COPE

for Child Health

A Process and Tools for Improving the Quality of Child Health Services

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AVSC International

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Improving the Quality of
Child Health Services

AVSC International
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Introduction to the COPE for Child Health Edition

In 1995, AVSC published *COPE: Client-Oriented, Provider Efficient Services*, a handbook designed to help clinic and hospital staff improve the quality of their family planning services and to help them use their resources more efficiently. Since that time, service providers have asked that the handbook be revised to include other aspects of health services, such as child health, maternal care, and other areas of reproductive health.

With this new edition of the COPE handbook, AVSC, in collaboration with UNICEF, the Africa Bureau of USAID, and USAID REDSO/ESA, has adapted the COPE approach to child healthcare. In this document we have

- Modified the chapters on the COPE process and tools;
- Added a fifth COPE tool, the IMCI Record Review; and
- Revised the appendices to include areas of child and maternal health.

The primary COPE tool is a series of 10 self-assessment guides that are based on ***client rights (in this case, children and their parents or other primary caretaker*** [*] ***) and staff needs*** (described in Figure 1-1 below). Using input from many experts in the field of Child Health and from the experience of the Integrated Management of Childhood Illness (IMCI) program, these 10 self-assessment guides have been adapted to include questions specifically related to childhood illness.

IMCI is an approach to child health services developed by WHO, UNICEF, USAID, and others in response to the problem of child survival. Its philosophy is that when healthcare providers work with children, they are dealing with a "whole child", not with an individual condition or disease. The tools that IMCI-trained health workers use are the IMCI flow charts. These charts employ recognition of symptoms and signs to create a pathway to diagnosis and management.

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[*] Terminology can become complicated, and we want to use terms that will be understood best by our primary clients for this book – service providers and parents or other primary caretakers of children. In this handbook, we use the term *parent or other caretaker* recognizing that this is usually the mother, but is sometimes the father, other relative, guardian or other primary caretaker of the child. The term 'client" refers to the parent/other caretaker, and/or the child himself/herself.

COPE for Child Health is compatible with IMCI, and can be used as a support to IMCI. Examples of how this can happen include:

- Having site staff check their own IMCI record-keeping (please see Chapter 7 for an explanation, and Appendix D for the blank forms for staff to use when doing COPE); and

- Identifying supplies and equipment needs at the site, and enabling a plan of action to be developed to deal with them.

COPE and the tools for child health can equally be used in sites and healthcare systems where IMCI has not been introduced by omitting the tool called IMCI Record Review (Chapter 7).

Given IMCI's focus on the 0-5 age group, many of the questions in the COPE for Child Health Self-Assessment Guides also focus on this age group. The tool, however, applies to the service site as a whole, and therefore, to all clients seen at the site, regardless of age.

COPE is simple to use, easy to understand, and cost-effective. COPE takes little time and few resources, and, most importantly, ***COPE has been shown to work*** (Lynam *et al*., 1993; Rabinowitz *et al*. 1994).

HOW TO USE THIS HANDBOOK

This handbook contains all the elements needed to facilitate COPE for improving the quality of child and maternal healthcare[*].

Chapter 1 gives an overview of how *quality* may be understood.

Chapter 2 describes how to orient a healthcare delivery site to COPE and initiate the first COPE exercise.

Chapters 3 – 8 include full instructions for organizing the first COPE introductory meeting and for using the self-assessment tools (the Self-Assessment Guides, the Client Interview, Client Flow Analysis, and the IMCI Record Review) and for developing an Action Plan. Each of these chapters contains filled-in samples of each form needed for the COPE exercise. Blank copies of these forms are included in the Appendices of this book for easy duplication for staff members to use.

[*] Although this handbook focuses on child health and a companion tool focuses on maternal care, some maternal care issues are addressed here in recognition of the critical role of maternal care in child health and the difficulty of separating the two.

Chapter 9 describes how using COPE can improve a site over time. It offers suggestions for continuing COPE, establishing a COPE Committee and includes a discussion of various levels of follow-up activities.

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 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 solve problems***.

Facilitators:

- Should treat the information in this handbook as suggestions, not instructions;
- 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.

SHARING COPE EXPERIENCES

At a later date, this handbook will be published in a new, condensed, easy-to-use version. Until then, since this edition of ***COPE for Child Health*** is in draft form, AVSC welcomes feedback from users. Please forward any problems, suggestions, and comments from your experiences with COPE to Julie Becker, Reproductive Health Linkages at:

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1. Improving Quality of Child Healthcare with COPE

COPE stands for Client-Oriented, Provider-Efficient services. It is **a self-assessment approach and set of tools** designed to manage and improve quality of care in healthcare delivery sites. Using the COPE approach, staff members work on site in multidisciplinary teams to:

- Discuss the quality of the services they provide;
- Identify areas of their work which need improvement;
- Identify what they need to provide better services; and
- Find ways to solve identified problems.

COPE tools can be used by the staff:

- For self-assessment;
- As a support for performance improvement; and/or
- As reference material for self-improvement.

THE COPE APPROACH

Thinking about Quality: Addressing Client* Rights and Staff Needs

We have all been consumers of health care services and know that the quality of those services varies from place to place, leading to reactions ranging from feeling satisfied and wanting to use those services again, to feeling angry and determined never to return. Many clients never articulate such feelings to the staff who have served them and rarely do staff ask what their clients think. But clients do have opinions, and the result of poor quality service may be that clients just stop using the services they really need.

Children have the RIGHT to safe and effective healthcare.

In our work around the world, AVSC staff and in-country partners have begun to ask clients about the sort of services they want. To many, the safety of the services they receive is of utmost importance; to others, the way the providers treat them, or the

* "Client" in this context refers to the child and his or her caretaker, usually the mother.

privacy that is afforded are key elements in deciding whether or not to use the services again. Having to wait a long time or finding that services are unavailable after seeking them out may be dangerous, or at the least a serious disincentive to using services; similarly receiving poor or ambiguous information may frustrate and deter clients.

In an attempt to help health workers improve their services, AVSC took these different ***views of quality*** and developed a framework which takes as its premise that clients, in this case children and their parents or primary caretakers, have a right to expect certain things when they come for services. We also recognized that health workers are often themselves frustrated by being unable to provide the sort of services they know are needed, and with them, developed a framework for defining these needs. The result is a list of ***7 client rights*** and ***3 staff needs***, which are listed on Figure 1-1 below.

Figure 1-1

CLIENT RIGHTS AND STAFF NEEDS

1. Client right to information
2. Client right to access to services
3. Client right to counselling and informed choice
4. Client right to safe and effective care
5. Client right to privacy, confidentiality and expression of opinion
6. Client right to dignity and comfort
7. Client right to continuity of care
8. Staff need for good management and facilitative supervision
9. Staff need for information, training, and development
10. Staff need for supplies, equipment and infrastructure

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.

Typical problems that COPE can address:

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

- Staff schedules may be poorly organized; for example, there may be only one nurse available at the busiest times of the day;
- Sites may have inadequate infection prevention measures;
- In sites that have no signs that direct clients to the child health clinic, shy parents or caretakers who are reluctant to ask the way may leave without receiving treatment for their children;
- Pamphlets, posters, and other informational materials may be locked away in cupboards, while parents/caretakers sit in waiting areas for hours with nothing to read; or
- Waiting rooms may be crowded and contain nothing for children or their mothers to look at or do while waiting.

One of the most important health workers for the child is her mother.

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 and other staff themselves could make changes that would substantially improve the quality of services.

Although COPE is not a magic bullet that will solve every problem, it does have the following strengths:

First, COPE ***recognizes that staff and clients are the experts on the quality of services at their clinic or hospital, and takes advantage of this expertise.*** Often these experts have little opportunity to express their opinions or to define what they think of as "quality" services. Through COPE, service providers and staff, with the help of clients, identify problems and develop plans for improvement. Active involvement of both clients and staff increases the likelihood that the process of improving services will be continuous.

Second, because COPE ***is a flexible process***, it works in both large and small institutions.

Third, COPE helps to improve performance through the questions staff ask themselves which ***communicate standards*** in an indirect way. This leads staff to question the way they do things.

Fourth, COPE works through a set of ***trigger questions*** that if addressed two or three times a year can directly focus attention on quality.

Fifth, ***COPE for Child Health*** recognizes ***that one of the most important health workers for the child is the mother*** or other primary caregiver in the home.

For a synopsis of key COPE concepts, see Figure 1-2 at the end of this chapter.

Who Does COPE?

COPE is carried out by staff at a service site (staff from clinics, wards, laboratory, X-ray, surgical units, nursing, administration, receptionists, ancillary staff, affiliated community health workers, etc.) with assistance from an experienced COPE facilitator. Little equipment is needed to do COPE for the initial exercise. The most important thing needed is two or three days from 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.

The 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. ***One ultimate objective is for someone at the site to become proficient in leading the exercise.***

The COPE facilitator will introduce COPE and explain how to do the self-assessment exercise using the guides in this document. In brief, groups of staff work together in teams to discuss the questions posed in the 10 guides (see next page). The teams identify which aspects of their services need improving and develop a time-specific plan of action for presentation and discussion with the larger group. It is important that the facilitator and team leaders allow for full participation of other team members and not dominate the process.

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 provide follow up to the 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.

The Steps of a COPE Exercise

An initial COPE exercise is made up of:

- **The introductory session,** in which COPE is explained to participants;
- **Self-assessment,** (see COPE tools below);
- **The action plan meeting,** in which staff incorporate findings into the action plan; and
- **Follow-up,** to assess progress on the action plan.

How Much Time Does a COPE Exercise Require?

One COPE exercise takes place over the course of two to three days, although it only takes a few hours of staff time during those days. Apart from the Introductory Meeting and Action Plan Meeting, most of the exercise takes place as staff members do their normal work.

After the initial exercise, repeat COPE exercises can be held as frequently as the staff feels the need, but it is best to do them two to three times a year to keep the focus on quality.

COPE TOOLS FOR IMPROVING CHILD HEALTHCARE

The five COPE tools that make up a COPE for Child Health exercise are:

- **Self-Assessment Guides:** The 10 Self-Assessment guides have been organized according to the rights of the client and needs of the staff that are necessary to ensure quality child healthcare services (see Figure 1-1). The questions that appear in the guides suggest ways in which managers, supervisors, doctors, nurses, and other staff can work together to ensure that client/staff needs are fulfilled. A description of the 10 Self-Assessment guides and how to use them can be found in Chapter 4. Sample forms for staff to photocopy and fill in are in Appendix A.
- **Client Interviews:** These are performed by staff with the aid of a Client-Interview Form. For a description of the client-interview process see Chapter 5. Sample forms are in Appendix B.

COPE can be used as a reference and, through the use of trigger questions, as a memory

- **Client–Flow Analysis (CFA):** CFA is a "low-tech" method of tracking clients through the Maternal and Child Health Clinics, and Casualty if appropriate, 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 in Chapter 6. Sample forms are in Appendix C.
- **IMCI Record Review Checklists:** These are for sites that use the Integrated Management of Childhood Illness approach. A description of the checklists appears in Chapter 7. Sample checklists are in Appendix D.
- **Action Plan:** This is prepared by the staff using the other three tools, describes the problems staff members 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 is given in Chapter 8. A sample form of the Action Plan is in Appendix E.

COPE helps to improve performance and communicate standards.

Figure 1-2

HOW COPE IMPROVES QUALITY - 10 KEY CONCEPTS

1. Self –Assessment Promotes a Sense of Ownership

When staff assess their own services, rather than being told what they need by outsiders, they develop a sense of *ownership*. The staff members feel that the problems and challenges they uncover are theirs, and they feel responsible for addressing them.

2. Wisdom of the Experts

The experts on the services at a site are those who provide them and those who use them – the staff, and their clients. These people bring their brains with them to the facility. COPE uses them.

3. Team-building

Multidisciplinary groups solve their own problems and this makes them feel part of a team at the site – the team that provides quality services.

4. Staff Involvement at All Levels

Many improvements at a facility depend on the support of the administration and top clinicians – the medical officer and head nurse. While this level of staff is very important in order to get things moving, other levels of staff are equally important to clients. A client comes into contact with many staff at a service delivery site, and all these people are important to how the client views the service.

5. Provides a Forum.

Very often staff members have said – I knew that we could improve the services by doing that. But I've never had the opportunity to talk to the matron / head doctor / administrator before. COPE provides the right occasion.

6. Simplicity

A very important part of why COPE works is that it is simple to use. There are no complicated flowcharts or diagrams to learn about. The Plan of Action format is simple to fill in and easily understandable. Staff do not have to go through a rigorous training exercise to be able to do COPE. Anyone can understand it, because it is based on common sense.

7. Cost Effectiveness

COPE costs nothing apart from the time of a facilitator (initially, until staff can do the exercise without help) some flipchart paper, and some photocopies, as well as a small amount of staff time for participation during regular work hours.

8. Transferability

After observing one or two exercises, and with the help of some basic tips, any supervisor can facilitate the COPE intervention.

9. Practicality

COPE relates to what staff members do in their daily work; it is not a process full of theory and charts – it is all about 'How can I do what I do better?'

10. Adaptability

COPE has been used successfully at many types of facilities – from major national referral hospitals to small clinics with 5 staff members. It has been used in private hospitals, the public sector and NGOs. COPE was developed in Africa, and has been used successfully in Bangladesh, Colombia, Guatemala, Indonesia, the Philippines and the United States.

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2. 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 maternal and child healthcare 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 maternal and child health facilities or the government and institutional policies about maternal and child health 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; and
- The site's staff see the importance their headquarters gives to the exercise and to quality improvement.

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 not possible, the facilitator and the management staff should meet on the first day of the exercise before the COPE Introductory Meeting. A thorough and effective orientation for the key site managers makes it easier for them to join hands with the facilitator in the first COPE exercise. At the same time, it makes the concepts of staff involvement and empowerment less threatening to managers. Moreover, staff members respond more positively when their own management is involved; they realize that the leadership values quality and the staff's involvement in improving services.

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.

Scheduling COPE

During the advance visit or 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.[*]

Identifying Participants

As many different types of staff members as possible should participate in the exercise– including administrators and maternal and child health service providers, as well as guards, doormen, receptionists, and cleaners. If the site is a hospital, representatives from other departments (for example, staff from family planning, postpartum, gynecology, and male wards) should be included. All have a contribution to make towards improving the quality of maternal and child services. At smaller sites, as many staff as possible should participate. At larger hospital sites, the numbers of participants should be limited – about 25 is ideal, but up to 35 or 40 can participate easily. Larger groups have also been done successfully.

If the advance visit is feasible, the facilitator should take the opportunity to talk to as many of the staff members as possible 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, for example receptionists and cashiers.

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[*] 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 <u>are</u> problems at the site before analyzing these. If CFA is included, COPE is conducted over three days (see Figure 6-2, page 6.7, for a sample schedule that included 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 (approx. 1 and 1/2 hour)

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

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 2-2 lists all the materials needed to conduct a COPE exercise.

Figure 2-2

MATERIALS AND SUPPLIES NEEDED FOR COPE

HANDBOOKS

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

COPE TOOLS*

- 3-5 copies of each of the 10 Self-Assessment Guides (Appendix A)
- 15 copies of the Client Interview Form (Appendix B)
- 1 copy of each of the IMCI Record Review forms (Appendix D)

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 (enough to share with participants)
- Tape for putting up the large sheets of paper

****If Client-Flow Analysis will be performed***:

- Ruler, Calculator, and a Watch
- 100 copies of Client Register form, 5 copies of the CFA chart, and 1 copy of the CFA Chart Summary (Appendix C)
- Large sheets of graph paper (five sheets should be sufficient)
- Colored pens for graphing client flow

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3. The COPE Introductory Meeting

As suggested in the last chapter, 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. This Introductory Meeting is then followed, usually on the same day in the afternoon, by the self-assessment using the COPE tools (see Chapters 4-7). On the next day, staff members develop their Action Plan (see Chapter 8).

PURPOSES 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, Client Interviews and the IMCI Record Review (in sites using IMCI); and
- 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 2-2). 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 "Facilitating COPE Meetings" (see page 3.6) 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 maternal and child health–it has even been suggested for use in running a garage. COPE gives service providers an opportunity to stand back and look at 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
WHAT IS "QUALITY"?

This is the time to get staff members really involved! The facilitator can often confuse the group by simply asking for a definition of quality, or by asking what improving quality means. A better way to get them to think about what quality means is to ask them to put themselves in the shoes of a client coming for a health care service. Ask: "What would you like to see if you walked into a clinic…?" Get them to be specific. Write their responses on flipchart paper. This process starts them thinking about quality, gets them involved and records their responses.

Ask them to compare their responses with the Client Rights and Staff Needs Chart (see Figure 1-1). You will probably find that whatever their backgrounds, clients everywhere in the world want similar things from their health care providers. Staff members also need similar things from their organizations.

TOPIC 4
FOCUS ON CHILD HEALTH

The facilitator should choose three (3) facts that are most important for participants to remember about child health in the site's country or region. Write these on flipchart paper; discuss and reinforce these. For example, if the site deals with many cases of malaria in pregnant women and children, or if vaccination coverage is low, the site should discuss the implications for service delivery.

TOPIC 5
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 that 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.

TOPIC 6
HOW TO IMPROVE QUALITY

Tell staff "We can improve quality by using the wisdom of the experts." Ask them, "Who are the experts on your services here?" Eventually they will say that they are, and their clients are. Tell them that this is how COPE works–by using their expertise, and that of their clients to improve quality.

TOPIC 7
HOW COPE WORKS

The facilitator should explain how the COPE tools are used:

- **Self-Assessment.** This is carried out by teams of staff, often 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" page 4.2)

- **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 6.5).

- **IMCI Record Review.** This tool can be used in sites that understand and follow the IMCI program for child health. One or two participants should be identified to perform the record review, and the facilitator should meet with them briefly after the Introductory Meeting (see Chapter 7).

- **Action Plan.** This is developed during the Action Plan Meeting to resolve some of the problems staff identify during the exercise (see Chapter 8).

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

REMINDER: 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.

TOPIC 8
PROBLEM SOLVING THROUGH COPE

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 child health service sites, for example, a client's or health service provider's desire for updates on recent advances in immunization regimens; constraints to counselling; or 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 in the guides.

Action Plan

Writing up an Action Plan prompts staff to think of *alternatives* for solving problems using existing resources. The plan also prompts participants to determine a staff member responsible for assuring that the problem is solved 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 on recommendations. The meeting also gives staff an opportunity to *prioritize the actions* they will take to address the recommendations they have identified, while taking into account the *available resources* at the site.

TOPIC 9
DETERMINE TEAMS AND CLARIFY THEIR NEXT STEPS

During the Introductory Meeting, the facilitator and participants should decide on the number and make-up of the teams for working on the Self-Assessment Guides and should determine which guide or guides different teams will work on. The number of teams (usually 4 or 5) and the number and type of staff members on each team will depend on the 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. The team make-up 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.

After the close of the Introductory Meeting, the facilitator should meet in small groups with team members who will carry out client interviews, and with those working on client flow analysis and the IMCI Record Review. Each team member should have a clear understanding of the forms to be filled and how to use them.

TOPIC 10

THE ACTION PLAN MEETING

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

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

TOPIC 11

QUESTIONS

The facilitator should ask participants if they have any questions.

FACILITATING COPE MEETINGS

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 first, so that staff at the site does not feel that the facilitator is there to judge them.

To encourage staff ownership in the process, 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. The success of COPE depends on the enthusiasm of the staff. If the facilitator shows enthusiasm, staff will also get excited about COPE.

Create a Comfortable Environment

Effective facilitation involves not only conveying ideas but creating an environment that is conducive to discussion and trust. Staff will be more likely to participate fully if they feel physically comfortable and if they trust that they can speak their minds freely without facing blame or punishment. To achieve this, the facilitator should:

- Come prepared with the materials and supplies needed (see Figure 2-2)
- 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, 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.

Facilitate Discussion

The following suggestions are meant to help the facilitator guide participants, especially if they are having a difficult time being specific about problems, and help keep them focused without leading the discussion.

1. 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?"

2. 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."

3. Rephrase

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 re-statement 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?"

4. Talk about Strengths as Well as Problems

Facilitators should reinforce the positive. For example, "COPE is done in good sites such as this one, where staff have shown 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. 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.

5. 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.

6. 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 is best if this record does not use specific names or places–just the problems and the solutions found.

7. 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.

Tips for the Facilitator: COPE Introductory Meeting

1. Choose just three to five things you want the participants to remember. Spend your time talking about these things. Don't distract them with things that are not relevant.
2. Make your participants talk as much as you can. Involve them. The more they are involved, the better the results.
3. Make nice flipcharts with all your content correctly spelled. Misspelling seems to get participants agitated.
4. Make sure you know how the Rights of the Client / Needs of the Provider are organized. Make a nice flipchart of these, and keep it covered at the beginning.
5. Do not ask the participants 'what is quality?' It is difficult for them to define. Ask instead 'if you (or your sister, husband, cousin) were going for a child health service, what would you like to find?' Make them be specific and practical.
6. Never, ever tell anyone they have given the wrong answer, or imply that their comment is not worthwhile. There are no wrong answers.
7. Ask the participants 'who are the experts on your services?' Let them acknowledge that *they* are the experts, along with their patients/clients. This leads into the fact that therefore we are going to ask *them* how to improve services, and *their clients*.
8. Then introduce the self-assessment and client interviews portion.
9. Always introduce the self-assessment part of COPE first. This is the heart of COPE.
10. Call the self-assessment a 'guide', not a checklist, or a questionnaire. Call the questions 'trigger questions'.
11. Divide participants into groups before you give them the self-assessment guides. The groups should have all levels of staff – i.e. do not put all the nurses together, all the cleaners together, etc.
12. Make sure participants leave the Introductory Meeting with a clear idea of what they have agreed to do next.

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4. Self-Assessment Guides

PURPOSE OF THE SELF-ASSESSMENT GUIDES

Self-Assessment is at the heart 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 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

To perform the exercises:
3 to 5 copies of each Self-Assessment Guide from Appendix A (more copies may be needed for larger sites)

To record findings:
Flipcharts and flipchart paper
Markers
Tape

The Self-Assessment Guides

The Self-Assessment Guides for Child Health are based on the rights of clients and needs of staff presented in Figure 1-1, page 1.2. A copy of each guide appears in Appendix A.

USING THE SELF-ASSESSMENT GUIDES

During a COPE introduction, staff participants should be divided into multidisciplinary teams. Each team works on one or more of the guides. The number of teams and the number of participants on each team depend on the number of guides the site would like

to address and the number of participants available at the site (see "Determine Teams and Clarify their Next Steps," page 3.5).

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.

The guides are written for child health services in general. They contain some "trigger questions" about specific child health areas. Although the major emphasis is on outpatient clinic settings–child welfare clinics, emergency outpatients, vaccination clinics, etc.–major links to inpatient services are also touched upon.

These guides are for prompting staff to think about areas in which they may be able to improve services for clients. The guides are not exhaustive–there may be problems in services at some sites that do not appear here. If staff have problems that do not appear here, they should feel free to mention them anyway. Similarly, the participants should not confine themselves just to the area covered by the guide they are working on. If problems arise which relate to another guide, they should mention them also. In any case, the areas dealt with by the guides overlap; for example, questions of equipment and supplies may relate to safety as well as to provider rights and continuity of services.

Participants do not have to answer every question. They only need to look at questions that are relevant to the services offered at the site.

The guides are not of equal length, and require varying amounts of input. The longest and in many ways the most important is Number 4–The Client Right to Safe and Effective Care. One group works on this guide alone. Other groups can work on one or more of the other 10 guides.

The guides are not given in order of importance, but more generally in the order that a client would come into contact with each area. For instance, a client will probably be given information before receiving a procedure–therefore the Information Guide comes first.

The word 'clients' in these Guides refers to the child and parent or other caretaker.

STEP 1

INSTRUCTIONS TO PARTICIPANTS

The facilitator should hand out the Self-Assessment Guides while discussing them at the introductory meeting–this generally relaxes the atmosphere 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." It may be necessary to ask why two or three times to get to the root cause of the problem.

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 workday. 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).

Teams may find it helpful to walk around the site and observe services and facilities for themselves and discuss issues with colleagues and co-workers in different areas.

Staff working as a team on 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 brief meeting to begin discussion of the guides, then break to think about the issues discussed, and finally meet again to agree on findings.

Each team should develop an individual action plan to bring to the Action Plan Meeting for development of a final action plan.

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 recommendations 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 RECOMMENDATION IDENTIFIED FOR THE ACTION PLAN

PROBLEM/CAUSE	*RECOMMENDATION*	*BY WHOM*	*BY WHEN*
No heavy-duty gloves to protect cleaning staff	*Buy gloves with petty cash*	*Sarah Jotto*	*October 3*

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5. Client Interviews

PURPOSE OF CLIENT INTERVIEWS

The Client Interview tool is designed to help encourage service providers and other staff 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 children, and all parents or other caretakers who bring children for services, and expectant mothers. Client Interviews help the site find out

- What clients know about the services offered;
- What clients think about the services offered; and
- 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 are 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 3.4).

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. See Tips (next page) for conducting successful client interviews. 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.

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 5-1 for a sample Client Interview Form). The form is simply a guide to get an interview underway. Interviewers might use the form to

Tips for the Facilitator: Client Interview

1. For the client interviews, tell the participants 'this is very hard to do. We all know how polite our patients are. It is a challenge to get them to make any suggestions for improvement. But if we want to improve our services, that is essential. If they all say ' your services are wonderful, and the staff is wonderful' that is very nice, but it doesn't help us improve. What we really want to know is 'what suggestions do you have for improvement?'

2. Tell them to tell all client interviewees that this interview is entirely anonymous – we will not even ask their name. What we want to do is to find out what most patients think of the service, not individuals.

Tips for Client Interviewers:

1. 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 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 criticism, instead of explaining it away
   - Follow up on general comments – get people to be specific
   - Thank the client for his or her help

make a few notes about the client's responses to questions 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 4.4, for 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 5-1

SAMPLE CLIENT-INTERVIEW FORM

CLIENT-INTERVIEW FORM

SITE: ______________ **DATE:** _________

1. Why did you come to the clinic today? ____________________________________
   ____
2. Did you get what you came for? ____
3. If not, why not? ____
4. Have you been given information about:
   Breastfeeding? _________________________
   Nutrition for you and your child? _________
   Warning signs for sick children? __________
   Vaccinations for the child? _______________
   Easy-to-understand explanations of how to take medicines? __________
   Easy-to-understand explanation of how to care for the sick child? ______
   Family planning? ____
   (Ante-natal clinic) Warning signs in pregnancy and labour? __________
   Other? ____
5. Did you have to wait a long time at any point in your visit to the clinic today?
   If yes, for how long, and at what point? ___________________________________
6. What do you like best about this hospital/clinic? _____________________________
   ____
7. What do you like least about this hospital/clinic? ____________________________
   ____
8. What suggestions do you have to help us improve services? ____________________
   ____
   ____
9. Is there anything else you would like to tell us? _____________________________
   ____
   ____
10. Interviewer Comments:____
    ____
    ____

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6. 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 adaptation 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 counselling as one part of a visit for child-welfare or prenatal visit. 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 facility's child healthcare 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 collected on the CFA forms to reflect the type of services offered, staff in any department can analyze client waiting time and staff utilization

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

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* 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).

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 AND CANNOT 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 workloads for each staff member during

the workday, 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 judgement 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

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 ANALYISIS

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 COPE exercise that includes CFA.

Selecting Participants

CFA may involve departments other than child health 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 child health 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; and
- Staff members who will be responsible for graphing and conducting a preliminary analysis of the information collected.

Tips for the Facilitator: Client-Flow Analysis

1. Generally, leave this to a follow-up COPE exercise. There are two reasons not to introduce it at the first COPE: 1. It is all too much new information and instructions to take in at one time; and 2. The staff tend to concentrate on this (concrete numbers, nice graphs, etc.) instead of the Self-assessment which is the heart of COPE

2. When explaining the client flow analysis, do a little role-play. Hold the CFA paper, and Say 'now I am a client, and I have just come into your hospital. Where do I go first?' When they say reception or whatever, go to one of the audience and say ' now I am coming to you at reception. What do you do with my paper?" Correct any misunderstandings about how to fill it out, and then move onto another member of the audience 'now I am coming to see the nurse. What do you do with my paper?' etc. This makes them laugh, and really lets them see how to do it.

3. Do not let them follow more than about 50 clients – it is too much work to summarize and graph them all. And it is just as important that they learn *how* to do the CFA as the *results*. If they learn how to do it, they can use it themselves to find out all sorts of things about their clinic in the future.

4. Show one staff member how to fill in a few lines of the graph, and a few lines of the CF summary. Then have him or her teach another staff member, and so on. In this way, many staff become involved in the CFA, learn how to do it, and understand what the results mean for their clients.

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 for child health services. There may be several entry and exit points. 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 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.

Using the Client Register Form

Before data collection begins, the participants should number the Client Register Forms consecutively in the "Client number" space provided on the form. The forms should be given to clients in numerical order as the clients arrive. If there are two or more entry points for clients, participants should use a different numbering system for each entry (for example, A1, A2, A3, etc., or another).

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 11 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

Figure 6-3

SAMPLE CLIENT REGISTER FORM

COPE/CHILD HEALTH CLIENT REGISTER FORM

Client number: 27 **Time of client's arrival in clinic:** 8:30 a.m.

Type of visit: CW/FP (Postpartum)

	Staff member Initials/service	Time service started	Time service completed	Total contact (in minutes)
First contact	FM/Reception	8:50	8:55	5
Second contact	BT/Growth Monitoring	9:25	9:30	5
Third contact	PM/Vaccination	9:35	9:40	5
Fourth contact	MW/Family Planning	10:20	10:40	20

Throughout data collection, each staff member who has contact with clients and writes information on this form should enter his or her initials (or a previously determined identification word) under "Staff member initials" and indicate the service provided. Then log in the hour and minutes that the contact begins and ends under "Time service started" and "Time service completed." If contact is less than a minute, a full minute should be entered. If possible, each 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 reasons for the visit (for example, initial visit, follow-up visit) enters this information under “type of visit”.

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–Charting Client Flow (see below).

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:

Time		Total
In	Out	minutes
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. Enter the visit code 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* **Page *1 of 1***

SITE: Karibuni Clinic **DATE:** September 18, 1998

Client number	Time In	Time Out	Total minutes	Contact minutes	Waiting minutes	Visit code		Comments
01	8:00	8:50	50	40	10	B		
02	8:10	9:20	70	11	59	B		
03	8:15	9:23	68	14	54	A		
04	8:15	9:25	70	6	64	A		
05	8:15	9:26	71	3	68	A		
06	8:15	11:00	165	57	108	D		
07	8:20	1:30	310	74	236	D		
08	8:20	11:00	160	17	143	C		
09	8:20	10:22	122	8	114	C		
10	8:28	12:55	267	193	74	B		
11	8:30	9:34	64	8	56	A		
12	8:30	9:40	70	7	63	A		
13	8:30	10:08	98	24	74	D		
14	8:30	10:15	105	6	99	A		
15	9:00	1:20	260	52	208	B		
16	9:00	2:10	310	111	199	B/D		
17	9:00	10:05	65	16	49	C		
18	9:00	10:05	65	6	59	C		
19	9:00	10:30	90	6	84	C		
20	9:30	10:11	41	6	35	C		

Visit Codes*

A. Vaccination **B. Sick Child** **C. Growth Monitoring** **D. Counselling**

*Adapt to your own clinic needs. 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, 1998

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."

3. 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."

EXAMPLE:

Waiting minutes	/	Total minutes	=	%Time waiting
60		95		63.15%

4. Find "Average number of minutes" and "Average contact minutes" by dividing by the total number of clients.

STEP 4

GRAPHING CLIENT FLOW

The Client-Flow Graph

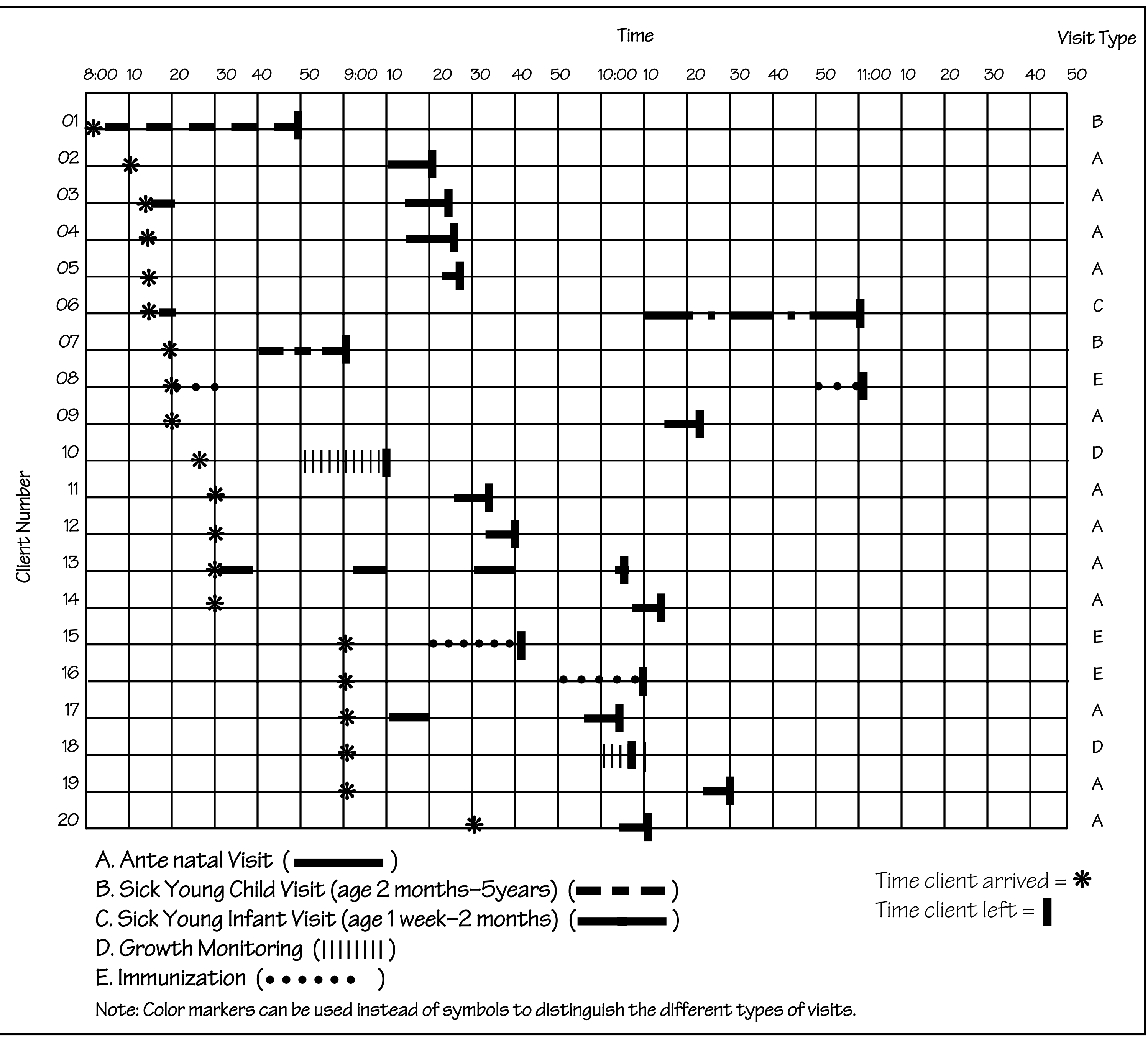
Staff use the information on the Client Register Forms to create a graph of client flow. Using this graph, staff can address a number of issues (for example, whether excessive waiting time is tied to a type of visit, or the gender of the client). The following items are needed to create the graph:

- 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 type of visit); and
- Ruler

Creating a Client-Flow Graph

Before beginning the graph, the aspect of clinic operations that is to be charted must be determined and a color must be assigned to each item in this group. For example, if type of visit will be charted, each type of visit will be recorded in a different color (see Figure 6-6 for sample Client-Flow Graph).

FIGURE 6–6 Sample Client-Flow Graph



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. In the meanwhile, they may have free time and relatively few clients later in the day. To find out whether staff utilization is a problem, participants calculate the percentage of time staff spent in contact with clients:

1. On a blank sheet of paper, fist 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 number of staff who worked during the session.

EXAMPLE:

Minutes in the session	x	Staff members	=	Staff minutes available
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.

EXAMPLE:

Contact minutes	/	Staff minutes available	=	Percentage staff time in contact
665		1950		34%

STEP 6

GRAPHING STAFF UTILIZATION

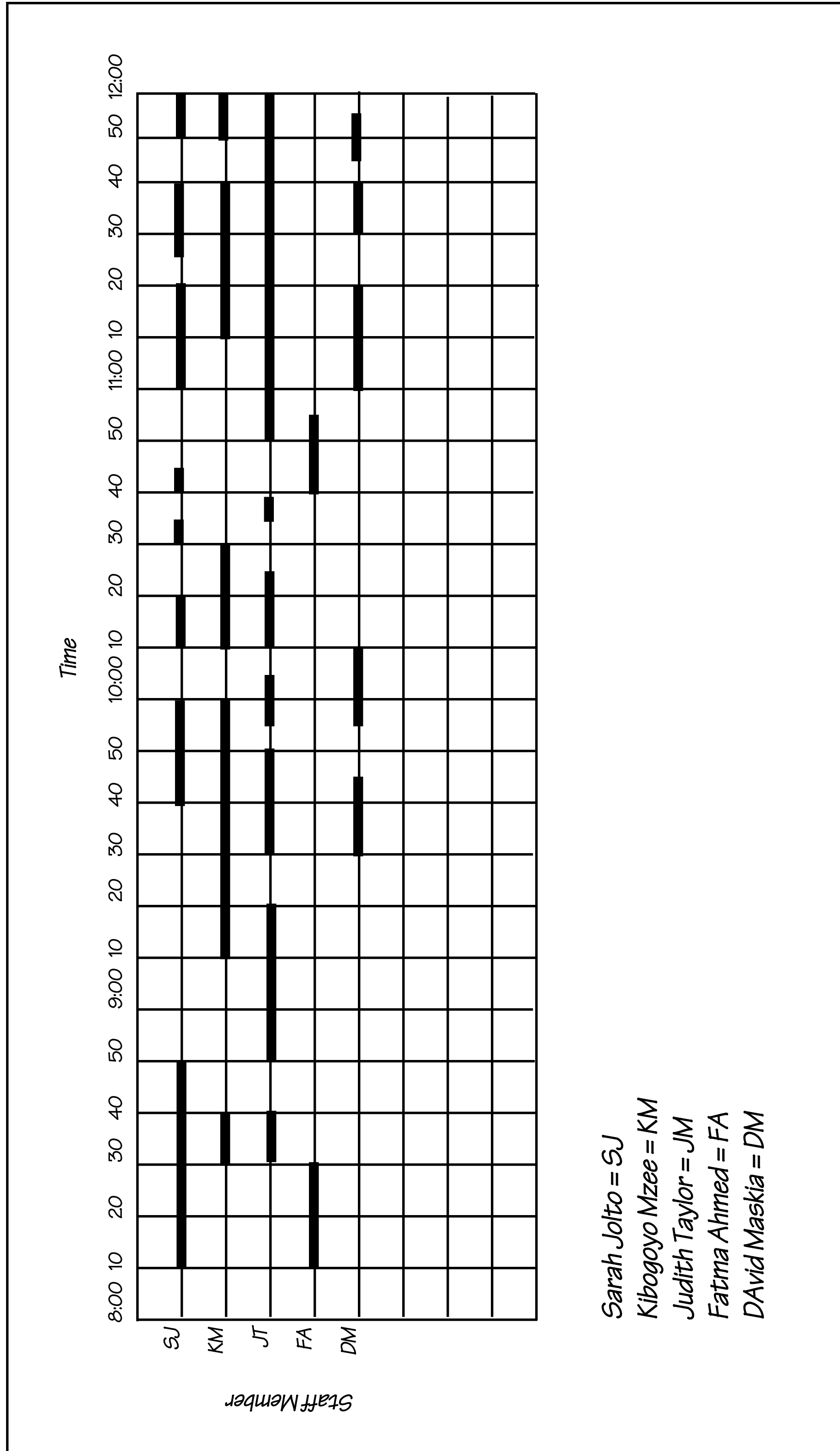
Like the Client-Flow Graph, the Staff-Utilization Graph is used to give a clear, visual representation of data. This graph shows the actual time staff spent in contact with clients during the session. The items needed to create this graph are the same as those needed for the Client-Flow Graph.

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.


Time
8:00
10
20
30
40
50
9:00
10
20
30
40
50
10:00
10
20
30
40
50
11:00
10
20
30
40
50
12:00
SJ
KM
JT
FA
DM
Staff Member
Sarah Jolto = SJ
Kibogoyo Mzee = KM
Judith Taylor = JM
Fatma Ahmed = FA
DAvid Maskia = DM

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 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 record problems identified using the format: *problem, recommendation, by whom, by when* (see Figure 4-1, page 4.4, for sample problem recorded in this format), and 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.

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7. The Integrated Management of Childhood Illness (IMCI) Record Review

PERFORMING THE CHILD HEALTH RECORD REVIEW

Sites that use the IMCI approach may want to perform the IMCI Record Review as a supplement to the Clients' Right to Safety guide in Appendix A. A COPE team member who knows the clinical procedures for IMCI should conduct this record review in addition to other team activities. The two checklists, which follow below, will enable the staff member to identify areas of strengths and weakness in the way IMCI protocols are followed, and also provide an opportunity for staff to review how well records are kept.

STEP 1

CHOOSING RECORDS FOR REVIEW

From the clinic's files, the reviewer randomly selects 20 patient records that show the procedures followed at the time the patient was assessed. Choose 10 records for the young infant (age: 1 week to 2 months) and 10 for the sick young child (age: 2 months to 5 years).

STEP 2

COMPLETING THE IMCI RECORD REVIEW CHECKLIST

Using the following procedure, the reviewer checks each patient record against the IMCI Record Review Checklist to see whether essential information has been recorded (see Figures 7-1 and 7-2 for sample completed checklists; a blank copy of the form appears in Appendix D).

1. The reviewer writes each record number on the checklist under the heading "Patient Record Number."

2. For each of the 20 patient 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 7-1,

patient record number 045 contained the information requested in item 1- "possible bacterial infection"-whereas patient record number 130 did not.

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 record keeping for child health clients.

For example, in Figure 7-1, 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 looked for, 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 records has 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 4.4) and presents them for discussion at the Action Plan Meeting.

Figure 7-1

IMCI RECORD REVIEW CHECKLIST
Management of the Sick Young Infant Age 1 Week up to 2 Months

SITE: ______________________________

DATE: ______________________________

REVIEWER: ______________________________

(Select 10 records at random)

	1	2	3	4	5	6	7	8	9	10	
Patient Record Number:	045	130	276	017	028	009	087	202	112	245	
Checklist Item: Was this child assessed for:											Total
1. possible bac-terial infection	x		x			x	x			x	5
2. diarrhoea	x	x	x	x	x	x	x	x	x	x	10
3. feeding problems or low weight	x	x	x		x	x		x		x	7
4. breastfeeding frequency	x	x	x		x	x		x		x	7
5. immunization status (BCG, OPVO, DPT	x	x	x		x						4
6. other problems	x	x					x	x			4
Were the mother's health needs assessed?	x	x	x		x			x		x	6

Figure 7-2

IMCI RECORD REVIEW CHECKLIST
Management of the Sick Young Child Age 2 Months up to 5 Years

SITE: ____________________________________

DATE: ____________________________________

REVIEWER: ____________________________________

(Select 10 records at random)

	1	2	3	4	5	6	7	8	9	10	
Patient Record Number:	055	160	273	019	029	139	080	209	132	265	
Checklist Item: Was this child assessed for:											Total
1. general danger signs: a) unable to drink or breastfeed; b) vomits everything; c) convulsions; d) lethargic or unconscious	x		x			x	x			x	5
2. cough or difficulty breathing		x	x	x		x	x			x	6
3. diarrhoea	x	x	x		x	x		x			6
4. fever	x	x	x		x	x		x		x	7
5. an ear problem	x	x	x		x						4
6. malnutrition, anaemia	x	x					x	x			4
7. immunization status (BCG, OPVO, DPT	x	x	x		x			x		x	6
8. vitamin A deficiency		x			x					x	3
9. feeding pattern (if child has anaemia or very low weight, growth faltering or is under 2 years old)		x			x					x	3
Were the mother's health needs assessed					x						1

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8. Action Plan

THE ACTION PLAN MEETING

The Action Plan is developed by staff members to address the problems they have discovered at their site. 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 and IMCI tools. Using these findings, participants identify:

- Possible sources of problems at their site;
- Recommendations for dealing with problems;
- Staff members to be responsible for carrying out recommendations agreed upon;
- A date by which each recommendation will be carried out (dates will vary for the different solutions); and
- A date on which to conduct a follow-up COPE exercise

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

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) and the IMCI Record Review

To record findings:
Flipchart paper
Colored markers
Tape

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; and
- Encourage lively discussion without letting participants argue in a hostile way.

TOPIC 2
PRESENTING FINDINGS

Using the information from each of COPE tools that teams 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 (and possible cause), recommendation, by whom, by when* (see Figures 8.1 and 8.2).

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 recommendations, and more than one recommendation 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 recommendation, 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 recommendation for each

problem: problems that have more than one source may have more than one recommendation.

To find underlying causes of problems, the facilitator should ask “Why” once or twice. For instance, if the problem is lack of essential drugs, the facilitator asks the group “Why”. They may respond: “no good ordering system for procurement before stockouts,” or “delays in ordering from Central Stores.” The facilitator should again ask “Why” in order to help the staff look for deeper causes of problems. Different causes will have different recommendations for addressing them.

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 like to accept and act upon suggestions that they have made for themselves.

Figure 8-1

EXAMPLES OF THE PLAN OF ACTION

Explain the format, and do one simple example. Tell participants to always put a name and actual date.

Problem/cause	Recommendation	By Whom	By When
No signs to child welfare clinic	Have signs made and put up	Mr. Wamai, Hospital Engineer	15 March

Then do one vague, poor example:

Problem/cause	Recommendation	By Whom	By When
Poor quality	Improve quality	Everyone	Soon

Explain that the Plan of Action has to be as concrete as possible, or nothing will happen.

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/cause, 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 8-2). 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.

Figure 8-2

SAMPLE COMPLETED ACTION PLAN

PROBLEM/ CAUSE	***RECOMMENDATION***	***BY WHOM***	***BY WHEN***
No forum to discuss child health services because of no organizing body	*Form child health services planning committee*	*Judith Taylor*	*October 19 (one month)*
Some providers not trained in counselling because trainings are too few and far between	*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 do not 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)*

TOPIC 5
PLANNING A FOLLOW-UP MEETING

After recording the results of the discussion on each team's findings, 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 "Establishing a COPE Committee," p.9-2).

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.

A 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 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.

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. Facilitators may wish to reread the general tips on facilitating COPE meetings in Chapter 3.

When necessary, the facilitator should guide participants to look at other recommendations. 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.

Tips for the Facilitator: The Action Plan Meeting

1. When the groups present, try to get lots of comments from the floor.
2. Often you will not be able to get everyone in the room to agree. Get the best consensus and then move on.
3. If there are far too many problems to discuss at one session, get staff to prioritize them, and leave the other problems to be dealt with by the committee later.
4. Do not forget to include any suggestions from the Client Interviews in the Plan of Action.
5. Do not forget to tell them when they have finished how good they already are in terms of quality improvement; and how honest and open to have been able to do something like COPE.
6. Close the session by asking: 'What were the 5 things you will take away with you today? What will you remember?' Have a flipchart prepared of the five things you really want them to remember. All this will help it stay in their minds.

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9. 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. Therefore, follow-up to COPE has three important components:

- Immediate follow-up of a COPE exercise by a facilitator;
- Site-level follow-up of recommendations; and
- Subsequent 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.

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

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

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.

Establishing a COPE Committee

COPE is not intended to be a one-time intervention. Identifying problems and coming up with recommendations through the Action Plan is an important first step. To provide continuity, 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.

Staff often become very enthusiastic, even during the first COPE exercise, when they realize that they can use their own resources to begin to remove barriers to quality services. A designated committee authorized to follow up the Action Plan can tap into this enthusiasm, and small improvements are often made immediately.

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 choose a representative for the committee; or
- Have each type of staff (example, doctor, nurses, clerks) choose a representative for the committee.

While there is no right or wrong way to decide how many people should serve on the committee and how committee members should be chosen, 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 (5 – 8 members is preferable). In small service sites with only 4 - 6 staff members, the entire staff is the committee. Larger sites often have one overall coordinating committee and smaller committees at the ward or department level;

- 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; and

- The group should elect a committee chairperson who will be responsible for scheduling and facilitating committee meetings.

After the committee has been established, the facilitator makes plans to review progress with the committee members (perhaps as a member of the committee, if the facilitator is a staff member; or during a supervisory visit or the subsequent COPE exercise, if the facilitator comes from outside the service site).

Initial 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 9-1). Unresolved items for which a solution seems possible should be incorporated into the next Action Plan.

THE SECOND AND SUBSEQUENT 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 6.7). Or, if Client Flow Analysis was performed during a previous COPE exercise and client waiting times or staff utilization was identified as a problem, Client-Flow Analysis (CFA) should be conducted during the follow-up exercise (for information on implementing CFA, see Chapter 6) to assess progress.

Figure 9-1

SAMPLE COMPLETED FOLLOW-UP SUMMARY SHEET

FOLLOW-UP SUMMARY
Karibuni Clinic at Three-Month Follow-Up

PROBLEM/CAUSE*	RECOMMENDATION	STATUS	COMMENTS
No forum to discuss child health services	Form child health services planning committee	Solved	Meets once a month
Some child health providers not trained in counseling	Develop on-the-job training	Attempted	Currently in the planning stage
Staff need infection prevention update	Provide update	Unsolved	Canceled several times for various reasons
Some staff do not 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

***The simplest and most effective way to find the cause of problems is to ask "Why" three (3) times (see page 8.3).**

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, Clients Interviews, Client-Flow Analysis, and Action Plan); and
- Action Plan Meeting.

The site facilitator should run these meetings. 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 Chapter 3). Participants should be advised to incorporate unsolved problems from the previous COPE exercise into their discussion during this exercise.

Subsequent Action Plan Meetings

The Action Plan Meeting and the development of the new Action Plan should take place in much the same way as they both did in the first COPE exercise at the site (see pages

8.1 - 8.6). Again, the site facilitator should run this meeting, with the headquarters or external facilitator providing support only as needed.

The site facilitator should re-emphasize 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; and
- That staff should agree on a schedule to continue the COPE process and to integrate COPE elements into their work.

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COPE

SELF-ASSESSMENT GUIDES

FOR

CHILD HEALTH

SERVICES

Appendix A

**The Ten Guides to
Client Rights and Staff Needs**

Client right to information

Client right to access to services

Client right to counselling and informed choice

Client right to safe and effective care

Client right to privacy confidentiality and expression of opinion

Client right to dignity and comfort

Client right to continuity of care

Staff need for good management and facilitative supervision

Staff need for information, training, and development

Staff need for supplies, equipment, and infrastructure

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1. RIGHT TO 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 / Cause, 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 members, including support staff, know how to advise people about obtaining child health and related services and information? Can all staff answer the following questions:
   - What services are available (antenatal care; vaccinations; growth monitoring and promotion; nutritional counselling; emergency child health services, curative, etc.)
   - What times are services available?
   - What is the cost of services?
   - Where is the paediatric ward, casualty, and child welfare clinic?
   - Where is the next referral level for cases that cannot be handled at your facility?

2. Are signs that show the place, days, times and costs of all maternal and child health services prominently displayed in your facility?

3. Do you have all the written materials and visual aids that you need?

4. Are the materials ***known***, ***readily available***, and ***used*** in information-giving and counselling?

5. Are there educational activities and materials, such as health talks, posters and pamphlets about a variety of health matters to engage mothers when they are unoccupied, or waiting to be seen in the MCH, antenatal or postpartum clinics, or when they are in-patients, (for instance in the maternity ward) on:
   - STDs including HIV/AIDS;
   - Maternal and child nutrition, vitamin supplements, growth monitoring and promotion;
   - The need for antenatal care (recommended number of visits and when);
   - Danger signs in pregnancy and labour and when to seek help;
   - Family planning methods postpartum, including immediate postpartum methods (tubal ligation, post partum IUD, condoms, LAM);
   - Other family planning methods;
   - Breast feeding;
   - Child immunizations;
   - Caring for the sick child (including danger signs and when to seek further help);
   - The importance of using clean or boiled water for any child food or drink preparation;
   - Prevention of accidents in the home, (protecting children from the fire and boiling liquids, falls, and poisons (chemicals, medicines, etc.); and/or
   - Vaccinations (including TT for the mother), and all the recommended childhood vaccinations?

6. At the postpartum / child welfare visit, are mothers given information about the above and:
   - Danger signs in childhood illness;
   - Childhood diarrhoea;
   - Acute respiratory infection;
   - Signs of dehydration;
   - Vaccination schedules, including measles and when to attend for the next in the series; and
   - How to interpret growth monitoring charts, and how to recognize growth faltering?

7. Do staff in antenatal clinics, and postpartum, counsel clients about breastfeeding, including:
   - Its importance for the health of mother and baby;
   - Breast care;
   - The value of colostrum;
   - The reasons for early (within 30 minutes of delivery) and exclusive (no other fluids or foods) breastfeeding;
   - The possibility of using BF as a contraceptive method (LAM); and
   - If the mother is HIV positive, the risks to the baby of becoming infected through breastmilk vs. the risks of not breastfeeding?

8. Are mothers in endemic malarial areas given information about prevention including impregnated bed-nets and window screens to prevent mosquito bites; and treatment for malaria?

SICK CHILD

9. Do all staff seeing a sick child:
   - Give the diagnosis and information about any procedure;
   - Give information about what to do at home (e.g. fluids, feeding, medicines); and
   - Give information about when to come back?

10. Do staff know the key messages that should be given for each of the following areas:
    - Acute respiratory infection;
    - Diarrhoea;
    - Nutrition (breastfeeding, feeding the sick child, complementary feeding, treating of malnutrition and anaemia, vitamin A supplementation, nutrition for pregnant and lactating women);
    - Fever (measles, malaria);
    - Immunisations; and
    - HIV (prevention, testing and counselling for pregnant women, care for HIV positive children, counselling positive pregnant women about reproductive options)?

11. Are there guidelines / job aids on the above readily available?

12. Does the information you give to the mother of a child with diarrhoea include:
    - Continue to breastfeed, and increase the frequency of feeds;
    - Give extra fluids for the weaned child; and
    - Explanation and demonstration of the preparation of ORS?

13. Does counselling for the mother of a malnourished child include the following:
    - Include some vitamin A rich foods (e.g. spinach, sukuma, cowpea leaves, other locally available green leafy vegetable);
    - Include some protein when possible (e.g. egg, fish, meat, beans combined with cereals, etc);
    - Increase the frequency of feeding, and give frequent snacks;

- Include some (vitamin fortified) oil;
- Include locally-available fruits; and
- Give fortified foods, vitamin supplements, where available?

14. Do you make sure these messages are based on what the mother has available / what is feasible for her?

15. Do men as well as women understand the importance of bringing the right food into the home? Are men as well as women counselled about nutrition?

16. Does counselling for the sick child include the following:
    - Continue feeding;
    - Increase fluids;
    - Increase amount / frequency of feeding after an illness; and
    - When to come back?

WELL CHILD

17. Do you give mothers of well children information about:
    - Potential adverse reactions to vaccinations;
    - How to manage adverse reactions;
    - Information about what was actually done, and the findings e.g. kind of vaccination, growth progress; and
    - When to return?

18. Do all staff in the outpatient clinics and on the paediatric ward know the childhood vaccination schedule, including measles?

OTHER ISSUES YOU THINK ARE IMPORTANT:

19. ____

20. ____

21. ____

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2. RIGHT TO ACCESS TO 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 / Cause, Recommendations, By Whom, By When"

If you are aware of a problem that is not addressed on this guide, please include it.

---

1. Are clinic opening hours convenient for most parents and children?
2. Can clients and patients who need them afford the child health services at your site? Is there a system of discounts / fee waivers / prepayments / subsidies for those who are unable to pay?
3. Does your site offer all the child health services it could?
4. Are children seen in the child health clinic even if the health card cannot be found?
5. Are children seen in your child health clinic even if they have previously attended elsewhere?
6. Are women encouraged to seek antenatal care?
7. Are pregnant women encouraged to deliver at a facility?
8. Do you attend emergency cases in children immediately, with no wait - i.e. those:
    - Who are not able to drink;
    - Who have difficult breathing;
    - Who are vomiting everything;
    - With high fever;
    - With a history of convulsions; and/or
    - Who are lethargic / unconscious?
9. If you are unable to deal with emergency childhood illness do you have a fast, efficient referral system to a next level unit nearby?
10. Are essential and emergency child health services physically available to those who need them in your area? (service points well distributed geographically; good transport systems; affordable transport etc.)
11. If not, do you have a community group of volunteers with cars, or taxi drivers using agreed fares, or other community contingency plans?
12. Are these services available 24 hours?
13. Are child health visits combined with reproductive health, including family planning visits postpartum?
14. Do staff look for, and treat, signs of worm infestation?

15. Do staff always verify the vaccination status of the child at every visit or in the wards, no matter what the reason for the visit, and even if the child is sick?

16. Do staff always verify the nutritional status of the child, at every visit?

17. Do staff verify the vitamin A status of each child at every visit?

18. Do the mothers of hospitalized sick children have access to information on such topics as nutrition, warning signs of severe illness, prevention of childhood illness, care of their infant or child, etc?

OTHER ISSUES YOU THINK ARE IMPORTANT:

19. ______________________________

20. ______________________________

21. ______________________________

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3. RIGHT TO COUNSELLING AND INFORMED CHOICE

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 / Cause, Recommendations, By Whom, By When"

If you are aware of a problem that is not addressed on this guide, please include it.

---

1. Are the women and men and children who come to your facility treated the way you or your family wants to be treated?
2. Do all staff (doormen, receptionists, medical staff, accounts staff, lab and pharmacy staff, etc.) treat parents and children with courtesy, consideration, attentiveness, and with full respect to their dignity?
3. Do staff use language that clients will understand? Are posters and pamphlets in languages which clients will understand?
4. Are educational and information materials reviewed and discussed by staff before being put up or used?
5. Do you take advantage of every opportunity to inform mothers about child health and the services available at your facility?
6. Do staff know how to do counselling, (especially HIV counselling and other new issues)?
7. Is sufficient time allotted for interacting with / counselling parents, or the children themselves, where appropriate?
8. Do staff encourage mothers, (and children where appropriate), to ask questions? Do they have two-way discussions with the client? Do they ask open-ended questions?
9. Do staff give mothers the opportunity to discuss their feelings?
10. Is there support, monitoring and supervision for counselling?
11. Are all procedures and interventions, including the reason for them, explained to mothers, and where appropriate, children?
12. Are mothers given child health records, including growth monitoring charts, that they can keep? If so, are these explained to them?
13. Are parents counselled about family planning methods that might be appropriate to their reproductive intentions, personal life, including their sexuality; breastfeeding status; and reproductive health, if they are interested?
14. Do staff inform mothers if there is a contraindication or common side effect to the service or treatment or procedure?

15. Do staff explain alternative choices or procedures or treatments?

16. Do staff ask mothers, and where appropriate children, whether they understand the information they have been given? Do they ask them to repeat key information or instructions concerning the treatment of sick children at home, to be sure they have understood?

17. Are all women in the maternity wards given time to talk about and ask questions about any areas of concern, such as breastfeeding, nutrition for themselves and for the baby, prevention of household accidents, general childcare, etc.?

18. Do staff spend time with women who have problems with breastfeeding, to encourage and help them; for instance, showing them correct feeding positions?

19. Are low birth-weight babies carefully followed, and their mothers given special advice and counselling?

20. Are the mothers of children at especial risk given special attention and extra time in counselling? e.g. those with:
    - Malaria;
    - Measles;
    - The malnourished; and/or
    - The very sick?

21. Have staff encouraged and helped with the formation of a support group for HIV positive women?

22. For women who are HIV positive, do you support their informed choice for breastfeeding?

23. Do staff counsel HIV positive women on the issues of HIV and pregnancy, including for instance the importance of taking Vitamin A supplements, and the risk of having an HIV positive baby?

24. If harmful practices (such as female genital mutilation) are prevalent in your area, do you explain to mothers about the associated dangers and problems for their girl-children?

25. If harmful practices (such as female genital mutilation) are prevalent in your area, do you take the opportunity of public meetings (such as village gatherings and church groups) to explain about the dangers and problems of these practices on their girl children?

26. Is anyone connected with your clinic (community health workers etc.) responsible for discussing these issues with communities?

27. Do you have a mechanism for dealing with reports of child abuse in your community?

28. Does your community offer any programs for prevention of, or for dealing with, child abuse?

OTHER ISSUES YOU THINK ARE IMPORTANT:

29. ____

30. ____

31. ____

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4. RIGHT TO SAFE AND EFFECTIVE CARE

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 / Cause, Recommendations, By Whom, By When"

If you are aware of a problem that is not addressed on this guide, please include it.

INFECTION PREVENTION

1. Are written infection prevention guidelines, charts, posters, leaflets, and handbooks available for staff, and are they used?
2. Do all staff wash their hands before and between all procedures, and after handling waste?
3. Are buckets and bowls with 0.5% chlorine solution always available in every examination room, every delivery room, and every C-section room, for immediate decontamination of instruments, gloves, and medical waste, and for wiping down soiled surfaces?
4. Are disposable needles and syringes used (and disposed of) whenever possible? Are reusables properly sterilized or high-level disinfected before use?
5. Are needles and other sharp objects placed in safe containers before disposal?
6. Do staff have facilities for disposing of contaminated waste and know the proper procedures?
7. Do staff know procedures for clean cord care and prevention of sepsis and tetanus?

PREGNANCY AND DELIVERY

8. Are women encouraged to attend the antenatal clinic?
9. Are women checked for anaemia antenatally (inspection of mucus membranes, or lab tests)?
10. Are women offered dietary supplements (iron, folic acid, Vitamin A,) where needed?
11. Are women advised about the use of iodized salt?
12. Are women informed about and offered tetanus injections (TT) during antenatal visits?
13. Are women screened for weight (low weight gain, or sudden weight gain) hypertension, and oedema during ante-natal visits?
14. Are pregnant women in endemic malarial areas offered malaria prophylaxis or treatment, where appropriate?
15. Are women screened and treated for syphilis in pregnancy?

16. Are women admitted for delivery examined, and labour dynamics, foetal heart rate and vital signs recorded, and reviewed at regular intervals by trained staff?

17. Is emergency transport available to the next level, when you are unable to deal with obstetric emergencies at your facility?

NEONATES AND INFANTS

18. Is your unit equipped and staffed to deal with neonatal emergencies such as birth asphyxia, hypothermia, infections etc?

19. Is birth asphyxia treated immediately with:
    - Aspiration of mouth and nostrils;
    - Ventilation with positive pressure; and/or
    - Cardiac massage if the heart rate does not increase after effective ventilation?

20. Are the following available for newborns:
    - Suction and resuscitation equipment, including oxygen and Naloxone;
    - Careful attention to cleanliness; and
    - Careful vigilance for possible infections, and prompt treatment?

21. Are there facilities for warming newborns, especially premature babies?

22. Do babies always receive antibiotic eye drops or ointment, or silver nitrate, in case of maternal GC infection?

23. Do you have a policy to ensure early (within 30 minutes of birth) and exclusive breastfeeding (no other fluids or foods whatever)?

24. Is a qualified clinician always available 24 hours for consultation in case of maternal or neonatal complications?

25. Do all staff in the emergency clinic know how to recognize the very sick young infant?
    - Check for bacterial infection;
    - Check for diarrhoea; and
    - Check for feeding problems / growth faltering.

26. Are staff able to recognize signs of child abuse? Is there an effective referral system in place to handle this problem?

YOUNG CHILD

27. Do all staff in the emergency and child welfare clinic recognize the general danger signs of severe childhood illness?
    - Is the child unable to drink or breastfeed?
    - Does the child vomit everything?
    - Has the child had convulsions?
    - Is the child lethargic or unconscious?

28. Do all staff in the emergency and child welfare clinic recognize the main symptoms and signs of severe childhood illness?
    - Cough or difficult breathing;
    - Diarrhoea; and
    - Fever.

29. Each time they see a young child, do staff check for:
    - Malnutrition and anaemia;
    - Immunization status; and
    - Need for Vitamin A or iron supplements?

30. Do all staff in the emergency and child welfare clinic know how to manage the child with cough or difficult breathing?
    - Ask about cough;
    - Count breath rate;
    - Look for chest indrawing;
    - Identify severe pneumonia; and
    - Give appropriate antibiotic where needed.

31. Do all staff know how to manage the child with diarrhoea?
    - Ask if a sick child has diarrhoea;
    - As if there is blood in the stool;
    - Offer water, to see if the child can drink;
    - Looked at skin turgor;
    - Look for dehydration; and
    - Explain ORS

32. Do all staff in the emergency and child health clinic know how to manage the malnourished child?
    - Look for visible wasting;
    - Check growth chart;
    - Look for oedema of both feet;
    - Identify anaemia (palmar pallour} or need for Vitamin A supplements;
    - Give mother advice on nutrition; and
    - Look for signs of immunosuppresion (HIV/AIDS).

33. Do all staff in the emergency and child health clinic know how to manage the child with fever?
    - Ask if child has fever;
    - Ask if child has had measles in past 3 months;
    - Look for stiff neck;
    - Look for generalized rash;
    - Classify febrile illness – malaria, measles, very severe febrile illness; and
    - Treat the illness.

34. Do all staff in the emergency and child health clinic know how to manage poisoning and accidents such as burns?

35. Are staff able to recognize signs of child abuse? Is there an effective referral system in place to handle this problem?

36. Do you have a policy or guidelines on deworming, and /or iron supplements for the malnourished / anaemic child?

OTHER ISSUES YOU THINK ARE IMPORTANT:

37. ____

38. ____

39. ____

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5. RIGHT TOPRIVACY, CONFIDENTIALITY, AND EXPRESSION OF OPINION

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 / Cause, Recommendations, By Whom, By When"

If you are aware of a problem that is not addressed on this guide, please include it.

---

1. Do staff respect clients' confidentiality by not discussing them (except to get advice from other clinic personnel)?
2. Is access to patient records strictly controlled within the facility?
3. Does your facility have a private space where clients will not be observed or overheard during counselling, if necessary?
4. Does your facility offer a confidential counselling and testing service for HIV for women who want it?
5. Do staff respect mothers (and the children's) opinions, even if they are not the same as their own?

OTHER ISSUES YOU THINK ARE IMPORTANT

6. ______________________________
7. ______________________________
8. ______________________________

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6. RIGHT TO DIGNITY AND COMFORT

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 / Cause, Recommendations, By Whom, By When"

If you are aware of a problem that is not addressed on this guide, please include it.

---

1. Do staff perform physical examinations and other procedures with the child's and mother's dignity, modesty and comfort in mind?
2. Are enough staff available at times when your area is busiest?
3. Do you think client waiting times for services are reasonable?
4. Are emergencies always dealt with immediately, without waiting?
5. Otherwise, are clinic clients seen in turn (first come, first served)?
6. Are women allowed to keep their babies with them 24 hours a day in the maternity ward?
7. Are children who are in pain treated kindly, and offered appropriate and timely analgesia?
8. Are parents allowed to visit hospitalized sick children whenever they wish, and to stay with them where possible?
9. Are mothers allowed to stay and offer comfort to the child during procedures?
10. Do inpatient children have access to occupational therapy, or enjoyable activities where appropriate?
11. Do in-patient children who need it have access to physiotherapy?
12. Do you pay special attention to the needs of disabled children?
13. Are staff able to recognize, and manage, cases of physical or sexual abuse?
14. The list below describes some areas of the facility that 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 warm enough for young children)?
    - Toilet facilities;
    - Registration/reception;
    - Counselling areas;
    - Waiting areas;
    - Examination rooms;
    - Pharmacy;
    - Paediatric wards;
    - Maternity wards;
    - Delivery rooms;

- Emergency/casualty treatment areas;
- Recovery and waiting (ward area/toilet); and
- Mortuary.

15. Are all parts of your unit always clean?

16. Is community involvement in maintaining clinic hygiene and grounds refuse collection encouraged?

OTHER ISSUES YOU THINK ARE IMPORTANT:

17. ____

18. ____

19. ____

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7. RIGHT TO CONTINUITY OF CARE

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 / Cause, Recommendations, By Whom, By When"

If you are aware of a problem that is not addressed on this guide, please include it.

FACILITY

1. Are child immunization visits always combined with reproductive health visits, including family planning, postpartum? Are mothers actively referred to family planning and other reproductive health services when they bring their children in?

2. Do you maintain, and use, good records and relevant information on your patients?

3. Are patient-held child health records, including growth monitoring charts and immunization records used and encouraged, and explained to mothers?

4. If standard record cards are unavailable, are exercise books standardized?

5. Do you have a program to involve fathers and other family members in care for the child / pregnant woman / new mother?

6. Is there a good system of communication between your facility and other facilities you refer patients to, or that refer patients to you?

7. Are high-risk pregnant women followed up at the facility or in the community?

8. Is there a program for following up HIV positive mothers and their children, either at the facility or in the community?

COMMUNITY

9. In the case of clients who travel to the site for maternal or child health, are the clients given information about where to obtain follow-up services in their local community?

10. Is there a system of community follow-up for clients who do not return for vaccination, weighing, malnutrition, ORT, vitamin A, and other issues that require home care?

11. Does your facility have a good relationship and good communication with community health workers, for referral, and collaborative care?

12. Are community members active in ensuring linkages between the facility and the community?

MOTHER

13. Are mothers given clear information about when to bring the child back should the illness get worse or become complicated?

14. Are mothers told to seek medical attention or return to the facility if these symptoms or signs occur without waiting for an appointment?

15. Are mothers reminded at every visit about when the next vaccination due, e.g. for triple, polio, and measles?

16. Are mothers of sick children always taught how to care for them at home?

17. For dehydrated children, are mothers shown how to give ORT while still at the health centre?

18. Are clients given a follow-up date for a return visit either for next well child visit, or follow-up on illness?

OTHER ISSUES YOU THINK ARE IMPORTANT:

19. ____

20. ____

21. ____

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8. STAFF NEED FOR GOOD MANAGEMENT AND FACILITATIVE SUPERVISION

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 / Cause, Recommendations, By Whom, By When"

If you are aware of a problem that is not addressed on this guide, please include it.

1. Do you have a committee for discussing and improving the quality of your maternal-child healthcare services, and for discussing available data?
2. Do staff feel that they are part of a team and are able to give suggestions to the management, supervisors and the quality improvement committee (if one exists) about services?
3. Do staff feel that their supervisor / manager is supportive, encouraging, and respectful of staff, and helps them do their work better, including providing constructive feedback to all staff?
4. Do staff regularly interview mothers in the emergency and outpatient clinics, and in the wards, to measure their satisfaction with the services you offer, and to find areas for improvement, e.g. opening hours for working women?
5. Does a workplan exist for the facility?
6. Are there strong links between the different departments or wards? For example, do staff share information, give referrals, visit other parts of the facility to give health talks, etc.?
7. Do you hold regular maternal and child morbidity and mortality meetings, or audits of morbidity and mortality?
8. Do staff routinely record and review causes of complications in order to improve clinical practices?
9. Do you hold audits of conditions e.g. diarrhoea, tuberculosis, HIV?
10. Are there good referral mechanisms in place, for occasions when staff do not feel competent to deal with a clinical problem outside their own area of expertise?
11. Is there a mechanism through which community health workers can discuss issues with facility-based workers, and refer?
12. 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?
13. Does management encourage in-service training, updates and orientations, and visits of outside lecturers?
14. Does the facility have a 'rooming-in' policy (allow mothers and infants to remain together 24 hours a day)?

15. Are we reaching our targets for the population (vaccination coverage, use of antenatal care, vitamin A, assisted delivery, well baby services, etc)?

DATA

16. Are department or clinic reports submitted regularly and on time?

17. Do supervisors share and discuss data, reports, and service statistics with their staff, to help them improve their work?

18. Are all clients' medical or health records completed properly, with all essential information included?

19. Is there an effective mechanism in place so that all births and deaths are registered?

OTHER ISSUES YOU THINK ARE IMPORTANT:

20. ____

21. ____

22. ____

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9. STAFF NE ED FOR INFORMATION, TRAINING AND DEVELOPMENT

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 / Cause, Recommendations, By Whom, By When"

If you are aware of a problem that is not addressed on this guide, please include it.

---

1. Are regular (for example, once a week, or once every two weeks) in-service orientations, updates, training and up to date information provided to keep staff skilled and well-informed?

2. Do you have a system to measure the knowledge and skills which staff take from these sessions?

3. Do staff in the facility have the skills necessary for diagnosing, treating and counselling clients in relation to the child health services they offer?

4. Does the facility have trained providers skilled in maternal/ child health services (ARI, CDD, IMCI etc.)?

5. Do staff have training in how to maintain the cold chain for vaccines?

6. Are staff trained and competent in the management of paediatric emergencies, or has anyone been trained in the integrated management of childhood illness (IMCI)? This includes the general danger signs and management of emergencies such as:
   - High fever;
   - Severe malaria;
   - Severe dehydration;
   - Severe diarrhoea;
   - Severe acute respiratory infection;
   - Convulsions; and/or
   - Asthma, etc.

7. Do staff receive updates on how to monitor growth and malnutrition?

8. Do all staff in wards or clinics know 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?)

9. Have you received an update on the 'MINPAK' for child nutrition?
   - Exclusive breastfeeding for 4-6 months;
   - Appropriate complementary feeding and continued breastfeeding;
   - Appropriate nutritional case management: 2 doses of Vitamin A for every measles case; appropriate feeding practices;
   - Prenatal iron/folate supplements; and
   - Use of iodized salt.

10. Have staff members had orientation or updates on the importance of breastfeeding, and how to help a mother who is having difficulty in breastfeeding her baby?

11. Are staff trained in the use of the Lactational Amenorrhoea Method (LAM) for family planning, and to complement breastfeeding training?

12. Are staff trained in the management of poisoning emergencies (chemicals, medicines, etc.)?

13. Are there clear guidelines / protocols at your facility for clinical treatment (e.g. IMCI Guide), and for dealing with emergencies? Are they used?

14. Do you have a library of reference books and other materials on child health (such as the Guide to IMCI) available, and are they accessible to staff? Do they use it?

15. If needed, can your supervisor (site supervisor, or area supervisor) arrange for relevant training at your site?

16. If site staff have been trained, do you have a policy that those trained people given an in-service update to other clinical staff?

17. Do you have a policy that those trained people give an orientation to all staff (including non-clinical staff, such as receptionists and guards) so that they are able to recognize a possibly very sick child, perform first aid, or obtain treatment swiftly?

18. Is your pharmacist / drug dispenser trained in explaining to mothers how to give medicines to their children at home? Do they check that mothers fully understand the information?

OTHER ISSUES YOU THINK ARE IMPORTANT:

19. ____

20. ____

21. ____

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10. STAFF NEED FOR SUPPLIES, EQUIPMENT AND INFRASTRUCTURE

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 / Cause, 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 stocks which can expire always observe the first-expired, first-out (FEFO) rule?
2. Does the facility have essential supplies? (Discussion should include drugs, gloves, needles, antibiotics and other drugs, bleach or powdered chlorine, vaccines, vitamin supplements and other items a shortage of which might disrupt services.)
3. Does the facility keep an inventory and do periodic stocktaking to help you to know when to reorder all supplies?
4. Is there always a sufficient supply of essential drugs?
5. Is there a system for obtaining re-supplies quickly?
6. Does the facility have IEC materials (posters, leaflets, and pamphlets) on childhood illness, nutrition, breastfeeding, etc?
7. Is all equipment in good condition? If not, do staff know how to get repairs done, or obtain replacement equipment?
8. Do staff feel that their work environment is clean, well ventilated, comfortable, and well equipped enough for them to carry out their duties?
9. Do staff always have enough buckets, bowls, and bleach to ensure that a 0.5% chlorine solution is always available in all the places needed for decontamination and infection prevention?
10. Do staff always have heavy-duty gloves to dispose of contaminated waste?
11. Are rigid containers for disposing of needles etc. readily available in all areas of the facility where disposable needles are used?

EQUIPMENT

12. Do you have the following, and in good repair:
    - Sufficient water for clinic use;
    - Thermometers;
    - Scales for weighing children and infants accurately;
    - Soft cloths for applying gentian violet;
    - Clean drinking water for mixing ORS and for offering fluid to child when assessing for signs of dehydration;

- Glasses, cups and spoons;
- Disposable syringes and needles for injectable drugs, and for vaccinations;
- Timers for counting fast breathing (where available);
- A wall-chart showing vaccination schedules, for both mothers and staff to refer to;
- Enough growth charts for every child who comes to your clinic;
- Management of Childhood Illness Flowcharts or case management algorithms; and
- Reporting forms?

VACCINES

13. Do you maintain a working cold chain for vaccines?

14. Are cold chain vaccine monitors available?

15. Do you have a system for assessing the cold chain, and vaccine supply?

16. Has the vaccine temperature been within acceptable range twice daily for the last month?

17. Do you have a constant supply of the following vaccines, and are they easily re-ordered?
    - BCG
    - OPV
    - DPT
    - Measles

DRUGS

18. Is the essential drugs list up to date?

19. Is the list displayed?

20. Are all drugs on the essential drug list available?

21. Is there a displayed price-list for essential drugs?

22. Do you have a quantitative assessment of drugs supply with critical indicators, e.g. number of days of stockouts?

23. Do you have a constant supply of the following drugs (no stockouts in the last 6 months), and within the expiry date:

    Antibiotics:
    - Cotrimoxazole:
        - Adult Tablet (80 mg trimethoprim + 400 mg sulphamethoxazole)
        - Pediatric Tablet (20 mg trimethoprim + 100 mg sulphamethoxazole)
    - Cotrimoxazole Syrup (40 mg trimethoprim + 200 mg sulphamethoxazole)
    - Amoxycillin caps(250 mg)
    - Amoxycillin Syrup (125 mg per 5 ml)
    - Chloramphenicol Intramuscular (1000 mg vial mixed with 5 ml sterile water = 200 mg/ml)
    - Gentamicin intramuscular:
        - 2 ml vials containing 20 mg=2ml at 10 mg/ml, or
        - 2 ml vials containing 80 mg=8ml at 10 mg/ml to be mixed with 6 ml sterile water

- Benzylpenicillin intramuscular. Vials of 600 mg (1 000 000 units) to which sterile water will be added
- Nalidixic Acid Tablets (250 mg)
- Tetracycline Tablets (250 mg)
- Furazolidone Tablets (100 mg)
- Erythromycin Tablets (250 mg)

Antimalarials:

- Chloroquine Tablets:
  - 150 mg base
  - 100 g base
- Chloroquine Syrup (50 mg base per 5ml)
- Sulfadoxine and Pyrimethamine Tablets (500 mg sulphadoxine + 25 mg pyrimethamine)
- Quinine Intramuscular:
  - 300 mg/ml (in 2 ml ampoules) using quinine salt
  - 150 mg/ml (in 2 ml ampoules) using quinine salt

Antipyretics:

- Paracetamol Tablet (500 mg)
- Paracetamol Tablet (100 mg)
- Paracetamol syrup

Other drugs:

- Small bottles of safe, soothing cough remedy (optional)
- Tetracycline Eye Ointment - small tubes
- Gentian Violet - small bottles
- Mebendazole Tablets (100 mg or 500 mg)
- Iron/Folate Tablets (200 mg ferrous sulfate + 250 mcg folate [60 mg elemental iron])
- Iron Syrup (100 mg ferrous fumerate per 5 ml [20 mg elemental iron per ml])
- Vitamin A Capsules
  - 200,000 IU
  - 100,000 IU
  - 50,000 IU
- Vitamin A Syrup

For rehydration therapy:

- Ringer's Lactate Solution for IV administration
- Oral Rehydration Salts Premixed Packets - or the following ingredients with amounts specified for mixing with 1 litre water:
- Glucose (20.0 g) - (or 40 g. Sucrose)
- Sodium chloride (3.5 g)
- Trisodium citrate, dihydrate (2.9 g) - (or 2.5 g sodium bicarbonate)
- Potassium chloride (1.5 g)

For poisoning:

- Ipecac syrup to induce vomiting
- Activated charcoal, to absorb poisons from the gut

OTHER ISSUES YOU THINK ARE IMPORTANT:

24. ____

25. ____

26. ____

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CLIENT INTERVIEW FORM

FOR

CHILD HEALTH

SERVICES

Appendix B

CLIENT INTERVIEW FORM

DATE:____________________ **INTERVIEWER:**____________________

1. Why did you come to the clinic today?____________________

2. Did you get what you came for? ____________________

3. If not, why not? ____________________
____

4. Have you been given information about:
   - Breastfeeding ____________________
   - Nutrition for you and the child ____________________
   - Warning signs for sick children ____________________
   - Vaccinations for the child ____________________
   - Easy-to-understand explanation of how to take medicines ____________________
   - Easy-to-understand explanation of how to care for the sick child ____________________
   - Family planning ____________________
   - (Antenatal clinic) Warning signs in pregnancy and labour ____________________
   - Other ____________________

5. Did you have to wait a long time at any point in your visit to the clinic today? If yes, for how long, and at what point?____________________

6. What do you like <u>best</u> about this hospital / clinic? ____________________
____

7. What do you like <u>least</u> about this hospital / clinic? ____________________
____

8. What <u>suggestions</u> do you have to help us improve services at this hospital / clinic? _____
____
____
____

9. Is there anything else you would like to tell us? ____________________
____
____

10. Interviewer comments: ____________________
____
____
____
____

INSTRUCTIONS FOR DOING CLIENT INTERVIEWS

It is not easy to do client interviews – our clients always want to tell us good things, and it takes skill to get them to give any suggestions.

- Begin by introducing yourself to the client.
- Explain that the purpose of the interview is to find out how clients feel about services offered at the facility, and to get the clients suggestions on how services might be improved.
- Stress that the interview is confidential, and that the clients name is not needed, and will not be used.
- Adapt the questions listed here to your facility and the client you are interviewing.
- Please write any additional information the client gives you, even if it is not covered by the questions.
- Thank the client for his or her help.
- There may be some problems brought up by the client, or things that seem to you to be problems from the client interview.
- After the interview, put any problems into your Plan of Action, along with recommendations, by whom these should be done, and by when.

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CLIENT-FLOW ANALYSIS FORMS

FOR

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Appendix C

COPE/CHILD HEALTH CLIENT REGISTER FORM

Client Number ________________ Time of client's arrival at hospital ______________
Type of visit ___________________

	Staff member initials	Staff Position	Time service started	Time service completed	Total minutes
First Contact					
Second Contact					
Third Contact					
Fourth Contact					
Fifth contact					
Sixth Contact					

Type of visit (include all relevant ones):

W: Well child / vaccinations A: Ante-natal F: Family Planning
S: Sick child P: Postpartum O: Other

Comments: ____

COPE/CHILD HEALTH CLIENT REGISTER FORM

Client Number ________________ Time of clients arrival at hospital ________________
Type of visit ___________________

	Staff member initials	Staff Position	Time service started	Time service completed	Total minutes
First Contact					
Second Contact					
Third Contact					
Fourth Contact					
Fifth contact					
Sixth Contact					

Type of visit (include all relevant ones):

W: Well child / vaccinations A: Ante-natal F: Family Planning
S: Sick child P: Postpartum O: Other

Comments:____

COPE/CHILD HEALTH. CLIENT FLOW CHART

SITE: ______________________ DATE :___________ PAGE:______*

Client Number	TIME In Out	Total Minutes	Contact Minutes	Waiting Minutes	Visit Code	Comments

Visit codes / Type of visit (include all relevant ones):

W: Well child / vaccinations A: Ante-natal F: Family Planning
S: Sick child P: Postpartum O: Other

***Use as many pages as necessary**

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IMCI RECORD REVIEW CHECKLISTS

FOR

CHILD HEALTH

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Appendix D

IMCI RECORD REVIEW CHECKLIST

Management of the Sick Young Infant Age 1 Week up to 2 Months

SITE: ______________________________

DATE: ______________________________

REVIEWER: ______________________________

(Select 10 records at random)

	1	2	3	4	5	6	7	8	9	10	
Patient Record Number:											
Checklist Item: Was this child assessed for:											Total
1. possible bac-terial infection											
2. diarrhoea											
3. feeding problems or low weight											
4. breastfeeding frequency											
5. immunization status (BCG, OPVO, DPT											
6. other problems											
Were the mother's health needs assessed?											

IMCI RECORD REVIEW CHECKLIST
Management of the Sick Young Child Age 2 Months up to 5 Years

SITE: ______________________________

DATE: ______________________________

REVIEWER: ______________________________

(Select 10 records at random)

	1	2	3	4	5	6	7	8	9	10	
Patient Record Number:											
Checklist Item: Was this child assessed for:											Total
1. general danger signs: a) unable to drink or breastfeed; b) vomits everything; c) convulsions; d) lethargic or unconscious											
2. cough or difficulty breathing											
3. diarrhoea											
4. fever											
5. an ear problem											
6. malnutrition, anaemia											
7. immunization status (BCG, OPVO, DPT											
8. vitamin A deficiency											
9. feeding pattern (if child has anaemia or very low weight, growth faltering or is under 2 years old)											
Were the mother's health needs assessed											

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ACTION PLAN FOLLOW-UP SUMMARY FORM

FOR

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Appendix E

FOLLOW-UP SUMMARY FOR THE ACTION PLAN

Problem/Cause	Recommendations	Status	Comments

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