important part of CFA—addressing problems and improving service delivery based on findings—is done when participants incorporate CFA findings into the discussions at the COPE Action Plan Meeting.

MATERIALS AND SUPPLIES

The following materials are needed to perform CFA. A blank copy of each of the instruments listed below appears in Appendix D.

To gather information:

- 100 copies of the Client Register Form
- 5 copies of the Client-Flow Chart
- 1 copy of the Client-Flow Chart Summary

To make graphs:

- Up to 5 large sheets
of graph paper
- Colored pencils or pens
- Calculator
- Ruler

To record findings:

- Flipchart paper
- Colored markers
- Tape

PERFORMING CLIENT-FLOW ANALYSIS

The CFA system presented here is an adaptation of the computerized patient-flow analysis developed by the Family Planning Evaluation Division of the U.S. Centers for Disease Control and Prevention (Graves et al. 1981). For COPE, this tool has been simplified and redesigned to encourage self-assessment. Staff members graph and analyze the data and incorporate findings into the Action Plan.

STEP 1

PREPARATION

The decision of whether to include CFA will depend on individual circumstances at each site. The facilitator should collaborate with site administrators during preliminary discussions about COPE to determine whether CFA should be performed. In some circumstances (for example, if an outside facilitator will not be able to return to a site to help staff perform CFA during a later COPE exercise), it may be necessary to perform CFA during the first COPE exercise.

Scheduling

If CFA will be included, COPE will be conducted over three days rather than two. CFA will require data collection during one clinic session. The length of the session will depend on circumstances at individual clinics. See Figure 6-2 for a sample schedule of a COPE exercise that includes CFA.

Selecting Participants

CFA may involve departments other than family planning services (for example, prenatal, child-welfare, and obstetric and gynecologic services). Staff from all departments covered should be involved in CFA.

Before the Introductory Meeting, the facilitator should collaborate with site administrators to identify the staff members who will be responsible for graphing and charting data collected during CFA. This group should include staff who have direct contact with family planning clients, including:

- The staff member who has first contact with clients (often a doorman or receptionist). Sometimes a staff member is assigned to perform this function specifically for CFA.
- The first staff member who talks to clients about the reason for the visit
- Any staff member who conducts group-education sessions for clients
- Any staff member who has service contact with clients during their visit
- The last staff member who has direct contact with clients before they leave the facility
- Staff members who will be responsible for graphing and conducting a preliminary analysis of the information collected

FIGURE 6-2 Sample COPE Schedule Including CFA

DAY 1

Morning—Initiating the exercise

- Tour of facility/meet management and participants in COPE
- COPE Introductory Meeting with key staff (approximately 1½ hours)
- Discuss plans for CFA

Afternoon—Client Interviews and Self-Assessment

(carried out during routine work hours at staff's convenience)

- Conduct Client Interviews
- Conduct Self-Assessment

DAY 2

Morning—CFA data collection, Client Interviews, and Self-Assessment

(carried out during routine work hours at staff's convenience)

- Collect data for CFA during clinic session
- Continue Client Interviews
- Continue Self-Assessment

Afternoon—CFA data analysis, Client Interviews, and Self-Assessment

(carried out during routine work hours at staff's convenience)

- Graph and chart the CFA data collected
- Preliminary analysis of CFA findings
- Continue Client Interviews
- Continue Self-Assessment

DAY 3

Morning—Client Interviews and Self-Assessment

(carried out during routine work hours at staff's convenience)

- Prepare Client-Interview Action Plan
- Prepare Self-Assessment Action Plan

Afternoon—Action Plan

- Hold Action Plan Meeting with same staff that met for the Introductory Meeting (approximately 2 hours)
- Schedule dates for follow-up meeting and next COPE exercise

Preparing Participants

If CFA will be performed, the facilitator should introduce CFA to all participants at the Introductory Meeting. The data-collection process and Client Register Forms should be explained to all staff who will have contact with clients during the clinic session that will be analyzed. Poor data collection may result if staff are confused about CFA or are not aware that it is being done.

The facilitator should explain that data collection is simple and will require only a few seconds of staff time at the beginning and end of their contact with each client during one clinic session. The facilitator should stress that, to be of maximum use, the information must be complete, legible, and accurate. Before or after the Introductory Meeting, the facilitator should meet with the staff members who will graph the CFA data to discuss how this part of the exercise is performed.

Determining Entry and Exit Points

Through discussion, the facilitator should help participants identify how and where clients enter the site and arrive at the family planning services. There may be several entry and exit points for family planning clients. If possible, the facilitator should tour the facility and observe these points personally before the COPE exercise begins.

Timekeeping

To ensure that the times recorded are consistent, staff members should synchronize their watches with the clinic clocks.

Introducing CFA Materials

The facilitator should familiarize staff with the data collection methods used for CFA, describe the use of method and visit codes, and familiarize staff with the CFA forms and graphs.

STEP 2

DATA COLLECTION

The Client Register Form

The Client Register Form is used to collect information about a client's entry and exit times, the amount of time the client spends with each staff member, the client's contraceptive method, and the reason for the visit. This information is later graphed and charted through the use of other forms. Figure 6-3 contains a sample completed Client Register Form.

person should calculate total contact time in minutes and enter the number in the “Total contact” column on the form.

Entering client information

1. The staff member who has first contact with clients (for example, a doorman, guard, receptionist, or a clerk in any of the services to be covered) notes each client’s time of arrival on a Client Register Form and gives the form to the client.

All clients who visit the site during the session carry the form with them during their entire clinic visit—presenting the form in turn to each staff member they have contact with—and leave the form with the last staff member they see.

2. The first staff member with whom clients discuss both the reason for the visit (for example, initial visit, follow-up visit) and the family planning method they use or want to use enters this information under “type of visit” and “contraceptive method.”

For clients who are not sure of the contraceptive method they want or who want to obtain a different method than the one they currently use, the staff member should note this information on the form. If these clients select a method during their visit, the method chosen should also be recorded. Any other important information about the client’s visit (for example, if the client leaves the clinic without completing the visit) should be noted on the form under “Comments.”

3. If clients attend a group-education session, the staff person responsible for conducting the session enters the beginning and ending time of the session on each client’s form.
4. The last staff member who has contact with clients collects the Client Register Form. This staff member gives all completed forms to the staff member who will be responsible for completing Step 3.

STEP 3

CHARTING CLIENT FLOW

The Client-Flow Chart and Summary

These forms are used to collate and chart the information collected through use of the Client Register Forms. The information can be charted either throughout the clinic session or after the session is over and all Client Register Forms have been collected. Figures 6-4 and 6-5 contain completed samples of a Client-Flow Chart and a Client-Flow Chart Summary.

Using the Client-Flow Chart

For each Client Register Form, staff should enter the following information on the Client-Flow Chart:

1. Enter the client number from the Client Register Form in sequential order, beginning with client number "01" (if more than 20 clients visited the clinic during the session, use additional pages of the Client-Flow Chart and continue to use consecutive register forms).
2. For "Time," enter the time the client arrived at the site under "In" and the time the client left the site (the ending time from the last contact) under "Out."
3. For "Total minutes," enter the total number of minutes the client spent in the clinic from "In" to "Out."

Example:

<u>In</u>	<u>Time</u> <u>Out</u>	<u>Total</u> <u>minutes</u>
9:30	11:05	95

4. Find the total of the column "Total contact (in minutes)" on the Client Register Form, and enter this figure on the Client-Flow Chart under "Contact minutes."
5. To calculate "Waiting minutes," subtract the number of "Contact minutes" from the number of "Total minutes."
6. For "Visit code" and "Method code," enter the codes corresponding to the information entered on the Client Register Form.
7. Under "Comments," enter any pertinent information (for example, "client left before completing visit").

Repeat this process until the information from each Client Register Form has been entered on the Client-Flow Chart(s).

FIGURE 6-4 Sample Client-Flow Chart

CLIENT-FLOW CHART*

SITE: Karibuni Clinic

DATE: September 18, 1995

Client number	Time		Total minutes	Contact minutes	Waiting minutes	Visit code	Method code	Comments
	In	Out						
01	8:00	8:30	50	40	10	Y	B	
02	8:10	9:20	70	11	59	Y	A	
03	8:15	9:23	68	14	54	Y	A	
04	8:15	9:25	70	6	64	Y	D	
05	8:15	9:26	71	5	66	Y	A	
06	8:15	11:00	165	57	108	X	H	
07	8:20	1:30	310	74	236	Y	C	
08	8:30	11:00	160	17	143	X	H	
09	8:30	10:22	112	3	109	Y	D	
10	8:35	12:55	260	193	67	Y	C	
11	8:30	9:34	64	8	56	Y	A	
12	8:30	9:40	70	7	63	Y	A	
13	8:30	10:08	98	24	74	Y	A	
14	8:30	10:15	105	6	99	Y	A	
15	9:00	1:20	260	52	208	Y	C	
16	9:00	2:10	310	111	199	Y	C	
17	9:00	10:05	65	16	49	Y	A	
18	9:00	10:05	65	6	59	Y	I	PRENATAL CARE VISIT
19	9:00	10:30	90	6	84	Y	A	
20	9:30	10:11	41	6	35	Y	A	

Method codes:

- A Injectable
- B Pill
- C Tubal occlusion
- D Condom
- E Vasectomy
- F Norplant implants
- G IUD
- H Counseling
- I Other

Visit codes:

- Y First visit
- Z Revisit

*Use as many pages as necessary

Using the Client-Flow Chart Summary

When the Client-Flow Chart is complete, calculate averages for the session by using the Client-Flow Chart Summary Form. If more than one Client-Flow Chart was used to record information for the session, enter the information for each page in the space provided on the summary.

FIGURE 6-5 Sample Client-Flow Chart Summary

CLIENT-FLOW CHART SUMMARY

SITE: Karibuni Clinic DATE: September 18, 1995

Page	Total number of clients	Total minutes	Contact minutes	Percentage time spent in contact
Page 1	20	2,521	665	26%
Page 2				
Page 3				
Page 4				
Page 5				
Totals	20	2,521	665	26%

Average number of minutes: 126
(divide total minutes by total number of clients)

Average contact minutes: 33.2
(divide total contact minutes by total number of clients)

1. For each page of the completed Client-Flow Chart, enter the total number of clients charted in the space provided on the Client-Flow Chart Summary (each Client-Flow Chart has room for charting 20 clients).
2. For each page of the completed Client-Flow Chart, add up the "Total minutes" column and enter the figure in the space provided on the summary form. Repeat the process for the "Contact minutes" column. Add up the figures from each page and enter this number on the summary form under "Totals."

- For “Percentage time spent in contact,” find the percentage time an average client spent in contact with providers by dividing “Contact minutes” by “Total minutes.”

<i>Example:</i>				
<u>Waiting</u>	÷	<u>Total</u>	=	<u>% Time</u>
<u>minutes</u>		<u>minutes</u>		<u>waiting</u>
60		95		63.15%

- Find “Average number of minutes” and “Average contact minutes” by dividing the totals by the total number of clients.

STEP 4

GRAPHING CLIENT FLOW

The Client-Flow Graph

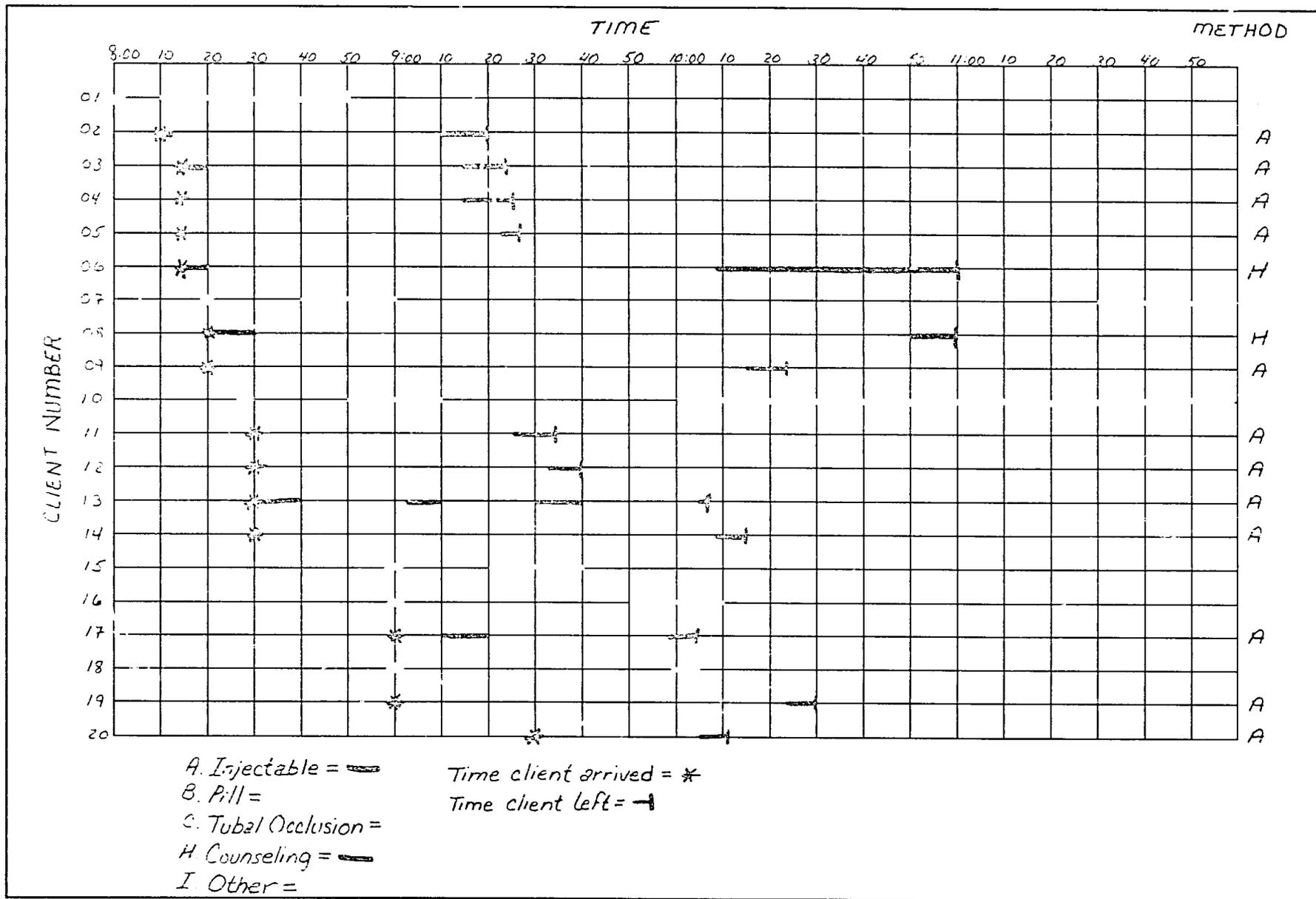
Staff use the information on the Client-Register Forms to create a graph of client flow. Using this graph, staff can address a number of issues (for example, whether excessive waiting time is tied to a particular contraceptive method, type of visit, or the gender of the client). The following items are needed to create the graph:

- Graph paper
- The completed Client Register Forms
- Colored pencils or pens (a different color for each aspect of operations being graphed—for example, a different color for each method or for each type of visit)
- Ruler

Creating a Client-Flow Graph

Before beginning the graph, the aspect of clinic operations to be charted must be determined and a color must be assigned to each item in this group. For example, if type of contraceptive method will be charted, each method will be recorded in a different color (see Figure 6-6). If type of visit will be considered, a different color should be assigned for each type of visit—for example, green for initial visit, red for return visit, blue for prenatal visit, etc.

FIGURE 6-6 Sample Client-Flow Graph



6.13

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To create a graph, follow these steps:

1. Using the graph paper, enter the time the clinic session began in the top left square of the graph. Across the top of the page, enter the time in 5- or 10-minute intervals until the time the session ended. Each square of the graph represents a 5- or 10-minute period.
2. Enter the client numbers down the left side of the graph to correspond to the horizontal lines. Begin with client number "01."
3. For client number 01, choose the color pen or pencil that corresponds to the aspect of services being considered. Using this color, make a symbol (for example, an asterisk or a vertical bar) at the points on the graph indicating the time the client entered and left the clinic.
4. Using the same color, draw a horizontal line corresponding to the time the client spent with each staff member. The space between these lines shows waiting time.
5. Repeat 3 and 4 for each client in the session.

STEP 5

EXAMINING STAFF UTILIZATION

In some sites, the staff time available may not be used as efficiently as possible. For example, staff may prepare for services first thing in the morning while clients are waiting—meanwhile, they may have free time and relatively few clients in the afternoon. As another example, the counselor may have a lot of clients while other staff are not very busy. To find out whether staff utilization is a problem, participants should calculate the percentage of time staff spent in contact with clients:

1. On a blank sheet of paper, first note total contact minutes in the session from the Client-Flow Chart Summary.
2. Next, calculate the total staff minutes available by multiplying the number of minutes in the session by the number of staff who worked during the session.

<i>Example:</i>				
<u>Minutes in the session</u>	x	<u>Staff members</u>	=	<u>Staff minutes available</u>
390		5		1950

3. To find the percentage of available time that staff spent in contact with clients, divide total contact minutes by the staff minutes available.

<i>Example:</i>		
<u>Contact minutes</u>	÷ <u>Staff minutes available</u>	= <u>Percentage staff time in contact</u>
665	1950	34%

STEP 6

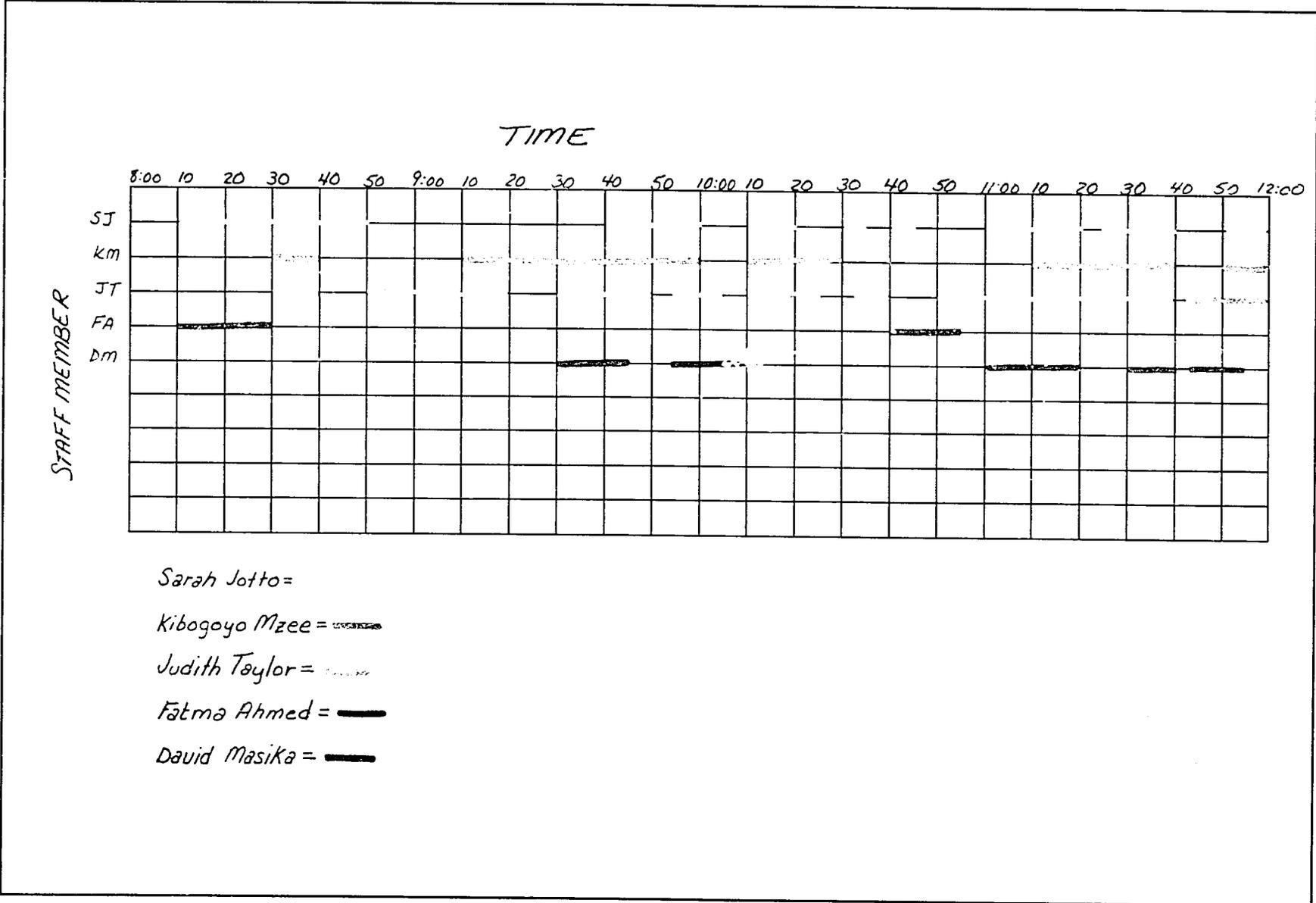
GRAPHING STAFF UTILIZATION

Like the Client-Flow Graph, the Staff-Utilization Graph is used to give a clear, visual representation of data. This graph shows the actual time staff spent in contact with clients during the session. The items needed to create this graph are the same as those needed for the Client-Flow Graph.

Before beginning the graph, assign a different color for each staff member who had contact with clients during the session. To create a graph, follow these steps (see Figure 6-7 for a sample Staff-Utilization Graph):

1. Using graph paper, enter the time the clinic session began in the top left square of the graph. Across the top of the page, enter the time in 5- or 10-minute intervals until the time the session ended. Each square of the graph represents a 5- or 10-minute period.
2. Enter the initials of all staff members who had contact with clients down the left side of the graph to correspond to the horizontal lines.
3. Go through each Client Register Form for each staff member. If the staff member's initials appear as a "contact" for a client, draw a horizontal line in the staff member's assigned color corresponding to the time spent providing service to that client. Gaps between contact times will represent tea breaks, meal breaks, and other activities.

FIGURE 6-7 Sample Staff-Utilization Graph



6.16

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STEP 7

ANALYZING AND RECORDING FINDINGS

Preliminary analysis

Once the charts and graphs are completed the facilitator and the staff involved in CFA analysis should have a preliminary discussion of the findings. The following questions may help staff analyze what the graphs represent.

Client service and waiting times

- Could waiting times for clients be reduced? If so, at what stage of the client's flow through the clinic?
- Can you think of some ways in which services could be reorganized to do this?

Staff utilization

- Are staff fully utilized in your clinic?
- Are a few staff members doing the major part of service delivery? Why?
- Could staff time be better used?
- Could staff time be reorganized so that clients have shorter waiting times?

Recording findings

As these questions are addressed, the facilitator should ask staff to do the following in preparation for discussions at the Action Plan Meeting (using the format illustrated in Figure 4-1, page 4.5):

- Note the problems they have identified for the Action Plan
- Propose solutions to the problems they have identified
- Identify the person(s) who will be responsible for carrying out the solutions
- Suggest a target date for action

Staff should be prepared to use the graphs and charts to give a brief presentation about their analysis at the Action Plan Meeting. Staff should discuss the results of the CFA during the Action Plan Meeting.

Action Plan

PURPOSE OF THE ACTION PLAN

Participants create an Action Plan to resolve problems identified through the COPE tools. Using the data collected through the COPE tools, participants identify:

- Sources of problems at the site
- Solutions to problems
- Staff members to be responsible for carrying out solutions agreed upon
- A date by which each solution will be carried out (dates for the different solutions will vary)

During follow-up to COPE, participants can refer to the Action Plan to gauge the success of the various solutions.

THE ACTION PLAN MEETING

During the Action Plan Meeting, which is held on the last day of the COPE exercise, teams present their findings from the Self-Assessment, Client-Interview, and Client-Flow Analysis tools. The purposes of this meeting are:

- To present the findings derived from the COPE tools
- To identify the possible sources of the problems
- To identify solutions to problems

- To assign a staff member to be responsible for carrying out the solution by an agreed-upon date
- To agree upon a date on which to conduct a follow-up COPE exercise

To encourage full participation, this meeting should be informal, and participants should be as comfortable as possible.

MATERIALS AND SUPPLIES

The following materials are needed for the Action Plan Meeting.

To present findings:

Team findings from Self-Assessment Guides, Client Interviews,
and Client-Flow Analysis (if performed)

To record findings:

Flipchart paper
Colored markers
Tape

CONDUCTING THE ACTION PLAN MEETING

This chapter contains a suggested outline for the Action Plan Meeting. Facilitators may wish to reread the general tips on facilitating COPE meetings on pages 1.6–1.9.

Facilitating the Action Plan Meeting

The role of the COPE facilitator in this meeting is to enable all participants' voices to be heard and to encourage healthy discussion of topics in every category.

When necessary, the facilitator should guide participants to look at other solutions. For example, sometimes participants assign too many of the recommendations to one staff member or do not look at enough possible solutions to problems. In other cases, the staff member chosen to oversee a solution may not be the best fit.

Figure 7-1 lists some of the difficulties staff may have in identifying problems, recommendations, or staff members assigned to oversee solutions. Facilitators may decide to use some of the questions listed in this figure to guide the discussion at the Action Plan Meeting.

FIGURE 7-1 Tips for Facilitating the Action Plan Meeting

FACILITATING DISCUSSION

Facilitators can use the following questions to help guide the discussions if staff have trouble identifying problems, solutions, or persons responsible for overseeing solutions.

If staff have trouble identifying the source of a problem

Is this really a problem? How is it a problem? Does something else lie behind it?

What do staff think could be the sources of the problem?

Is this problem a barrier to clients getting good services? Will the solutions listed improve the services?

If staff have not looked at all the possible resolutions for the problem

Is this the best recommendation for the solution, or is there a more effective or easier way to deal with this problem? Is there more than one possible solution?

If the person assigned to carry out a solution may not be the best choice

Is this the appropriate person to be responsible for implementing this recommendation?

If the time of completion chosen for a solution seems unrealistic

Is this time frame appropriate, or should it be changed?

If one or more staff members seem uncomfortable with assignments

Does anyone feel that they have been assigned a recommendation they cannot perform?

If a problem identified seems vague

Is this problem stated in a concrete way? (For example, "The water pipe at the upper part of the hospital is broken" is much more concrete than "There is low water pressure.")

If some recommendations have been assigned to an outside organization

Can anyone suggest an alternative solution that could be done by staff?

Are problems that can be solved by staff assigned to someone in the clinic?

Who will take responsibility for coordinating this recommendation with the other organization?

If many recommendations are assigned to one individual or organization

Do you think it is feasible for all these problems to be resolved by one person within the specified time? Can other staff be assigned some of the problems in order to implement the recommendations more quickly?

TOPIC 1

INTRODUCING THE MEETING

One staff member—preferably one of the participants chosen to become a site facilitator for future COPE exercises—should volunteer to take notes during the meeting for the future use of the site staff.

At the beginning of the meeting, the facilitator should:

- Thank participants for their hard work throughout the COPE exercise
- Remind participants that problems generally occur because the *system* is not working—that problems are not the fault of any one person
- Remind participants that COPE is an *internal*, not an external process. COPE is done *by* staff, *for* staff
- Point out positive things about the quality of services at the site and reinforce the point that the objective of the COPE exercise is to further improve the quality of services
- Encourage lively discussion without letting participants argue in a hostile way

TOPIC 2

PRESENTING FINDINGS

Using the information that teams from each of the COPE tools have recorded on flipchart paper, a representative of each team should present the team's findings and thoughts about the problems at the site. The format for these problems should be: *problem, recommendation, by whom, by when* (see Figure 4-1, page 4.5).

Before the first presentation, facilitators should ask participants not to discuss problems that have already been raised in another presentation. Instead, when the problem is *first* raised, teams that have an alternative solution should discuss it during that presentation. This way, participants can discuss the relative merits of solutions, and more than one solution may be used.

TOPIC 3

DISCUSSING FINDINGS

After each team's presentation, participants should discuss the team's findings. To be able to arrive at a workable solution, participants must first agree on whether something is a problem and on the source of that problem. Participants should not feel limited to identifying one solution for each problem: problems that have more than one source may have more than one solution.

Participants can reach consensus on issues through "brainstorming" discussions. Although not all of the participants will always agree completely with what is decided, those who disagree will usually go along with the majority of the group.

The facilitator's role in these discussions is to encourage participation and guide participants' discussion without dominating it. One of the main principles of COPE is that staff are far more likely to accept and act upon suggestions that they have made for themselves.

TOPIC 4

CREATING THE ACTION PLAN

Agreement reached during the discussions should be noted on the flipchart sheets. Either during the discussion or immediately afterwards, the facilitator should copy the results onto a master sheet—using the same format as on the flipcharts (problem, recommendation, by whom, by when)—to keep track of points raised. The master sheet and the flipchart sheets, altered as a result of discussion, form the Action Plan for the site staff (see Figure 7-2 for a sample Action Plan). The external facilitator may want to keep a copy of the Action Plan if he or she will assist in follow-up at the site.

TOPIC 5

PLANNING A FOLLOW-UP MEETING

After the results of discussion for the findings of each team have been recorded, the main work of the meeting is completed. At this point, the participants should set up a follow-up meeting for COPE participants or for the COPE committee, if one has been formed as a result of the exercise (see "COPE Committee," page 8.2).

The follow-up meeting is conducted as part of a follow-up COPE exercise. The purpose of this meeting is for staff to monitor and assess their progress in meeting the goals established in the last Action Plan. Scheduling a follow-up meeting and a return

FIGURE 7-2 Sample Action Plan

7.6

<i>PROBLEM</i>	<i>RECOMMENDATION</i>	<i>BY WHOM?</i>	<i>BY WHEN</i>
No forum to discuss family planning	Form family planning committee	Judith Taylor	October 19 (one month)
Some providers not trained in counseling	Develop on-the-job training	Kibogoyo Mzee	October 25 (5 weeks)
Staff need infection-prevention update	Provide update	David Masika	October 19 (one month)
Some staff don't know how to make chlorine solution	Demonstrate to all how to make the 0.5% solution	Fatma Ahmed	October 3 (2 weeks)
No heavy-duty gloves	Provide them from petty cash	Sarah Jotto	October 3 (2 weeks)

visit by an external facilitator encourages staff to carry out their suggestions and gives them impetus to focus on the changes they have decided to make.

The follow-up meeting and the follow-up COPE exercise should be held three to six months after the last COPE exercise. If possible, outside facilitators may arrange to return to the site to help the site facilitator conduct the follow-up COPE exercise. These arrangements should be confirmed with site administration after the Action Plan Meeting. They should be reconfirmed in writing after the exercise is complete.

TOPIC 6

REINFORCING THE POSITIVE

During the Action Plan Meeting, the staff's focus is on problems at the site. At the end of the meeting, the facilitator should again remind staff of some of the positive things about quality of services at the site so that staff do not end the exercise thinking that the site has nothing but problems.

The facilitator's final job is to applaud participants' commitment to providing quality services and to again thank staff for the hard work they have contributed to the performance of the COPE exercise.

Continuing COPE

COPE is based on the beliefs that improving the quality of services at a site is a continuous endeavor and that quality can always be improved. Over time, problems will be solved, and new problems will be identified—and the nature of the new problems will be different. Follow-up to COPE has three important components:

- Immediate follow-up of a COPE exercise by a facilitator
- Site-level follow-up of recommendations
- Follow-up COPE exercises at periodic intervals

IMMEDIATE FOLLOW-UP

The nature of immediate follow-up will depend on whether the facilitator is from outside or within the agency.

An outside COPE facilitator should:

- Send a letter or memo to the site facilitator or to site management congratulating them on the successful completion of the COPE exercise and the participation of the site's staff. The facilitator should attach a copy of the Action Plan to this letter and should use this opportunity to reconfirm the date for the COPE follow-up exercise.
- Communicate with the site facilitator periodically to check on the progress being made on the recommendations as stated in the Action Plan at the site

SITE-LEVEL FOLLOW-UP

A site facilitator may wish to distribute a copy of the Action Plan to all staff or to put the flipcharts in a prominent place where all staff can review what was discussed.

The site facilitator should plan to check periodically with those responsible for taking action on a recommendation—once a month, or perhaps just before an action is scheduled to be completed—to see whether there will be any problems or delays in carrying out the action.

Staff responsible for carrying out a recommendation should be reminded to let the facilitator know when the action has been completed. The facilitator should mark completed items on the flipchart and on the master copy of the Action Plan.

A week or two before the follow-up COPE exercise, the site facilitator should remind participants that they will be doing COPE again and that one of the components of the exercise will be to review the progress made on the previous Action Plan.

COPE Committee

COPE is not intended to be a one-time intervention. Identifying problems and coming up with possible solutions through the Action Plan is an important first step. Many sites find that it is helpful to establish a committee to follow up on progress, plan additional COPE meetings, serve as a resource for staff who need help completing tasks assigned in the Action Plan, etc.

FORMING A COPE COMMITTEE

There are a number of ways to form a COPE committee. The facilitator can:

- Ask for volunteers during the Action Plan Meeting
- Have each department or unit pick a representative for the committee
- Have each type of staff (for example, doctors, nurses, clerks) pick a representative for the committee

While there is no right or wrong way to decide how many people should serve on a committee and how committee members should be picked, it is useful for the facilitator to talk with participants about the committee during the Introductory Meeting. At the Action Plan Meeting, participants can discuss the way the committee should be formed. Factors to consider include:

- There should be enough members to represent different perspectives, but not so many that the committee is unwieldy (fewer than 10 members is preferable)
- Facilitators should suggest criteria for selection, such as staff who are enthusiastic about improving quality, who can and will participate actively, and who communicate easily with their peers
- Different types and levels of staff should participate
- The group should elect a committee chairperson who will be responsible for scheduling and facilitating committee meetings

FOLLOW-UP COPE EXERCISES

Like the first COPE exercise at the site, follow-up COPE exercises usually take place over two days. However, it is not necessary to include every COPE tool at each exercise. One of the most important aspects of COPE is its *adaptability*; the exercise should be tailored to concentrate on areas identified as problems during a previous COPE exercise.

The second COPE exercise at a site is a good time to introduce Client-Flow Analysis—in which case the exercise usually takes place over three days instead of two (see sample schedule, Figure 6-2, page 6-5).

The components of follow-up COPE exercises may include:

- Follow-up meeting for the previous Action Plan
- Introductory Meeting/reintroduction of the COPE self-assessment process
- All or some COPE tools (Self-Assessment Guides, Client Interviews, Client-Flow Analysis, and Action Plan)
- Action Plan Meeting

Follow-Up Meeting for the Action Plan

If possible, all participants from the last COPE exercise should participate in this meeting. The facilitator should begin by reintroducing the last Action Plan, reviewing each item on the plan, and discussing whether each recommendation has been successfully implemented.

Through this discussion, it may emerge that some items were not problems after all. Participants may also find that some recommendations took more or less time to implement than was allotted or that more lay behind the problem than was originally thought. The

results of this discussion should be noted on the COPE Follow-Up Summary Sheet (see Figure 8-1). Unresolved items for which a solution seems possible should be incorporated into the next Action Plan.

FIGURE 8-1 Sample Completed Follow-Up Summary Sheet

FOLLOW-UP SUMMARY

Karibuni Clinic at Three-Month Follow-Up

PROBLEM	RECOMMENDATION	STATUS	COMMENTS
No forum to discuss family planning services	Form family planning committee	Solved	Meets once a month
Some family planning providers not trained in counseling	Develop on-the-job training	Attempted	Currently in the planning stage
Staff need infection prevention update	Provide update	Unsolved	Cancelled several times for various reasons
Some staff don't know how to make chlorine solution	Demonstrate to all staff how to make the 0.5% solution	Solved	Everyone has now had demo
No heavy-duty gloves	Provide them from petty cash	Solved	Question now is how to maintain constant supply

Introductory Meeting/Reintroducing the COPE Tools

This meeting should be run by the site facilitator. If a headquarters or external facilitator is present, he or she should participate only to support the site facilitator.

The site facilitator should remind participants of the purpose of the self-assessment process and should reintroduce the material presented during the Introductory Meeting from the first COPE exercise (see "How COPE Works," page 3.5). Participants should be advised to incorporate unsolved problems from the previous COPE exercise into their discussion during this exercise.

If client waiting times or staff utilization was identified as a problem during a previous COPE exercise, Client-Flow Analysis (CFA) should be conducted during the follow-up exercise (for information on implementing CFA, see pages 6.1-6.18).

Action Plan Meeting

The Action Plan Meeting and the development of the new Action Plan should take place in much the same way as in the first COPE exercise at the site (see pages 7.1-7.7). Again, the site facilitator should run this meeting, with the headquarters or external facilitator providing support only as needed.

The site facilitator should reemphasize the following:

- Positive aspects of services at the site
- That the site should be commended for its interest in improving services for clients
- The indicators of quality introduced at the first meeting
- That the site can continue to hold periodic COPE exercises with the aid of the site facilitator to ensure continuous improvement of services for clients and increased efficiency for the staff
- That staff should agree on a schedule to continue the COPE process and to integrate COPE elements into their work

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Appendix A

Self-Assessment Guides

Clients' Right to Information

This guide relates to information, and the availability of materials in all parts of your facility. The team for this guide should include any staff who may give clients family planning information.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: "PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN."
If you are aware of a problem that is not addressed on this guide, please include it.

1. Do *all* staff know how to advise a potential family planning client about obtaining information and services? Can all staff answer the following questions:
 - Where is the family planning clinic?
 - What times are services available?
 - What methods are available?
2. Is your facility as active as possible in informing women and men about family planning methods and services available, even if these clients come to the facility for other reasons?
3. Do you take the opportunity to inform clients about other reproductive health matters, such as breast examination, Pap smears, prevention and treatment of sexually transmitted diseases (STDs)—including HIV infection?
4. Are signs that show the days and times of services prominently displayed throughout your facility? Are there signs identifying the family planning clinic? Are the costs of services, if any, displayed?
5. Are there enough educational activities about family planning and other reproductive health matters to engage clients when they are unoccupied or waiting to be served in clinics or when they are in-patients in a hospital?
6. Are brochures, posters, and pamphlets about family planning and other reproductive health matters available to clients in all parts of your facility?
7. Are instructional tools, such as flipcharts, models, and samples of methods, available for use in informing and educating clients in all departments or wards and during informational talks? Are these tools clean and easily accessible? Are they used?

8. Do clinics and wards hold regular informational sessions about all available family planning methods (both temporary and permanent) and about family planning and other reproductive health services for both men and women? Are enough of the sessions held?
9. If your facility is a hospital, are all women in the maternity and gynecology wards offered individual counseling about family planning before they are discharged? What about men and women in other wards (for example, in male wards and pediatric wards)?
10. Are clients always counseled about all methods that might be appropriate to their reproductive intentions, breastfeeding status, postabortion status, and personal life, including their sexuality?
11. Is sufficient time allotted for counseling?
12. Are clients provided with information that will help them select a method suitable for their needs? For example, are they told:
 - About methods that provide temporary protection from pregnancy
 - About methods' effectiveness
 - How methods work
 - About potential side effects or health benefits related to the use of specific contraceptive methods
 - About methods that provide protection against STDs, including HIV/AIDS
 - About health benefits other than those directly related to contraception
13. When a client chooses a temporary method (the combined pill, the progestin-only pill, the IUD, injectables, Norplant implants, spermicides, natural family planning, the lactational amenorrhea method, diaphragms, and condoms), do staff explain (in addition to the items listed in question 12):
 - How to use it (or the procedure for administration)
 - Potential side effects
 - Potential complications
 - The management of side effects
 - The follow-up needed
 - Resupply
 - Whether the method provides protection against STDs
14. Do staff ask clients whether they understand the information they receive and whether they have questions?
15. Do staff ask clients to repeat key information about their selected method to be sure they have understood?

**FOR FACILITIES THAT OFFER TUBAL OCCLUSION
OR VASECTOMY**

16. Do prospective clients for permanent methods receive the following information:

- Availability of temporary family planning methods
- That the client will no longer be able to have children after the procedure
- Benefits of permanent methods
- Description of the procedure, including type of surgery, anesthesia, etc.
- Risks of surgery, including potential complications
- That there is a small possibility of failure
- That the client is free to change her or his mind at any time before the procedure
- What to expect after surgery

17. After surgery, do clients receive the following information:

- How to care for the wound
- Date of the return visit
- Warning signs of complications
- The importance of seeking medical attention if problems arise
- When normal activities can be resumed (e.g. work, sexual relations)
- (*For vasectomy clients*) For the approximately 12 weeks or 20 ejaculations it takes to clear the semen of sperm, clients should use other contraceptive methods

18. Are postoperative instructions given to the client both orally and in writing?

**FOR FACILITIES THAT OFFER TREATMENT FOR
POSTABORTION COMPLICATIONS**

19. Do clients who have been treated for postabortion complications, including incomplete abortion, receive the following information:

- That there is an almost immediate return to fertility postabortion
- Where and how to obtain contraceptive methods and services

OTHER ISSUES YOU THINK ARE IMPORTANT

20. _____

21. _____

22. _____

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Clients' Right to Access

This guide refers to clients' right to access to services, including barriers to physical access to your facility. Other issues of access are also covered under sections on safety, choice, and continuity. At least one person who provides information, counseling, or services for family planning or other reproductive health issues should be included in the team for this guide.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: "PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN." *If you are aware of a problem that is not addressed on this guide, please include it.*

1. Is the cost of family planning and other reproductive health services within the reach of all potential clients? What about other costs, such as transportation to your facility?
2. Are the times of family planning and other reproductive health services convenient for all clients, including working women and men (for example, are counseling and services available daily, including weekends and after working hours)?
3. Are signs for family planning and other reproductive health services prominently displayed throughout your facility?
4. Is your facility conveniently located for potential clients (for example, is your site on a bus route, near a market, etc.)?
5. If your facility is a hospital, do women (including prenatal, postpartum, and postabortion clients) and men in all wards and outpatient departments have ready access to family planning and other reproductive health information and services?
6. Are women who have had a baby offered family planning counseling and services when they return for their first postpartum or well-baby checkup?
7. Are family planning and other reproductive health services readily available for men? Do men feel comfortable coming to your facility for information or services?
8. Are laboratory tests and physical examinations required before any contraceptive method is given to clients? Are all these tests essential?
9. Do staff try to minimize the number of visits a client has to make for each method? For example, what is the maximum number of pill packets given out at any one time?
10. Can providers communicate with potential clients of all language groups in this area?

11. Does the ministry of health, government, or headquarters institution have family planning guidelines? Do staff and administrators know the recommended eligibility requirements for clients (medical, age, parity, marital status, etc.)? Are these requirements barriers to services for some women and men?
12. Does your facility offer clients a choice of all contraceptive methods available, including both permanent and temporary methods?
13. Have staff had an update on family planning methods and on sexually transmitted diseases (STDs) like HIV infection?
14. Do *all* staff, including support staff, know how to advise a potential family planning client about obtaining information and services, including where the clinic is, when it is open, and the methods that are available?
15. Do staff give clients family planning and other reproductive health services even if their records cannot be found?
16. Does the facility offer these services? Do staff know where to refer clients for them?
 - Management of reproductive tract infections (including STDs such as HIV infection)
 - Management of breast abnormalities
 - Incomplete abortion or postabortion complications
 - Maternal and child health services
17. Is treatment for incomplete abortions provided independent of whether the client agrees to accept a contraceptive method?

**FOR FACILITIES THAT OFFER TUBAL OCCLUSION
OR VASECTOMY**

18. Do staff minimize the number of visits clients make before surgery, while still ensuring that clients have the opportunity to make an informed choice?

OTHER ISSUES YOU THINK ARE IMPORTANT

19. _____
20. _____
21. _____

Clients' Right to Choice

This guide relates to clients' right to choose the most appropriate contraceptive method for their needs. For permanent methods, this guide addresses issues of informed consent. The team for this guide should include at least one person who provides information, counseling, or services for family planning or other reproductive health services.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: "PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN."
If you are aware of a problem that is not addressed on this guide, please include it.

1. Does your facility offer a range of contraceptive choices that meets clients' needs? Do you have both temporary and permanent contraceptive methods?
2. Are there family planning methods not offered at your facility that you think could be?
3. If some methods are not available at your facility, do staff know how and where to refer clients for these services? Do they do so?
4. Are clients offered a full range of methods appropriate to their reproductive intentions, breastfeeding status, postabortion status, and personal life, including their sexuality?
5. Are there restrictions for some methods? Do clients usually receive the method of their choice?
6. Do all new clients receive counseling to help them select the method that will best meet their needs?
7. Do staff inform clients if there is a contraindication to the method they want? Do staff explain alternative methods?
8. Do staff inform clients about the methods that do and do not provide protection from sexually transmitted diseases, including HIV infection?
9. Are clients made aware that they may discontinue or change temporary contraceptive methods at any time they choose?

**FOR FACILITIES THAT OFFER TUBAL OCCLUSION
OR VASECTOMY**

- 10. Are there barriers or constraints for clients who want a tubal occlusion or vasectomy? If so, why? Can these barriers be overcome?
- 11. Do staff ensure that clients understand that tubal occlusion and vasectomy are permanent methods? Do staff confirm that clients interested in these methods do not want to have any more children?
- 12. Before surgery, do staff reconfirm that clients still wish to proceed with the surgery?
- 13. Before performing postpartum tubal occlusion, do staff verify the condition of the baby and reconfirm the client's desire to proceed with surgery?
- 14. Do staff ensure that the informed consent process is followed and that a signed informed consent form is attached to the client's records?

OTHER ISSUES YOU THINK ARE IMPORTANT

- 15. _____
- 16. _____
- 17. _____

Clients' Right to Safety

This guide relates to safety issues, particularly screening, infection prevention, and reporting of complications. The team for this guide might include hospital ward or maternal and child health staff, a surgeon or ancillary ward member, a housekeeper or cleaner, as well as family planning service providers. If your site performs sterilizations, a member of this team should conduct a Sterilization Record Review.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: "PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN." *If you are aware of a problem that is not addressed on this guide, please include it.*

GENERAL SAFETY, SCREENING, AND FOLLOW-UP

Screening includes client evaluation from several perspectives. The information needed will depend on the service being requested: general health and medical history, behavior, social history, physical exam, and laboratory testing. When looking at screening practices at your facility, please consider these different perspectives.

1. Do staff feel they have sufficient guidance, updates, and backup to provide safe services?
2. Are all contraceptives in stock within the expiration date?
3. Is the right equipment available to provide services efficiently and safely?
4. Are staff well informed about the potential health benefits and contraindications for the different methods offered?
5. Are clients informed about the warning signs of potential complications? Are they told to seek medical attention or return to the facility if these symptoms occur?
6. Are clients told that if they have a problem they should return to the clinic without waiting for their follow-up appointment?
7. Is there a plan for routine follow-up for all methods of family planning?
8. Do staff routinely record and review causes of complications in order to improve clinical practices?

9. Is a qualified clinician always available for consultation in case of complications?
10. Are staff aware of the procedure for reporting a family planning-related death, even though occurrence of this is rare?

INFECTION PREVENTION

11. Are written infection-prevention guidelines, charts, posters, leaflets, and handbooks available for staff? Do staff understand and follow the guidelines for protecting themselves and others during their work?
12. Are disposable needles and syringes used whenever possible? Are reusables properly sterilized?
13. Are sterile or high-level disinfected gloves available when necessary?
14. Are needles and other sharp objects placed in safe containers before disposal?
15. Are reusable materials and instruments decontaminated in a 0.5% chlorine solution for 10 minutes before further processing? Do staff have enough buckets, bowls, and bleach to ensure that chlorine solution is always available where it is needed?
16. Are soiled surfaces (examination couches, operating tables, etc.) wiped with 0.5% chlorine solution after each procedure?
17. Are decontaminated instruments and materials washed and rinsed well before further processing?
18. Are reusable materials sterilized or high-level disinfected before use? Are methods for high-level disinfection understood by staff?
19. Is equipment for sterilizing reusables available and functioning? Are proper chemicals for sterilization and high-level disinfection available and used correctly?
20. Do staff wear heavy-duty gloves to clean dirty instruments and to dispose of contaminated waste?
21. Is contaminated waste disposed of in a safe way (for example, burning or burying)?
22. Do all staff wash their hands after handling waste?
23. Do staff fully understand infection-prevention techniques?

CONTRACEPTIVE METHODS

Norplant Implants

24. Is aseptic technique used for insertion and removal?
25. Is local anesthetic given correctly?
26. Are insertion and removal techniques appropriate?
27. Are there any problems with removal?

IUD

28. Do staff follow specific guidelines for screening IUD clients? Do staff conduct an assessment of risk for infections (from reproductive tract infections or from incomplete abortion) and a physical exam for each client? Do staff feel competent to do the screening?
29. Is aseptic, no-touch technique used for IUD insertion?
30. Are staff trained to do postpartum and postabortion IUD insertion as well as interval insertion?
31. Are bimanual and speculum exams done before insertion?
32. Are the tenaculum and uterine sound used properly?

Injectables

33. Do staff follow guidelines for the timing of first injection and reinjection?
34. Is the correct intramuscular injection technique used?
35. Are needles and syringes disposed of properly?

Tubal Occlusion

36. Are clients fully screened and assessed for medical fitness before sterilization is performed?

37. Before surgery, do staff ensure that:
- The client has fasted for six hours before surgery
 - The surgeon has examined the client
 - The surgeon and assistant follow correct practices for scrubbing, gowning, and gloving
 - The operating site is cleaned with soapy solution and disinfected with iodine or spirit
 - The operating room is regularly cleaned with disinfectant
38. Is the technique for minilaparotomy under local anesthesia routinely used?
39. When performing minilaparotomy under local anesthesia, does the surgeon use *no more than 20 ml of 1% lidocaine (lignocaine)* for local anesthesia?
40. Are the drugs used before and after surgery recorded on the client's record form?
41. For minilaparotomy, is the uterine elevator used effectively in interval procedures?
42. For minilaparotomy, is the tubal hook used effectively?
43. Do the surgeons use absorbable sutures to tie the tubes?
44. Are the client's vital signs monitored and recorded during and after surgery? Is this information correctly entered on the client's record form?
45. Are the problems encountered during surgery recorded?
46. Is the client observed for at least one hour before discharge?
47. Is a qualified clinician available for referral in the case of the following complications? Do staff know what procedures to follow if these complications occur:
- Bladder injury
 - Bowel injury
 - Cardio/respiratory distress
 - Excessive bleeding
48. Does the clinic have equipment that enables staff to deal with the above complications? If not, what are the procedures followed by staff?
49. Are all clients given postoperative instructions both orally and in writing?
50. Do clinicians check for infection and other problems during the follow-up visit?

Vasectomy

51. Are clients fully screened and assessed for medical fitness before vasectomy is performed?
52. Is the no-scalpel technique used?
53. Do clinicians check for hemostasis?
54. Are the medications used before and during surgery recorded on the client's record?
55. Are vasectomy clients provided with condoms after surgery? Are they instructed to use condoms or another temporary method for 12 weeks or 20 ejaculations after the vasectomy? Is the reason for this explained?
56. Are all clients given postoperative instructions both orally and in writing?
57. Does the clinician check for infection, hematoma, and other problems during the follow-up visit?
58. Is semen analysis provided for postvasectomy clients?

OTHER ISSUES YOU THINK ARE IMPORTANT

59. _____
60. _____
61. _____

Clients' Right to Privacy and Confidentiality

Clients have a right to privacy and confidentiality during the delivery of services and during counseling and physical examination. The team for this guide could include receptionists, guards, physicians, clerks, or any other staff.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: "PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN."
If you are aware of a problem that is not addressed on this guide, please include it.

1. Does your facility have a private space where clients will not be observed or overheard during family planning counseling?
2. Are there ways to ensure that there are no interruptions during client counseling (for example, signs and locks on doors)? Do these work?
3. Do staff explain to clients what type of examination is being done, and why?
4. Do clients have privacy during examinations?
5. When a third party is present during counseling or examination, do staff explain that person's presence and ask the client's permission? If case discussions are held in the presence of a client, are clients given the opportunity to be involved in discussions?
6. Do staff respect client confidentiality by not discussing a client except to get advice from other clinic personnel?
7. Is access to client records strictly controlled?
8. Do all staff respect the client's right to confidentiality—for example, by keeping information from the client's spouse, partner, or parent if the client so desires?

OTHER ISSUES YOU THINK ARE IMPORTANT

10. _____
11. _____
12. _____

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Clients' Right to Dignity, Opinion, and Comfort

This guide combines the three closely related "rights" to dignity, opinion, and comfort. Team members could include family planning or other reproductive health providers and counselors, receptionists, doormen, etc.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: "PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN." *If you are aware of a problem that is not addressed on this guide, please include it.*

1. Do all staff (doormen, receptionists, family planning staff, accounts staff, lab and pharmacy staff, etc.) treat clients with courtesy, consideration, attentiveness, and with full respect to their dignity?
2. Are the women and men who come to your facility treated the way you would want to be treated?
3. Do staff use language that clients will understand?
4. Do staff encourage clients to ask questions?
5. Do staff respect clients' opinions?
6. Do staff perform physical examinations and other procedures with the client's dignity and modesty in mind? Is the client's comfort addressed during physical exams?
7. Do staff ask clients about ways to improve services or about other services they might like?
8. The list below describes some areas of the facility that family planning or other reproductive health clients may use. Do you think these are pleasant, comfortable areas (for example, is there enough space, and is the space well organized, clean, well lit, comfortable, well ventilated, and pleasant)?
 - Registration/reception
 - Counseling areas
 - Waiting areas
 - Examination rooms
 - Pharmacy
 - Operating room (reception/scrub and gowning/operating area)
 - Gynecology wards

- Maternity wards
- Delivery rooms
- Emergency/casualty treatment areas
- Recovery and waiting (ward area/toilet)
- Toilet facilities

9. Are all parts of your facility always clean?
10. Are enough staff available at times when the clinic is busiest?
11. Are staff in the clinic fully occupied and well utilized during the entire time they are working?
12. Do you think client waiting times for services are reasonable?
13. Are clients served in the order in which they arrive?
14. Are records organized so that retrieval is quick and easy?
15. Is the time clients spend in contact with a health worker generally satisfactory?
16. Do new clients spend enough time with health workers?
17. Do you routinely give the maximum amount allowed of contraceptive supplies (for example, pills, condoms, spermicide) at any one time so that clients do not have to return too often?
18. Do you try to minimize the number of visits that a client has to make?
19. Are follow-up visits scheduled with the convenience of the client in mind?
20. Are staff nonjudgmental toward clients who have an induced abortion?

FOR FACILITIES THAT OFFER TUBAL OCCLUSION OR VASECTOMY

21. Do staff minimize the number of visits clients make before surgery, while ensuring that clients have the opportunity to make an informed choice?
22. Are waiting times for clients unnecessarily lengthened by waiting for a doctor to come and do something a nurse or another health professional could do?
23. Is tubal occlusion available immediately postpartum, or do some women have to return for the procedure at a later date to comply with administrative procedures?

- 24. If the client is awake during surgery, does the surgical team engage the client in conversation to distract him or her from the procedure? Do staff always ensure that the client is comfortable during surgery?
- 25. If a client is in obvious discomfort during the procedure, do staff talk to the client? Do staff consider using further analgesia?

OTHER ISSUES YOU THINK ARE IMPORTANT

- 26. _____
- 27. _____
- 28. _____

Clients' Right to Continuity

This guide focuses on clients' need for continuity of service. The team working on this guide might include a family planning or other reproductive health service provider and the staff member who is responsible for supplies.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: "PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN."
If you are aware of a problem that is not addressed on this guide, please include it.

1. Does the facility have enough family planning supplies? (Discussion should include contraceptive supplies, gloves, needles, and other items a shortage of which might disrupt services.)
2. Does the facility keep an inventory to help you to know when to reorder?
3. Is there a system for obtaining resupplies quickly?
4. Is all equipment in good condition? If not, do staff know how to obtain replacement equipment?
5. Do family planning workers know which contraceptive methods/brands can be replaced with others, in the case of stock-outs?
6. Do returning clients usually get the contraceptive method they came for? Can they get these methods without a long wait?
7. If the facility cannot provide a certain contraceptive method, do staff refer clients somewhere else?
8. If a client wishes to discontinue a particular contraceptive method (for a reason other than that he or she wants to have a child), is the client counseled about alternative methods?
9. Are all family planning clients given a return appointment? Is the appointment necessary?
10. Are all pregnant and postpartum women counseled about their contraceptive options, including when they can begin using different methods if they are breastfeeding? Are backup methods recommended for women who may be nearing the end of postpartum amenorrhea?

11. Are all postabortion women counseled about their contraceptive options?
12. In the case of clients who travel to the site for postpartum, postabortion, or sterilization services, are the clients given information about where to obtain services in their community?

**FOR FACILITIES THAT OFFER TUBAL OCCLUSION
OR VASECTOMY**

13. If clients booked for a tubal occlusion or vasectomy do not return for the procedure, do staff try to find out why?

OTHER ISSUES YOU THINK ARE IMPORTANT

14. _____
15. _____
16. _____

Staff Need for Good Supplies and Site Infrastructure

In order for health workers to provide good service, they need to have the right tools to do their jobs and a pleasant working environment. This guide relates to equipment and supplies and site facilities. This team might include a family planning or other reproductive health service provider, an operating room nurse, and someone who works with supplies.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: "PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN."
If you are aware of a problem that is not addressed on this guide, please include it.

1. Do the staff involved with family planning stocks always observe the first-expired, first-out (FEFO) rule?
2. Of the family planning methods offered, is there always a good supply of:
 - Progestin-only pills
 - Combined pills
 - Injectables
 - Norplant implants
 - IUDs
 - Diaphragms
 - Condoms
 - Spermicides
3. Do staff feel that the system of supplies enables them to provide quality services for clients?
4. Do staff feel that supplies of informational materials enable them to provide quality services for clients?
5. If your facility is a hospital, are family planning methods available in the maternity, gynecology, male, and pediatric wards? Are they available for women who are treated for abortion complications or incomplete abortion?
6. Do staff feel that their work environment is clean, well ventilated, comfortable, and well equipped enough for them to carry out their duties?

7. The list below describes equipment needed in the family planning clinic and in the wards. Are there enough of these items and are they in good repair?
- Blood pressure machines
 - Stethoscopes
 - Thermometers
 - Scales
 - Steam sterilizer, autoclave, or equipment for high-level disinfection
 - Pelvic examination equipment: specula (different sizes) and light source
 - Instrument trays
 - Gloves
 - IUD insertion equipment
 - Needles and syringes for injectables
 - Norplant implants insertion and removal kits
 - Local anesthetic
8. Do staff always have enough buckets, bowls, and chlorine to ensure that a chlorine solution is always available in all the places needed?
9. Do staff always have heavy-duty gloves to dispose of contaminated waste?
10. Do staff have contaminated-waste disposal facilities and procedures? Are these procedures routinely followed?
11. Do staff know the procedures for reordering commodities and obtaining replacement equipment?

FOR FACILITIES THAT OFFER TUBAL OCCLUSION OR VASECTOMY

12. The following equipment is needed to perform female and male sterilization. Does your site have enough of this equipment in good repair?
- Autoclave or sterilizer
 - Gloves
 - Minilap kits with uterine elevators and tubal hooks
 - No-scalpel vasectomy kits
 - Wall clock in the operating room
 - IV stand
 - Flashlight
 - Oxygen unit
 - Ambubag and masks
 - Demand resuscitator
 - Nasopharyngeal airways

- Endotracheal tubes
- Suction apparatus
- Laryngoscope
- Emergency laparotomy kit
- Emergency tray, including:
 - lidocaine (lignocaine, Xylocaine)
 - meperidine hydrochloride (pethidine, Demerol)
 - epinephrine (adrenaline)
 - Naloxone (Narcan)
 - Atropine
 - Hydrocortisone
 - Sodium bicarbonate
 - Calcium gluconate
 - Aminophylline
 - Diazepam (Valium)
 - Flumazenil (Mazicon, Reversed)
 - Antihistamine
 - IV fluids—dextrose (5% and 10%); normal saline
 - IV administration sets
 - Syringes and needles

OTHER ISSUES YOU THINK ARE IMPORTANT

13. _____
14. _____
15. _____

Staff Need for Good Management and Supervision

Health workers function much better in a supportive working environment that combines good management and supervision. The team working on this guide should include representatives from management, as well as family planning or other reproductive health service providers.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: "PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN."
If you are aware of a problem that is not addressed on this guide, please include it.

1. Does your facility have a family planning committee? Does it work well?
2. Do you regularly hold staff or committee meetings to discuss family planning services?
3. Do staff feel that they are part of a family planning team and are able to give suggestions to the management and the family planning committee (if one exists) about services? Does management encourage this?
4. Do staff at this facility follow guidelines set by the ministry of health, a government department, or agency headquarters?
5. Does management provide constructive feedback to all staff on family planning issues? Is management supportive, encouraging, and respectful of staff?
6. Do staff feel that supervision within the facility is adequate?
7. Does the support that your facility gets from your headquarters organization always meet your needs?
8. Do staff feel that the facility emphasizes and is committed to the provision of quality family planning services?
9. Are there strong links between the different departments or wards? For example, do staff share family planning information, give referrals, visit other parts of the facility to give health talks, etc.?
10. Do staff in the facility always give due respect and attention to workers from other departments and to community workers who may have referred clients? Are there guidelines for referring clients for family planning?

11. Is there a mechanism through which community-based distribution workers can discuss issues with facility-based workers?
12. Are clinic reports submitted regularly and on time? Do staff assess the quality of family planning services by discussing data from clinic reports? Are reports sent to headquarters used to give feedback to clinic staff?
13. Are all clients' family planning records completed properly? Is all essential information included?
14. Do staff ever interview clients to measure their satisfaction with family planning services?
15. Is someone routinely assigned responsibility for:
 - Family planning counseling in the clinic
 - Giving talks on family planning to clients in the clinic or in hospital wards
 - Coordinating sterilization services

**FOR FACILITIES THAT OFFER TUBAL OCCLUSION
OR VASECTOMY**

16. Are the following forms properly filled out? Is someone responsible for each type of form?
 - Client record forms
 - Informed consent forms
 - Operating room register
 - Complications forms
 - Death forms
 - Booking register

OTHER ISSUES YOU THINK ARE IMPORTANT

17. _____
18. _____
19. _____



Staff Need for Information, Training, and Development

For a site to be able to provide quality family planning services, staff need to be well informed and well trained. The team working on this guide might include family planning or other reproductive health service providers and ward or operating room staff (in a hospital).

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: "PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN."
If you are aware of a problem that is not addressed on this guide, please include it.

1. Are staff familiar with the ministry of health or institutional guidelines on family planning and infection prevention? Do staff have access to them?
2. Do all staff know when and where family planning services are available? Do all staff know the contraceptive methods that are offered?
3. Do *all* staff feel able to give basic family planning information?
4. Are updates and in-service training provided to keep staff well-informed?
5. Do enough staff in the facility have the skills necessary for counseling clients, including groups with special needs (for example, men, postpartum and postabortion women), on all methods? Are counseling staff always available during clinic hours?
6. Do enough staff have information to give to men and women about sexually transmitted diseases (STDs), including HIV infection? Do staff know how to show clients how to use a condom?
7. Do family planning staff feel competent to do STD screening by asking questions about exposure to risk of contracting STDs and by clinical screening?
8. Have all staff involved in giving family planning information observed a tubal occlusion, vasectomy, Norplant implant insertion or removal, and an IUD insertion or removal?
9. Does the facility have enough trained providers skilled in family planning and other reproductive health issues. Is there enough in-service training?

10. Are there enough doctors, clinical officers, or nurse-midwives who are competent in all methods offered that involve a clinical procedure (tubal occlusion, vasectomy, IUDs, Norplant implants, injectables)?
11. Do all staff in wards or clinics know enough about infection prevention? (For example, do staff know how to make up a 0.5% solution of chlorine from locally available bleach or chlorine that will kill HIV and the Hepatitis B virus?)

**FOR FACILITIES THAT OFFER TUBAL OCCLUSION
OR VASECTOMY**

12. Do all staff have access to the reference book *Safe and Voluntary Surgical Contraception*?*
13. Are theater and clinic staff familiar with sterilization complications? Do they know how to use death-reporting forms?
14. Are all the staff involved in sterilization services (including doctors, nurses, and assistants) fully trained to provide quality services?

OTHER ISSUES YOU THINK ARE IMPORTANT

15. _____
16. _____
17. _____

* World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception. 1995. *Safe and Voluntary Surgical Contraception*. New York: AVSC International.

Appendix B

Sterilization Record Review

Performing the Sterilization Record Review

All sites that offer sterilization services should perform this review as a supplement to the Clients' Right to Safety guide. A team member who knows the clinical procedures for sterilization should conduct this review in addition to other team activities.

STEP 1

CHOOSING RECORDS FOR REVIEW

From the clinic's files, the reviewer randomly selects 10 sterilization client records that show the procedures followed at the time of surgery.

STEP 2

THE STERILIZATION CLIENT RECORD REVIEW CHECKLIST

Using the following procedure, the reviewer checks each sterilization record against the Sterilization Record Review Checklist to see whether essential information has been recorded (see Figure B-1 for a sample completed checklist; a blank copy of the form appears on page B.4).

1. The reviewer writes each record number on the checklist under the heading "Serial Number."
2. For each of the 10 sterilization records, the reviewer looks for the information specified in the numbered items in the left-hand column of the checklist. If the information is contained in the record, the reviewer puts a check mark in the corresponding space on the checklist. For example, in Figure B-1, client record number 045 contained the information requested in item 1—"Physical exam completed"—whereas client record number 130 did not.

Items 7–10 on the checklist should be completed only if records show that a complication occurred during the sterilization procedure.

3. When each item on the checklist has been reviewed against each of the 10 records, the reviewer should note the number of check marks for each item in the "Total" column of the checklist. Based on this number, the reviewer can make generalized assumptions about the site's recordkeeping for sterilization clients.

FIGURE B-1 Sample Completed Checklist

STERILIZATION RECORD REVIEW CHECKLIST

SITE: Karibuni Clinic

DATE: September 12, 1995

REVIEWER: David M. M.

(Select 10 records at random)

CHECKLIST ITEM	SERIAL NUMBER										TOTAL
	045	130	236	017	013	025	069	191	023	202	
1. Physical exam completed	✓		✓		✓	✓		✓			5
2. Informed consent form signed and attached	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
3. Intra-op medications: Time	✓	✓	✓		✓		✓		✓	✓	7
Name of drug	✓	✓	✓		✓		✓		✓	✓	7
Strength of drug	✓		✓				✓			✓	4
Volume of drug	✓		✓				✓			✓	4
4. Intra-op vital signs recorded	✓	✓		✓	✓	✓		✓			6
5. Procedure notes recorded	✓	✓		✓	✓	✓		✓			6
6. Post-op vital signs recorded	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
COMPLICATIONS Note cases where a complication occurred								✓			1
7. Complication was described											
8. Procedure was recorded											
9. Medication given recorded								✓			1
10. Discharge status recorded								✓			1

For example, in Figure B-1, the information for item 1 was noted in only 5 of the 10 records. A sum of less than 10 in the "Total" column could mean either that the item was not performed (for example, the client did not receive a physical examination) or that the item was performed, but information about it was not recorded.

STEP 3

RECORDING FINDINGS

After completing the checklist, the reviewer identifies incomplete records, considers reasons why the records might be incomplete, and discusses recommendations for solving record-keeping problems with other team members or with the COPE facilitator. If a high proportion of the 10 records have incomplete information in one or more areas, the reviewer may decide to look at a larger selection of records to see whether the clinic has a general record-keeping problem.

The reviewer writes the findings on flipchart sheets using the same format as for other self-assessment items (see Figure 4-1, page 4.5) and presents them for discussion at the Action Plan Meeting.

STERILIZATION RECORD REVIEW CHECKLIST

SITE: _____

DATE: _____

REVIEWER: _____

(Select 10 records at random)

CHECKLIST ITEM	SERIAL NUMBER										TOTAL
1. Physical exam completed											
2. Informed consent form signed and attached											
3. Intra-op medications: Time											
Name of drug											
Strength of drug											
Volume of drug											
4. Intra-op vital signs recorded											
5. Procedure notes recorded											
6. Post-op vital signs recorded											
COMPLICATIONS Note cases where a complication occurred											
7. Complication was described											
8. Procedure was recorded											
9. Medication given recorded											
10. Discharge status recorded											

RV

Appendix C

Client-Interview Form

CLIENT-INTERVIEW FORM

SITE: _____

DATE: _____

Directions: Introduce yourself to the client. Explain that the purpose of the interview is to learn how clients feel about services offered at the facility and to get the client's suggestions on how services might be improved. Stress that the interview is confidential and that the client's name will not be used. Adapt the questions listed here to your facility and the client you are interviewing. Record any additional information the client volunteers. Thank the client for her or his assistance.

1. Why did you come to the clinic today?
2. Did you get what you came for? If not, why not?
3. Have you been given information about family planning? yes no

If yes: What methods did you hear about?

If no: Would you have liked to get family planning information?

4. If you came for family planning, did you get the method you wanted?
 yes no

If yes: What instructions were you given about your method?
Do you have any more questions about your method?

If no: Why not?

5. What do you like best about this clinic?
6. What do you like least about this clinic?
7. What suggestions do you have to help us improve services at this clinic?
8. Is there anything else you would like to tell us?

Interviewer comments:

Appendix D

Forms for Performing Client-Flow Analysis

CLIENT REGISTER FORM

Client number: _____

Contraceptive method: _____

Male Female

Type of visit: _____

Revisit First visit

Time of client's arrival in clinic: _____

	<u>Staff member initials</u>	<u>Time service started</u>	<u>Time service completed</u>	<u>Total contact (in minutes)</u>
First contact	_____	_____	_____	_____
Second contact	_____	_____	_____	_____
Third contact	_____	_____	_____	_____
Fourth contact	_____	_____	_____	_____

Comments: _____

CLIENT REGISTER FORM

Client number: _____

Contraceptive method: _____

Male Female

Type of visit: _____

Revisit First visit

Time of client's arrival in clinic: _____

	<u>Staff member initials</u>	<u>Time service started</u>	<u>Time service completed</u>	<u>Total contact (in minutes)</u>
First contact	_____	_____	_____	_____
Second contact	_____	_____	_____	_____
Third contact	_____	_____	_____	_____
Fourth contact	_____	_____	_____	_____

Comments: _____



CLIENT-FLOW CHART SUMMARY

SITE: _____ DATE: _____

Page	Total number of clients	Total minutes	Contact minutes	Percentage time spent in contact
Page 1				
Page 2				
Page 3				
Page 4				
Page 5				
Totals				

Average number of minutes: _____
(divide total minutes by total number of clients)

Average contact minutes: _____
(divide total contact minutes by total number of clients)

AS

Appendix E
Action Plan
Follow-Up Summary

FOLLOW-UP SUMMARY

PROBLEM	RECOMMENDATION	STATUS	COMMENTS