EngenderHealth's Quality Improvement Series




COPE® for Maternal Health Services

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

WORK IN PROGRESS

ENGENDERHEALTH

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

ENGENDERHEALTH
Improving Women's Health Worldwide

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Foreword

Maternity care is a critical component of a woman's overall health care. Yet, "at least 35% of women in developing countries receive no antenatal care during pregnancy, almost 50% give birth without a skilled attendant and 70% receive no postpartum care in the six weeks following delivery" (Family Care International 1998b). In large part because of this lack of care, maternal mortality is a leading cause of death among women of reproductive age in the developing world. For example:

- One out of 48 women in the developing world dies from pregnancy and childbirth (Family Care International 1998a).
- At least 200 women in the developing world die every day from unsafe abortion (Family Care International 1998c).
- As many as 300 million women—more than one-quarter of all adult women in the developing world—suffer from short- or long-term illnesses and injuries related to pregnancy and childbirth (Family Care International 1998a).

> "For obstetricians and midwives practicing in developing countries, maternal mortality is not about statistics. It is about women: women who have names, women who have faces. Faces which we have seen in the throes of agony, distress and despair. Faces which continue to live in our memories and continue to haunt our dreams. Not simply because these are women in the prime of their lives who die at a time of expectation and joy; not simply because a maternal death is one of the most terrible ways to die… but above all because almost every maternal death is an event that could have been avoided, and should never have been allowed to happen."
>
> *—Dr. Mahmoud Fathalla, Professor of Obstetrics and Gynecology, Assiut University, Egypt, and Member, EngenderHealth Board of Directors addressing the Technical Consultation on Safe Motherhood in Sri Lanka, 1997*

One of the strategies that hospitals, clinics, and other health care facilities are using to reduce maternal death and disability is quality improvement. By assessing the quality of their maternity care services and using the assessment results to improve services, health care staff can support women to have safe pregnancies and deliver healthy babies. This manual provides you with a process and set of tools to accomplish this.

COPE at a Glance

This section provides a brief overview of the COPE process and its key steps. The remaining sections of this manual explain each step in detail. Before conducting COPE, facilitators should read through this manual in its entirety and become familiar with the process and the tools.

ABOUT COPE

COPE is an ongoing quality improvement process used by health care staff to assess and improve the quality of care that they provide. The exercise uses four tools—Self-Assessment, Client Interviews, Client-Flow Analysis, and Action Plan Development. These tools enable supervisors and their staff to discuss the quality of their services, identify problems that interfere with the delivery of quality services, identify the root causes of those problems, recommend ways to solve the problems, implement the recommendations, and follow-up to ensure resolution of the problems.

Two assumptions inform the COPE process:

1. Recipients of health care services are not passive patients waiting to be seen by experts, but rather are autonomous health care consumers, or clients, who are responsible for making decisions about their own health care and who deserve—indeed, have a right to—high-quality health care.

2. Health care staff desire to perform their duties well, but without administrative support and critical resources, they cannot deliver the high-quality services to which clients are entitled.

COPE was developed around a framework of seven client rights and three staff needs that are implicit in these two assumptions (see Figure 1-1). The rationale is that the more these rights are honored and these needs are met, the higher the quality of care will be.

FIGURE 1-1 Client Rights and Staff Needs

QUALITY SERVICES

Clients Have a Right to:

Information
Access to Services
Informed Choice
Safe Services
Privacy and Confidentiality
Dignity, Comfort, and Expression of Opinion
Continuity of Care

Staff Have a Need for:

Facilitative Supervision and Management
Information, Training, and Development
Supplies, Equipment, and Infrastructure

Adapted from Huezo, C., and Diaz, S., 1993, Quality of care in family planning: Clients' rights and providers' needs, *Advances in Contraception* 9:129–139.

COPE empowers staff to proactively and continuously assess and improve the quality of their services. COPE's emphasis on the role of staff in continuous quality improvement makes this possible. It recognizes staff as the resident experts on quality and fosters teamwork by encouraging all levels of staff to collaborate in identifying obstacles to high-quality care and efficiently using existing resources to overcome those obstacles. At the same time, rather than finding fault with individual staff members, COPE focuses on identifying problems in service-delivery systems and processes. When staff work on COPE, they develop a sense of ownership of the assessment findings, become invested in implementing the recommendations they derive from the process, and feel good about the quality of services they deliver, their contributions to the facility, and the health of their community.

Since 1988, EngenderHealth* has been developing and refining COPE in collaboration with partners in developing countries. EngenderHealth continues to review lessons learned about what works and what does not work as COPE is introduced in an ever-increasing number of countries, organizations, and health care facilities. Originally developed for family planning services, COPE has, over time, been adapted for use with other health care services. This version of COPE is for use in maternal health or other pregnancy-related care settings.

* In March 2001, AVSC International officially changed its name to EngenderHealth.

IMPLEMENTING COPE

The initial COPE exercise should take place over a period of two to three days. Follow-up exercises should be conducted every three to six months thereafter and take two or three days to complete, depending on whether the facility opts to perform Client-Flow Analysis. For an overview of the COPE process, see Figure 1-2.

The Facilitator

When a facility makes the decision to implement COPE for the first time, it should obtain the services of an experienced COPE facilitator. This is usually an external facilitator, from the headquarters organization or from a technical-assistance agency, who has experience implementing COPE. During the initial exercise and the first follow-up exercise, a staff member from the site receives training to become a site facilitator. The site facilitator, with the assistance of the external facilitator, if needed, will be responsible for facilitating all subsequent COPE exercises at the site.

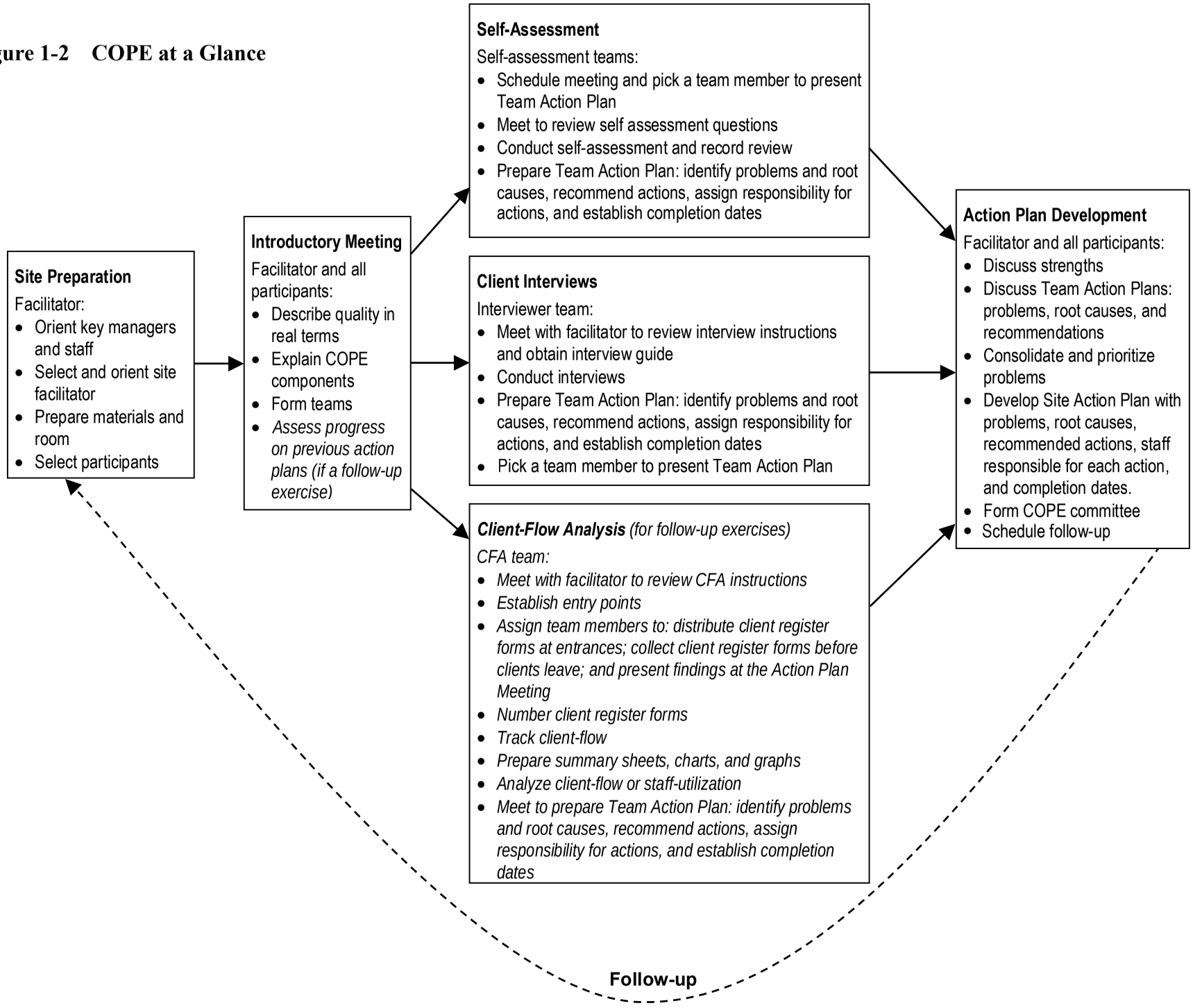
Preparing for a COPE Exercise

For the initial COPE exercise, the facilitator should use the time leading up to the COPE exercise, through site visits or correspondence, to build consensus with the site staff about the importance of quality improvement, gather information on the site, introduce the staff to COPE, instruct management on selecting staff participants and a site facilitator for follow-up COPE exercises, schedule the COPE exercise, and prepare materials for the exercise. For follow-up COPE exercises, the facilitator should schedule the exercise, prepare the materials, and help the administration select staff participants.

The Introductory Meeting

Each COPE exercise begins at the Introductory Meeting. During this meeting, the COPE facilitator explains COPE to all of the participants, and the participants form teams to work with each of the tools.

Figure 1-2 COPE at a Glance



The Four COPE Tools

COPE uses four tools—Self-Assessment, Client Interviews, Client-Flow Analysis, and the Action Plan—which are briefly described below. The COPE tools have practical and easy-to-use data collection and analysis forms that are designed to be *flexible* so that each site can adapt them to its particular needs.

Self-Assessment: COPE participants form teams, each of which is responsible for reviewing one or more of 10 Self-Assessment Guides (see Appendix B). Each guide has a series of questions related to the quality of maternity care services (based on international standards and guidelines) in the context of one of the client rights or staff needs identified as critical to high-quality care (see Figure 1-1 on page 1.2). The team members review the questions during their normal work day and decide which questions reveal a problem that they have observed or experienced at their site. One or two team members also review between 10 and 20 obstetric admission records, using the Obstetric Admission Record Review, to identify recordkeeping strengths and weaknesses. After they go through the self-assessment questions individually or as a team, the team members meet to discuss the problems they identified, determine the root causes of those problems, and recommended solutions to those problems, including who will implement the recommendations and when. They record their findings in a Team Action Plan for discussion at the Action Plan Meeting. A more detailed description of Self-Assessment begins on page 4.1.

Client Interviews: Although the number of interviews conducted may vary, generally three to five COPE participants volunteer to conduct a total of approximately 15 interviews (i.e., three to five interviews per volunteer). Each member of the client interview team conducts informal interviews with clients who have completed their clinic visit—using the Client-Interview Form (see Figure 5-2 on page 5.4) as a guide. Using open-ended questions, the interviewers encourage each client to discuss the quality of her visit, what was good and bad about the visit, and how the quality of the services could be improved. The interviewers record the clients' responses and then meet to discuss their findings. One of the interviewers prepares the findings—as a Team Action Plan—for presentation at the Action Plan Meeting. A more detailed description of the Client Interview begins on page 5.1.

Client-Flow Analysis (CFA): CFA team members track the flow of each antenatal and postpartum follow-up client who enters the clinic during a specified time period—for example, from 8 a.m. to noon, or from 8 a.m. to 4 p.m. Clients are tracked from the time they enter the clinic until the time they leave, using the Client Register Form (see Figure 6-3 on page 6.6) to record each contact with a provider and the duration of each contact. One or two team members then complete the Client-Flow Chart (see Figure 6-4 on page 6.9) and the Client-Flow Chart Summary (see Figure 6-5 on page 6.10). They then chart, graph, and analyze the data; discuss the findings; and record them—as a Team Action Plan or in some other format—for presentation at the Action Plan Meeting. EngenderHealth recommends that sites not perform CFA at the first COPE exercise. A more detailed description of CFA begins on page 6.1.

Action Plan Development: When COPE participants have completed the Self-Assessment, Client Interviews, and CFA, if performed, they convene at the Action Plan Meeting to discuss, consolidate, and prioritize the problems and recommendations in the Team Action Plans.

Through this process, the group develops a Site Action Plan (see Figure 7-1 on page 7.4) that lists each of the problems identified, the root causes of each problem, the actions recommended to solve each problem, the staff members responsible for implementing the recommended actions, and the completion date for each action. A more detailed description of Action Plan Development begins on page 7.1.

COPE Follow-Up

Once the COPE exercise is completed, the facilitator and the staff agree on a date for a follow-up exercise. At the follow-up exercise, the participants meet again and use the Follow-Up Summary (see Figure 8-1 on page 8.4) to assess their progress in solving the problems in the Action Plan from the former exercise. CFA may be conducted at the first follow-up exercise, particularly if waiting time or staff utilization was identified as a problem at the initial exercise. In addition, staff may wish to repeat one or more of the other tools during the follow-up exercise. COPE exercises should be conducted every three to six months in order to follow up on the previous Site Action Plan and to identify new issues that need to be addressed. A more detailed description of COPE Follow-Up begins on page 8.1.

If no quality improvement committee exists at the site, the site manager may wish to establish a COPE Committee. This committee receives routine reports on progress in implementing the COPE Action Plan, provides support to the COPE facilitator and staff as needed or requested, and reports to management about COPE activities, as needed or requested. The committee members may be selected before the conclusion of the Action Plan Meeting.

Preparing for a COPE Exercise

Once a site has agreed to perform an initial COPE exercise, it is important for the external facilitator to begin preparing for the exercise.* Through an advance site visit and orientation, if possible, and through correspondence, the COPE facilitator should build consensus about the importance of continuous quality improvement, get information about the site, explain COPE to the administration, instruct administrators on the selection of COPE participants and a site facilitator for future COPE exercises, schedule the COPE exercise, and prepare materials for the exercise. If an advance visit is impossible, the facilitator and administrators should meet on the first day of the exercise, before the COPE Introductory Meeting. Either during an advance visit or on the first day of the exercise, the facilitator should talk to as many of the staff members as possible (not just senior staff members) who have direct client contact in order to become acquainted with the services provided at the site and to encourage staff to participate in COPE.

BUILDING CONSENSUS ABOUT CONTINUOUS QUALITY IMPROVEMENT

It is important, when preparing for the COPE exercise, to begin to build a consensus at the site about the importance of continuous quality improvement and the value of COPE as a means of improving quality. This can be achieved by sending key administrators and managers quality improvement literature (including a copy of this manual) and conducting an orientation, which explains quality improvement theory and the COPE quality improvement process, prior to conducting the COPE exercise. Key site-level managers include those who are responsible for service delivery and have daily interaction with staff; senior managers at headquarters include those responsible for overseeing service standards, supplies, training, and supervision. The support of these key staff members is critical because the COPE process will identify needs at the site level and at the headquarters level, which will require support from managers at both levels.

* For subsequent exercises, the site facilitator should adapt the preparation to the needs of the site.

GETTING INFORMATION ABOUT THE SITE

The facilitator should review as much information about the site as possible before the exercise starts so that he or she can tailor COPE to the specific characteristics of the facility. Particularly useful would be information on:

- The site's staff (size and composition)
- The services available at the site and in the region
- The number of clients who use maternity care services at the site and in the region
- Governmental or institutional maternal and child health policies that may affect maternity care service delivery
- Indicators, such as maternal and infant mortality rates or case fatality rates

EXPLAINING COPE

The facilitator should explain COPE to management and any staff members he or she encounters at the advance visit. The important points to emphasize in communicating about COPE are:

- **Management's role.** In order for COPE to succeed, management *must* support the staff's involvement in the COPE exercises and give the staff responsibility for solving the problems identified.

- **Self-assessment.** COPE is a *self-assessment* process that can help management and staff members improve the quality of services at their site. It is not an external evaluation.

- **Problem identification and resolution.** COPE helps staff members identify barriers to quality and their root causes and develop strategies for overcoming those barriers.

- **Staff involvement.** COPE encourages all staff members to think about how, using existing resources, they can improve quality, increase efficiency, and orient services toward client needs.

SELECTING COPE PARTICIPANTS

As many staff members as possible should participate in the exercise, including one or more of the following:

- Representatives from administration (e.g., head doctor, matron, medical superintendent, hospital administrator, and hospital secretary)
- Labor and delivery staff
- Surgeons and theater nurses who provide routine or emergency obstetric care
- Maternity care staff, including doctors, nurses, counselors, and aides
- Receptionists

- Staff responsible for records
- Ancillary staff (e.g., supplies coordinator, housekeepers, gatekeepers, maintenance workers)
- Representatives from the ob/gyn ward, the family planning clinic, the emergency room, the pediatric ward, the pharmacy, the laboratory, supplies, and other departments

When conducting an initial COPE exercise at the site, if the site is part of a larger organization, such as the Ministry of Health, the COPE facilitator should plan to do the exercise along with a representative from the headquarters of the organization.* This has several advantages:

- The organization headquarters can learn about COPE's quality improvement process
- A trained COPE contact at headquarters can support the site facilitators
- The site's staff members can see the importance their headquarters gives to the COPE exercise, specifically, and to quality improvement, in general

SCHEDULING COPE

During the advance visit (or, if an advance visit is not possible, through correspondence), the COPE facilitator, headquarters representative, and site managers should schedule the COPE exercise. For an initial COPE exercise, they should schedule two days to perform the exercise. Follow-up exercises may require as many as three days, depending on which tools the site chooses to use. It is important to communicate to site management and staff that, while COPE may take place over the course of two to three days, actual meeting time for all staff will be limited to approximately two hours on the first day and approximately three hours on the last day. The other activities will take place during the course of the staff's regular work day.

The first COPE exercise consists of the Self-Assessment (including the Record Review), the Client Interview, and Action Plan Development and takes two days to complete (see Figure 2-1). EngenderHealth recommends that Client-Flow Analysis (CFA) be performed at a follow-up exercise, once the staff are more familiar with COPE or when waiting times are identified as a problem.

* Outside observers should be kept to a minimum, however. Staff members may be reluctant to discuss their site's problems openly if too many observers from headquarters or other organizations are present.

FIGURE 2-1 Sample Schedule for an Initial COPE Exercise

DAY 1

Morning—*Initiating the Exercise*

Tour the facility/meet management and COPE participants
Hold COPE Introductory Meeting with key staff members (approximately 2 hours)

Afternoon—*Client Interviews and Self-Assessment, including Record Review*
(carried out during routine work hours at staff member's convenience)

Conduct Client Interviews
Conduct Self-Assessment

DAY 2

Morning—*Client Interviews and Self-Assessment*
(carried out during routine work hours at staff member's convenience)

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

Afternoon—*Action Plan Development*

Hold Action Plan Meeting with the same staff members who met for the Introductory Meeting (approximately 3 hours)
Schedule dates for the follow-up meeting and the next COPE exercise
Form QI Committee

Whether or not the COPE facilitator can make a preliminary visit to the site, the facilitator or headquarters organization may wish to correspond with the site in advance to explain the COPE exercise and to request the attendance of key staff members. If corresponding with the site, the facilitator should be sure to include the following information:

- A description of COPE
- An explanation of the benefits of COPE
- Confirmation of the dates and times of the COPE exercise
- Information on selecting COPE participants and a site facilitator
- A list of materials that the site may need to provide

MATERIALS AND SUPPLIES

Facilitators should bring the supplies they will need to perform COPE with them to the site—facilitators should not assume that the site will have the supplies they need. Figure 2-2 lists all the materials needed to conduct a typical COPE exercise. However, the quantities will vary depending on the size of the facility and the number of staff members participating.

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 COPE exercises

COPE FORMS AND GUIDES

3–5 copies of each of the 10 Self-Assessment Guides
15 copies of the Client-Interview Form
1 copy of the Obstetric Admission Record Review Form (for sites that provide labor and delivery services)

If Client-Flow Analysis is performed:

Approximately 100 copies of the Client Register Form (but this will depend on client load for the time you are monitoring client flow and how many entrances there are to the site)
5 copies of the Client-Flow Chart Form
1 copy of the Client-Flow Chart Summary Form

OTHER SUPPLIES

Large sheets of paper (flipcharts or newsprint) for the Introductory Meeting, for recording information from COPE tools, and for the Action Plan Meeting (one complete flipchart pad should be sufficient)
Colored markers for recording the Action Plan. Facilitators should bring enough to share with participants.
Tape for putting up the large sheets of paper

If Client-Flow Analysis is performed:

A ruler
Large sheets of graph paper (five sheets should be sufficient)
A calculator
Colored pens for graphing client flow

COPE Introductory Meeting

The COPE Introductory Meeting should be held on the first day of the COPE exercise at a time when the meeting is least likely to disrupt services, and should take approximately two hours. Representatives of all departments and all types of staff should be invited to participate.

OBJECTIVES OF THE INTRODUCTORY MEETING

The Introductory Meeting has several objectives, including:

- To encourage participants to think about *quality services* and their commitment to quality improvement
- To introduce COPE and to explain how it can be used to improve quality
- To explain how COPE works and to introduce each of the COPE tools
- To develop participants' sense of *ownership* of the COPE process and awareness that, as the quality experts at their site, they have the power to improve the quality of their services
- To reassure participants that COPE does not evaluate or criticize individual performance, but rather identifies weaknesses in work processes and systems
- To select staff members to work in teams on the Self-Assessment Guides and Client Interviews (and the Client-Flow Analysis, if it is going to be performed during the COPE exercise)

For follow-up exercises, during the Introductory Meeting the staff also review the Site Action Plan from the previous exercise to assess their progress in implementing the recommendations.

MATERIALS AND SUPPLIES

The facilitator should bring all supplies needed for the COPE exercise (see Figure 2-2 on page 2.5) to this meeting. The facilitator will explain the COPE instruments to participants and will distribute other supplies to the teams that will be working with 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. See Appendix A for guidance on how to encourage staff members to actively participate in the Introductory Meeting. Facilitators should not expect too much at the first meeting—staff members usually need to become comfortable with and accustomed to COPE before they participate fully.

TOPIC 1
INTRODUCTIONS

The facilitator should introduce himself or herself and any colleagues who will be participating in the exercise. If possible, the participants should introduce themselves and describe their responsibilities.

TOPIC 2
WHAT IS COPE?

The facilitator should then explain COPE. The COPE acronym stands for "client-oriented, provider-efficient," and the goal of COPE is to improve quality. The COPE process can be applied to other services besides pregnancy-related care—for example, reproductive health services or child health services. COPE gives service providers an opportunity to stand back, look at services for a few hours, put themselves in their clients' shoes, and think about services from the client perspective. COPE encourages service providers to ask their clients what they think about the services available to them and gives staff members an opportunity to decide which problems they can resolve given existing resources. In addition, COPE helps staff explore their own needs—what they need, professionally, in order to provide the high-quality services to which their clients are entitled. COPE can also be helpful in determining when outside help is needed to resolve a problem.

TOPIC 3
WHY IS COPE BEING IMPLEMENTED AT THIS SITE?

The facilitator should explain that the management and staff at the site have expressed an interest in improving the quality of their services and that COPE can help staff members identify the problems at their site that need to be addressed and deal with the problems effectively.

TOPIC 4
WHAT IS "QUALITY"?

The facilitator should conduct a brainstorming exercise to define quality. Questions like "What services do you think clients have a right to expect?" or "If you were coming to this clinic for maternity care services, how would you want the staff to treat you?" are useful in helping participants articulate a response. The facilitator should ask the participants to answer the questions aloud and record their responses on a flipchart.

Throughout the discussion, the facilitator should emphasize the following to the participants:

- Quality services are the kinds of services that staff members would want to receive or would want their spouses, children, or parents to receive.
- Quality is about meeting clients' needs and enabling staff to work more efficiently.
- Quality improvement requires ongoing attention—it is not attained by one meeting or one training session, but should be a part of what staff members are always doing.

TOPIC 5
WHAT DO CLIENTS WANT AND NEED?

The facilitator should ask the staff members what they think their clients want or need from the maternity care service. Staff members usually raise issues like "nutrition information" or "support for clients with complications" in their definition of quality. The facilitator should focus the issues raised by staff members and cover as many of the "rights of the client" as possible (see Figure 1-1 on page 1.2). The facilitator should look for opportunities for staff members to discuss whether the needs of all clients are being met, whether services are available and accessible to clients at all stages of their pregnancy and throughout their reproductive years, and whether antenatal, labor and delivery, emergency obstetric, and postpartum services are available for all clients.

TOPIC 6
WHAT DO SERVICE PROVIDERS NEED?

The facilitator should ask staff members what practical things they need in order to meet the client needs they have identified. The facilitator should cover as many of the "staff needs" as possible (see Figure 1-1 on page 1.2).

TOPIC 7
WHY DO COPE? WHY IMPROVE QUALITY?

COPE gives service providers a process and a set of tools that they can use to assess the quality of their services and make plans to improve them. The facilitator should stress the following points:

- In every organization and every work situation, there is potential for improvement.
- Problems generally occur because a system is not working efficiently. By reducing the 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 clients *and* service providers. When this happens, client satisfaction and job satisfaction increase.
- Maternity care is a priority not only for the client and her family, but also for the health care facility, the ministry of health, and the government, all of which are responsible, in some capacity, for protecting the health of their constituents.
- If the facility does not provide user-friendly services (the facilitator should use concrete examples—lack of attention to clients, dirty facilities or equipment, very long waits, etc.), clients may not return for services and will certainly not recommend them to their friends and neighbors. Each dissatisfied client will tell others about her experiences.

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

TOPIC 8
WHERE ELSE HAS COPE BEEN IMPLEMENTED?

The facilitator should explain that COPE has been translated into 15 languages and implemented in more than 35 countries at large national teaching hospitals and at small service-delivery sites with just a few staff members. COPE has been introduced throughout Africa and in Asia, Latin America, the Near East, North America, Russia, and Eastern Europe.

TOPIC 9
HOW COPE WORKS

The facilitator should explain the four COPE tools and COPE follow-up to the participants.

- **Self-Assessment:** COPE participants form teams, each of which is responsible for reviewing one or more of 10 Self-Assessment Guides (see Appendix B). Each guide has a series of questions related to the quality of maternity care services (based on international standards and guidelines) in the context of one of the client rights or staff needs identified as critical to high-quality care (see Figure 1-1 on page 1.2). The team members review the questions during their normal work day and decide which questions reveal a problem that they have observed or experienced at their site. One or two team members also review between 10 and 20 obstetric admission records, using the Obstetric Admission Record Review (see Figure 4-3 on page 4.8) to identify recordkeeping strengths and weaknesses. After they go through the self-assessment questions individually or as a team, the team members meet to discuss the problems they have identified, determine the root causes of those problems, and recommended solutions to those problems, including who will implement the recommendations and when. They record their findings in a Team Action Plan for discussion at the Action Plan Meeting. A more detailed description of self-assessment begins on page 4.1.

- **Client Interviews:** Although the number of interviews conducted may vary, generally three to five COPE participants volunteer to conduct a total of approximately 15 interviews (i.e., three to five interviews per volunteer). Each member of the client interview team conducts informal, open-ended interviews with clients who have completed their clinic visit—using the Client-Interview Form, which may be adapted, as a loose guide (see Figure 5-2 on page 5.4). The interviewer asks each client to discuss the quality of her visit, what was good and bad about the visit, and how the quality of the services could be improved. The interviewers record the clients' responses and then meet to discuss their findings. One of the interviewers prepares the findings—as a Team Action Plan or in another format—for presentation at the Action Plan Meeting. A more detailed description of the client interview begins on page 5.1.

- **Client-Flow Analysis (CFA):** CFA team members track the flow of each antenatal and postpartum follow-up client who enters the clinic during a specified time period—for example, from 8 a.m. to noon, or from 8 a.m. to 4 p.m. They then track the clients from the time they enter the clinic until the time they leave, using the Client Register Form (see Figure 6-3 on page 6.6) to record each contact with a provider and the duration of each contact. One or two team members then complete the Client-Flow Chart (see Figure 6-4 on page 6.9) and the Client-Flow Chart Summary (see Figure 6-5 on page 6.10). They then chart, graph, and analyze the data, discuss the findings, and record them—as a Team Action Plan or in some other format—for presentation at the Action Plan Meeting. EngenderHealth recommends

that sites not perform CFA at the first COPE exercise. A more detailed description of CFA begins on page 6.1.

- **Action Plan:** When COPE participants have completed the Self Assessment, Client Interviews, and CFA, if performed, they convene at the Action Plan Meeting to discuss, consolidate, and prioritize the problems and recommendations in the Team Action Plans. Through this process, the group develops and agrees on a Site Action Plan (see Figure 7-1 on page 7.4) that lists each of the problems identified, the root causes of each problem, the actions recommended to solve each problem, the staff members responsible for implementing the recommended actions, and the completion date for each action. A more detailed description of Action Plan Development begins on page 7.1.

- **COPE Follow-Up:** Once the COPE exercise is completed, the facilitator and the staff agree on a date for a follow-up exercise. At the follow-up exercise, the participants meet again and use the Follow-Up Summary (see Figure 8-1 on page 8.4) to assess their progress in solving the problems in the Action Plan from the former exercise. CFA may be conducted at the first follow-up exercise, particularly if waiting time or staff-utilization was identified as a problem at the initial exercise. In addition, staff may wish to repeat one or more of the other tools during the follow-up exercise. COPE exercises should be conducted every three to six months in order to follow up on the previous Site Action Plan and to identify new issues that need to be addressed. A more detailed description of COPE Follow-Up begins on page 8.1.

TOPIC 10
PROBLEM SOLVING WITH COPE

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

Self-Assessment Guides

The questions listed in the self-assessment guides help providers think about common problems experienced in service delivery—for example, poor or nonexistent linkages between services, which may inhibit referrals; clients' or providers' knowledge deficits; providers' need for updates on recent advances in pregnancy-related care; and providers' infection prevention knowledge deficits.

The guides are simply to aid in *recognizing problems* and thinking about *the cause of problems.* Staff members are not expected to fill out the guides or answer every question. Teams should also discuss any service-delivery problems that are not covered in the guides.

In thinking about problems, it is important to be specific. By being as specific as possible about the problem, the staff can then recommend specific actions to solve the problem, actions that get to the root of the problem. For example, "There is low water pressure" leads to a vague solution—e.g., "Find out what is causing the problem and fix it." A more specific statement of the problem—"The water pipe at the upper part of the hospital is broken"—is much more specific and immediately suggests a specific action that will solve the problem—i.e., "Fix the broken pipe at the upper part of the hospital."

Action Plan Development

Writing up an Action Plan prompts service providers to think of and recommend ways to solve the problems they identify, using existing resources. The plan also prompts participants to assign a staff member responsibility for implementing the recommendations and solving the problem by a specified date. The Action Plan Meeting allows staff members to discuss the problems they have identified, review and clarify the root causes of problems, and agree on solutions. The meeting also gives staff members an opportunity to prioritize *the actions* they will take to arrive at the solutions they have proposed while taking into account the *available resources* at the site.

TOPIC 11
FORMING TEAMS

During the Introductory Meeting, the facilitator and participants should form a team, with appropriate staff members, for each of the Self-Assessment Guides. The number of teams and the number and configuration of staff members on each team will depend on the circumstances at the site and the requirements of the individual guides.

At large sites, organizing teams during the Introductory Meeting takes a lot of time. When this is the case, the facilitator and site managers may wish to organize the teams in advance of the exercise.

Depending on the size of the site and the number of guides that are to be used, some teams may need to work on more than one guide, and some staff may be assigned to more than one team. Each guide suggests a particular configuration of staff members that would ideally work on the guide (see Appendix B). Aside from these suggestions, the team composition should be multidisciplinary—that is, each team should be made up of staff members who perform a variety of functions at the clinic rather than, for example, having a team of all doctors or all maintenance staff.

TOPIC 12
THE ACTION PLAN MEETING

The facilitator should make sure that the participants know when and where the Action Plan Meeting will be held and that:

- Each team will be responsible for presenting its findings at the Action Plan Meeting
- The findings will be discussed, consolidated, and prioritized, and the resulting problems and recommendations developed into a Site Action Plan

TOPIC 13
QUESTIONS

The facilitator should ask the participants if they have any questions.

Self-Assessment

PURPOSE OF THE SELF-ASSESSMENT TOOL

A commitment to self-assessment is at the heart of COPE: in fact, every COPE tool helps staff answer the question "What problems at this facility inhibit providers' ability to provide clients with high-quality services?"

Self-assessment is performed by teams of staff members who use 10 Self-Assessment Guides (and the Obstetric Admission Record Review) to take a thoughtful look at services at their site.

MATERIALS AND SUPPLIES

The following materials are needed for work with the Self-Assessment Guides and the Obstetric Admission Record Review:

To perform the exercises:

- 3–5 copies of each Self-Assessment Guide (more copies may be needed for larger sites)
- 1 copy of the Obstetric Admission Record Review

To record findings:

- Flipchart paper
- Markers
- Tape

The Self-Assessment Guides

The Self-Assessment Guides are based on the client rights and staff needs (see Figure 1-1 on page 1.2), which are explained below. A copy of each guide appears in Appendix B. These guides are meant to apply to *all* maternity care clients and services.

1. *Clients' Right to Information*. Clients have a right to accurate, appropriate, and understandable maternal health information delivered through counseling and educational activities and through materials that are available throughout the health care facility.

2. *Clients' Right to Access to Services*. Clients have a right to access to services that is unimpeded by cost, hours of service, location, or physical or social barriers.

3. *Clients' Right to Informed Choice*. Clients have a right to the information and support they need in order to make informed decisions about their health care and to respect for the decisions they make.

4. *Clients' Right to Safe Services*. Clients have a right to safe services, delivered in accordance with guidelines by trained providers who are skilled in routine maternity care, complications and emergency management, and infection prevention.

   An *Obstetric Admissions Record Review* is performed as a supplement to the safety guide (see Appendix C).

5. *Clients' Right to Privacy and Confidentiality.* Clients have a right to privacy and confidentiality during counseling, physical examinations, and clinical procedures and in the handling of their personal information and medical records.

6. *Clients' Right to Dignity, Comfort, and Expression of Opinion.* Clients have a right to consideration for their feelings, modesty, and comfort and to respect for their opinions and decisions.

7. *Clients' Right to Continuity of Care.* Clients have a right to the services, supplies, referrals, and follow-up necessary to maintain their health.

8. *Staff Need for Facilitative Supervision and Management.* Staff need supervision and management that value and encourage quality improvement and give staff the support they need to provide high-quality services to their clients.

9. *Staff Need for Information, Training, and Development.* Staff need knowledge, skills, and ongoing training and professional development opportunities to remain up-to-date in their field and to continuously improve the quality of the services they deliver.

10. *Staff Need for Supplies, Equipment, and Infrastructure.* Staff need reliable inventories of supplies, instruments, and working equipment and the infrastructure necessary to ensure the uninterrupted delivery of high-quality services.

USING THE SELF-ASSESSMENT GUIDES

Teams of staff members will work with the Self-Assessment Guides. The number of teams formed and the number of participants per team will depend on how many and which of the guides your site chooses to work on and the number of participants available at the site (see "Forming Teams" on page 3.7).

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 these guides at all.

STEP 1
INSTRUCTIONS TO PARTICIPANTS

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

Using the Self-Assessment Guides

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

- **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 are relevant to quality of services at their 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.

- **The Self-Assessment Guides are each divided into five service categories.** The categories are general, antenatal care, routine labor and delivery care, emergency obstetric care (including postabortion care), and postpartum care (immediate and follow-up). In practice, these categories sometimes overlap, so some self-assessment questions could reasonably be assigned to more than one category. To save space and avoid redundancy, those questions have been placed, somewhat arbitrarily, in only one of the appropriate categories. (For examples of services in each category, see Appendix B.)

- **The bulleted lists under questions are included to give team members a sense of the scope of the service being discussed.** They are not comprehensive lists of what should be done or included in a certain service, nor are all sites expected to be able to cover every item in the bulleted lists.

Developing the Self-Assessment Team Action Plan

The facilitator should encourage the self-assessment team to consider the following as they develop their Team Action Plan:

- **Participants should be honest about problems at the site.** This exercise is not intended to judge or criticize *individuals* or *the site* but rather to identify problems in the site's *processes* and *systems* and to find ways to correct the problems identified.

- **Participants should get input from colleagues.** It may be helpful for teams to solicit comments from staff or departments not represented in the team.

- **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." For example, "Lack of emergency trolleys" is too vague, because without knowing why there aren't enough trolleys, it is impossible to recommend specific actions to solve the problem. "Staff are not returning trolleys to the emergency ward entrance once they finish using them" is very specific and leads to a clear solution.

- **Participants should use the "Multiple Whys" method to identify root causes of problems.** It is easier for staff to be specific about problems and solutions if they understand the root causes of the problems they identify. To identify root causes of problems, participants should ask themselves why the problem exists, then why the reason identified exists, and so on, at least three times, and then ask, "Are there any other causes" (see Figure 4-1).

FIGURE 4-1 Using Multiple Whys to Find Root Causes

MULTIPLE WHYS	
Problem:	There is a long delay between the time a complication occurs in labor or delivery and the time an appropriate provider arrives on the scene.
Why?	The staff do not know which providers are on call or how to reach them.
Why?	There is no duty roster calendar with on-call information posted in the client-care areas.
Why?	On-call information is only available from the administrator's office, which is often not open or accessible.
Other causes?	Providers do not let staff know when they are on duty.

STEP 2
WORKING ON THE GUIDES

During the Introductory Meeting, the facilitator will give the 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; the participants should think about the questions on the guides during their normal work day. The teams can meet at their convenience to do the active work on the guides. They may decide to meet during breaks, at a scheduled meeting during the workday, or before or after work.

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

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

STEP 3
RECORDING FINDINGS

Participants should record the problems and root causes they identify and recommendations for solving the problems for the Action Plan Meeting in the following format: problem, root causes, recommendation, by whom, by when. The "Problem," "Root Causes," and "Recommendations" should be as specific as possible. Whenever possible, staff, not management, should be assigned responsibility for implementing the recommendations. The staff should represent a variety of types and levels of staff, and their names and positions should be noted on the Action Plan. Finally, the completion date for each task should be realistic. 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 4-2).

FIGURE 4-2 Sample Problem and Solution for an Action Plan

Problem	*Root Causes*	*Recommendation*	*By Whom*	*By When*
Staff don't know how to perform manual removal of the placenta	*They haven't been trained to do the procedure*	*Organize training on the procedure and plan routine refreshers*	*Judith Taylor*	*10/19 (1 month)*

STEP 4
OBSTETRIC ADMISSION RECORD REVIEW

Obstetric records serve to document the care that is provided to an individual client. Besides documenting the number and type of services provided, such records are an invaluable source of information for improving the quality of services. In recordkeeping, it is often said that if it isn't noted, in all likelihood it wasn't done. In addition, in the case of complications, the obstetric record can provide important clues to what may have gone wrong or how something could be avoided in the future.

In order to assess the quality of recordkeeping at the facility, one or two members of the self-assessment team who are working on the "Clients' Right to Safety" guide and who are familiar with obstetrics procedures (e.g., ob/gyns, labor and delivery nurses, or midwives) should conduct a review of 10 to 20 records, depending on the size of the facility and the number of reviewers.

1. *Choosing records for review.* From the clinic's files, the reviewer should randomly select 10 to 20 obstetric clients' records, which show the procedures performed during the time of service.

2. *The Obstetric Admission Record Review.* Using the following procedure, the reviewer should check each record against the checklist to determine whether essential information has been recorded (see Figure 4-3 for a sample completed checklist; a blank copy of the form appears in Appendix C). The reviewer should use two checklists if reviewing more than 10 records.

    - The reviewers should write each client record number on the checklist under the heading "Record number." For each record, look for the information specified in the numbered items in the lefthand column of the checklist. If the information is completed correctly in the record, put a check mark in the corresponding space on the checklist. For example, in Figure 4-3, client record number 32 contained the information requested in item 3 (diagnosis), while client record number 15 did not.

      Items 12 through 16 should be completed only for records that indicate that a complication occurred during labor and delivery.

    - 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 row in the "Total" column of the checklist. Based on this number, the reviewer can make generalized assumptions about the site's recordkeeping for obstetric clients.

      For example, in Figure 4-3, the information for item 3 was noted in only 5 of the 10 records. A sum of less than 10 in the "Total" column could mean either that the item was not performed (for example, there was no diagnosis step) or that the item was performed but information about it was not recorded.

3. *Recording Findings.* After completing the checklist, the reviewer should identify incomplete records and consider reasons why the records might be incomplete. The latter step may be done in consultation with labor and delivery staff or other maternity care providers. For instance, if the date and time of discharge is not noted on more than one record, it would be worthwhile exploring with staff why this is so, and likewise for the mode of delivery. If a high proportion of the 10 records have incomplete information in one or more areas, the reviewer may decide to look at a larger selection of records to see whether the clinic has a general recordkeeping problem.

After consideration and/or discussion of possible explanations for the missing data, the reviewer should discuss recommendations for solving recordkeeping problems with other team members or with the COPE facilitator. The reviewer should then write the findings on flipchart sheets using the same format as for other self-assessment items (see Figure 4-2) and present them for discussion at the Action Plan Meeting, after other members of the Safety team have presented their findings.

FIGURE 4-3 Sample Obstetric Admission Record Review

OBSTETRIC ADMISSION RECORD REVIEW *

Site: *Karibuni Clinic* **Date:** *September 20, 2001* **Reviewer:** *David Masika*

Select obstetric records at random. Check each record for notes/information on each of the checklist items. Complete the second part of the table only for those records that indicate, for question 12, that there was a complication.

CHECKLIST ITEM	RECORD NUMBER										TOTAL
	04	*32*	*15*	*73*	*18*	*61*	*99*	*22*	*78*	*46*	
1. Date and time of admission	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	*10*
2. Date and time of delivery	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	*10*
3. Diagnosis (normal labor, eclampsia, infection, etc.)		✔			✔	✔	✔		✔		*5*
4. Vaginal exam details**				✔			✔				*2*
5. Vital signs (BP, temperature, heart rate)***	✔	✔	✔		✔	✔	✔		✔	✔	*8*
6. Mode of delivery	✔	✔	✔	✔	✔	✔				✔	*7*
7. Fetal heart beat			✔	✔			✔			✔	*4*
8. Birth weight	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	*10*
9. Client's condition at discharge	✔		✔				✔		✔	✔	*5*
10. Baby's condition at discharge			✔	✔		✔	✔			✔	*5*
11. Date and time of discharge	✔		✔	✔			✔	✔	✔	✔	*7*
For complications only (e.g., cesarean sections and blood transfusions)											
12. Complication			✔					✔			*2*
13. Description of management			✔					✔			*2*
14. Start and end time of procedure			✔								*1*
15. Medications and dosages			✔								*1*
16. Informed consent form signed by client and doctor											*0*

** Noted every four hours in active first-stage labor.
*** Noted every 30 minutes in active first-stage labor and every five minutes in second-stage labor.

Reviewers' Comments:

* Use additional pages as necessary.

Client Interviews

PURPOSE OF CLIENT INTERVIEWS

The Client-Interview tool is designed to help encourage service providers to routinely ask maternity care clients what they think about the quality of services at the facility. Client Interviews help the staff find out:

- What clients know about the services offered
- What clients think about the services offered
- How clients think services could be improved

MATERIALS AND SUPPLIES

The following materials are needed for performing client interviews:

To perform the interviews:
15 copies of the Client-Interview Form (see Appendix D)

To record findings:
Flipchart paper
Markers
Tape

CONDUCTING CLIENT INTERVIEWS

COPE requires only a small sample of client interviews. About 10 to 15 interviews—randomly selected from antenatal, routine labor and delivery, emergency obstetric, and immediate and follow-up postpartum clients—should be sufficient for each COPE exercise. Staff who volunteer to conduct the client interviews may agree to interview two to three clients each—they should be careful, however, not to interview the same client more than once. The purpose of the interviews is to get ideas from the clients. At some sites, staff have been surprised to learn new things about their clinic from the clients. The facilitator should encourage all staff members to informally ask

clients about services as a regular part of their activities even after the COPE exercise is complete.

Participants should 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

During the Introductory Meeting, the facilitator should ask for volunteers who will act as client interviewers. Getting clients to open up and say what they really think about services at the site can be difficult. The interviewers should be friendly and approachable so that clients will feel more comfortable opening up to them. Clients may be afraid of offending the interviewer. Therefore, interviewers should be sure to let clients know that they sincerely want their honest feedback in order to improve services.

STEP 2
RECRUITING CLIENTS FOR INTERVIEWS

Each interviewer should approach clients who have completed their clinic visit and request an interview. Interviewers should not interview clients to whom they personally provided a service. The interviewer should introduce himself or herself to the client, explain that the facility is trying to improve the quality of care at the site and would like the client's honest opinion about the quality of the service she received and what the facility could do to improve the services. In addition, the interviewer should explain that the interview will be private and confidential and that the client's name will not be used or written down. Interviewers should also explain that the client may skip any questions that she doesn't want to answer or may refuse to participate in the interview at all and that nothing she says will affect the care she receives at the clinic. The interviewer should also tell the client that the interview will last about 10 minutes and ask her if she is willing to participate in the interview.

STEP 3
CONDUCTING CLIENT INTERVIEWS

Although interviewers might decide to sit and chat with clients in the waiting room when recruiting, the actual interviews should be conducted individually and in private.

The interviews should be as informal as possible. Interviewers should start by asking clients about themselves and their families. The interviewer should then begin the interview. Interviewers do not have to stick to the format and questions on the Client-Interview Form (see Figure 5-2 on page 5.4). The form is simply a guide to get an

interview under way. Interviewers might use the form to 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.

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

Figure 5-1 presents some suggestions for conducting successful client interviews.

FIGURE 5-1 Tips for Client Interviewers

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

- Ask open-ended questions
- Don't become defensive
- Accept criticism; don't try to explain problems away
- Express empathy, where appropriate
- Ask for specifics, where appropriate
- Thank the client for her help

STEP 4
RECORDING CLIENT INTERVIEW FINDINGS

The interviewers should record the clients' responses to the interview questions. For example, if a client complained about the waiting time or about drugs not being available at the pharmacy, the interviewer should note those comments as problems. The facilitator should also encourage staff to report the positive things that clients say about the services they receive (e.g., "The nurse answered my questions and comforted me," or "The hospital is clean and pleasant"). In addition, interviewers should note their own reactions to the interviews and discuss them at the Action Plan Meeting.

Once the interviews are completed, the Client Interview Team should prepare to present its findings at the Action Plan Meeting. Interviewers may use flipchart paper to record their findings using the Action Plan format: *problem, root causes, recommendation, by whom, by when*, or they may simply write a summary of their findings to present at the Action Plan Meeting.

FIGURE 5-2 Sample Client-Interview Form

CLIENT-INTERVIEW FORM

Site:_____ **Date:**_____

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

1. Why did you come to this facility? Is this your first visit or a return visit?
2. Did you get what you came for? If not, why not?
3. What information did you receive?
4. Were you instructed to return for a follow-up visit? If yes, was an appointment scheduled?
5. Were you referred to someone else for other services? If yes, why?
6. What was the best thing about your experience during this visit?
7. What was the worst thing about your experience during this visit?
8. Would you return here for services? If not, why?
9. Would you refer your friends or relatives here?
10. What do people in the community say about the services provided at this facility?
11. Can you suggest specific ways that we could improve the services at this facility?
12. Is there anything else you would like to tell us?

Interviewer notes:

Client-Flow Analysis

PURPOSE OF CLIENT-FLOW ANALYSIS

Client-Flow Analysis (CFA)* tracks the movement of all antenatal and postpartum follow-up clients** through the clinic, from the time they arrive until the time they depart, for all or part of a clinic session. Staff note each contact the clients have with providers and the duration of each contact. This information is then charted, graphed, and analyzed. By visually demonstrating how client and staff time are used, the CFA graphs and charts permit rapid evaluation of client flow. Like other COPE tools, CFA helps staff identify strengths and weaknesses in clinic operations. CFA 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 a bottleneck
Identify lapses in client contact time	Explain what staff are doing during lapses
Identify missed contacts	Explain why contacts are missed
Identify unscheduled client contacts	Tell why extra contacts are made
Provide data for personnel cost estimates	Tell whether personnel costs are reasonable
Measure client waiting time	Tell whether waiting time is 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 of changes is a desired one

* 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).

** EngenderHealth is currently developing a CFA tool for labor and delivery and emergency obstetric care.

EngenderHealth recommends that facilities defer using CFA until after the initial COPE exercise. Ideally, CFA should be performed at a follow-up COPE exercise, particularly if an earlier exercise revealed that waiting time or staff utilization was a problem at the site.

Facilities may adapt the CFA materials to fit their specific circumstances and needs. For example, in some facilities, clients may receive family planning counseling as part of an antenatal or postpartum visit. In such facilities, it may be important to involve family planning staff in the CFA data-collection process. If adaptation is necessary, it should be completed by the external facilitator and site management in advance of the COPE exercise that will include CFA.

The benefits of CFA may include a reduction of staff and client waiting time (and frustration) at the clinic, a better distribution of workload 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.

Although CFA is a good tool for analyzing clinic efficiency, it is no substitute for the judgment and expertise of those who work at the clinic. CFA only *identifies* potential problems; it does not explain them. Staff members must seek explanations for any unusual occurrences identified in the analysis. Staff do the important part of CFA—addressing problems and improving service delivery based on findings—when they discuss and analyze CFA findings at the 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 E.

To gather information:

- 100 copies of the Client Register Form (but this will depend on the client load during the day in which you are monitoring client flow and the number of entrances to the site.)
- 5 copies of the Client-Flow Chart
- 1 copy of the Client-Flow Chart Summary

To make graphs:

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

To record findings:

- Flipchart paper
- Colored markers
- Tape

PERFORMING CLIENT-FLOW ANALYSIS

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

STEP 1
PREPAR1NG FOR CFA

During preliminary discussions about the COPE exercise, the facilitator should collaborate with site administrators to determine whether CFA will be performed.

Scheduling

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

Selecting CFA Team Members

Before the Introductory Meeting, the facilitator should collaborate with site administrators to identify the two or three staff members who will be responsible for graphing and charting the data collected during CFA. Graphing and charting the data will require one to two hours, depending on the size of the site and the amount of data gathered. It is therefore important to identify individuals who can devote this amount of time to the CFA process without disrupting services to clients.

CFA may involve departments other than maternity care services if clients also receive nonmaternity care services (e.g., child-welfare, family planning, and RTI/STI services) at the time CFA is performed. Staff from all involved departments should participate in the CFA and receive instructions on the data-collection process. If possible, the CFA Team should include staff who have direct contact with maternity care 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 why they came to the clinic
- Any staff member who conducts group-education sessions for clients

FIGURE 6-2 Sample COPE Schedule Including CFA

DAY 1

Morning—*Initiating the Exercise*

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

Afternoon—*Client Interviews and Self-Assessment*

- Conduct Client Interviews
- Conduct Self-Assessment

DAY 2

Morning—*CFA Data Collection, Client Interviews, and Self-Assessment*

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

Afternoon—*CFA Data Analysis, Client Interviews, and Self-Assessment*

- Graph and chart the CFA data
- Analyze preliminary CFA findings
- Continue Client Interviews
- Continue Self-Assessment

DAY 3

Morning—*Client Interviews and Self-Assessment*

- 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

- Any staff member who has service contact with clients during their visit
- The last staff member who has direct contact with clients before they leave the facility
- Staff members who will be responsible for graphing and conducting a preliminary analysis of the information collected

Explaining CFA at the Introductory Meeting

The facilitator should explain the purpose and process of CFA to all COPE participants at the Introductory Meeting. 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 they see during one clinic session. The facilitator should stress that, to be of maximum use, the information must be complete, legible, and accurate.

Preparing the CFA Team and Introducing Materials

After the Introductory Meeting, the facilitator should meet with the CFA team and explain the data-collection process and the CFA forms, charts, and graphs in more detail.

Determining Entry and Exit Points. Through discussion, the facilitator should help participants identify where clients enter the site and how they access maternity care services. There may be several entry and exit points for maternity care clients. If this is the case, the facilitator should ensure that clients arriving at each of the different entrances are included in the CFA sample.

Numbering the Client Register Forms. Participants should number the Client Register Forms consecutively in the "Client number" space provided on the form. 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., for one entry, and B1, B2, B3, etc., for another).

Timekeeping. To ensure that the times recorded are consistent, staff members should synchronize their watches and the clinic clocks before starting to collect data.

STEP 2
DATA COLLECTION

Using the Client Register Form

The Client Register Form is used to record each client's entry and exit times, the amount of time the client spends with each staff member, and the reason for the client's visit. Figure 6-3 contains a sample completed Client Register Form.

FIGURE 6-3 Sample Client Register Form

CLIENT REGISTER FORM

Client number: 05 Client's time of arrival: 8:15 a.m.

Type of client: A Type of visit: R

	Staff member initials	Time service started	Time service completed	Total contact (in minutes)
First contact	GH	9:23	9:26	3
Second contact				
Third contact				
Fourth contact				

Comments: _____

_____

_____

As the clients arrive at the clinic, they should each receive a Client Register Form. The first client should receive the form with client number "01." The second client should receive client number "02," and so forth. As each client moves through the clinic, each staff member with whom she has contact should write the start time and end time of the contact and the total minutes and should initial the form (or write a previously determined identification code, if more than one staff member has the same initials). If the contact lasts less than a minute, a full minute should be entered.

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) should note each client's time of arrival on a Client Register Form, give the form to the client, and explain to the client that she should carry the form with her during her entire clinic visit—presenting the form to each staff member she has contact with—and leave the form with the last staff member she sees.

2. The first staff member with whom the client discusses her visit should record the "Type of client"—"A" for antenatal or "P" for postpartum follow-up—and the "Type of visit"—"F" for first visit or "R" for repeat visit.

   Any other important information about the client's visit (for example, if the client leaves the clinic without completing the visit) should be noted on the form under "Comments."

3. If clients attend a group-education session, the staff person responsible for conducting the session should enter the beginning and ending time of the session on each client's form.

4. The last staff member who has contact with the client should collect the Client Register Form and give the completed form to the staff members responsible for charting and graphing the data.

STEP 3
CHARTING CLIENT FLOW

The Client-Flow Chart and Summary forms are used to collate and chart the information collected on 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

Staff should obtain the following information from the Client Register Forms and enter it on the Client-Flow Chart:

1. The "Client Number," beginning with client number "01." (If more than 20 clients visited the clinic during the session, use additional pages of the Client-Flow Chart.)

2. The time "In" (when the client arrived at the clinic) and "Out" (when the client left the clinic) for each client.

3. The "Minutes at the site" for each client, from "Time In" to "Time Out."

Example:

Time In	Time Out	Total minutes
9:30	11:05	95

4. "Contact minutes"—the sum of "Total contact (in minutes)" for each contact on the Client Register Form.

5. "Waiting minutes"—subtract the number of "Contact minutes" from the number of "Minutes at the site."

6. "Type of client" and "Type of visit"—use the codes at the bottom of the Client-Flow Chart that correspond to each.

7. "Comments"—any pertinent information the provider might have entered (e.g., "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

Page: *1 of 1*

CLIENT-FLOW CHART*

Site: *Karibuni Clinic* **Date:** *September 18, 2001*

Client number	Time In	Time Out	Minutes at the site	Contact minutes	Waiting minutes	Type of client	Type of visit	Comments
01	*8:00*	*8:50*	*50*	*40*	*10*	*A*	*R*	
02	*8:10*	*10:40*	*150*	*103*	*47*	*A*	*F*	
03	*8:10*	*10:25*	*135*	*33*	*102*	*A*	*R*	
04	*8:20*	*11:35*	*195*	*35*	*160*	*P*	*F*	
05	*8:20*	*11:10*	*170*	*155*	*15*	*A*	*R*	*Compl/refer'd*
06	*8:20*	*11:40*	*200*	*43*	*157*	*A*	*R*	
07	*9:10*	*11:45*	*155*	*48*	*107*	*P*	*F*	
08	*9:10*	*11:50*	*160*	*32*	*128*	*A*	*R*	
09	*9:30*	*11:50*	*140*	*29*	*111*	*P*	*F*	
10	*10:35*	*12:00*	*85*	*33*	*52*	*A*	*R*	

Client type:

A Antenatal
P Postpartum

Visit type:

F First visit
R Repeat visit

* Use as many pages as necessary

Using the Client-Flow Chart Summary

When the Client-Flow Chart is complete, use the Client-Flow Chart Summary form to calculate averages for the session. If more than one Client-Flow Chart page was used to record information for the session, enter the information for each page in the corresponding row of the Client-Flow Chart Summary form.

Figure 6-5 Sample Client-Flow Chart Summary

CLIENT-FLOW CHART SUMMARY

Site: *Karibuni Clinic* **Date:** *September 18, 2001*

Page number	Total number of clients	Total minutes at the site	Total contact minutes	Total waiting minutes
Page 1	*10*	*1,440*	*551*	*889*
Page 2				
Page 3				
Page 4				
Page 5				
Summary Total	*10*	*1,440*	*551*	*889*

Average number of minutes at the site per client: *144 minutes*

Average number of contact minutes per client: *55 minutes*

Average number of waiting minutes per client: *89 minutes*

Average percentage of time in contact with a provider: *38% of time at site*

Average percentage of time waiting to see a provider: *62% of time at site*

For each page of the Client-Flow Chart, a CFA team member should:

- Enter the number of clients charted in the "Total number of clients" column of the Client-Flow Chart Summary.
- Add up the "Total minutes at the site" for all clients and enter the figure in the "Total minutes at the site" column of the Client-Flow Chart Summary.
- Add up the "Contact minutes" for all clients and enter the figure in the "Total contact minutes" column of the Client-Flow Chart Summary.
- Add up the "Waiting minutes" for all clients and enter the figure in the "Total waiting minutes" column of the Client-Flow Chart Summary.

1. Add up each column of the Client-Flow Chart Summary and enter the figures in the "Summary Total" row.

2. Calculate the "Average number of minutes at the site per client" by dividing the "Summary total minutes at the site" by the "Summary total number of clients."

Example:

Summary total minutes at the site	÷	Summary total number of clients	=	Average number of minutes at the site per client
1,440		10		144 minutes

Clients spent an average of 144 minutes at the site.

3. Calculate the "Average number of contact minutes per client" by dividing the "Summary total contact minutes" by the "Summary total number of clients."

Example:

Summary total contact minutes	÷	Summary total number of clients	=	Average number of contact minutes per client
551		10		55 minutes

Clients spent an average of 55 minutes in contact with a provider.

4. Calculate the "Average number of waiting minutes per client" by dividing the "Summary total waiting minutes" by the "Summary total number of clients."

Example:

Summary total waiting minutes	÷	Summary total number of clients	=	Average number of waiting minutes per client
889		10		89 minutes

Clients spent an average of 89 minutes waiting to see a provider.

5. Calculate the "Average percentage of time in contact with a provider" by dividing the "Summary total contact minutes" by the "Summary total minutes at the site."

Example:

Summary total contact minutes	÷	Summary total minutes at the site	=	Average percentage of time in contact with a provider
551		1,440		38%

On average, clients spent 38% of their time in contact with a provider.

6. Calculate the "Average percentage of time waiting to see a provider" by dividing the "Summary total waiting minutes" by the "Summary total minutes at the site."

Example:

Summary total waiting minutes	÷	Summary total minutes at the site	=	Average percentage of time waiting to see a provider
889		1,440		62%

On average, clients spent 62% of their time waiting to see a provider.

STEP 4
ANALYZING CLIENT FLOW

MATERIALS AND SUPPLIES

The following materials are needed to create the graph:

To present findings:
Client-flow data from the completed Client Register Forms

To record findings:
Graph paper
Colored markers
Ruler

Creating a Client-Flow Graph

To create the Client-Flow Graph (see Figure 6-6), the team member responsible for graphing the data should pick different-colored pens for each client type—e.g., blue for an antenatal visit and yellow for a postpartum follow-up visit.

To draw the 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- to 10-minute intervals until the time the session ended. Each square of the graph shown in Figure 6-6 represents a 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."

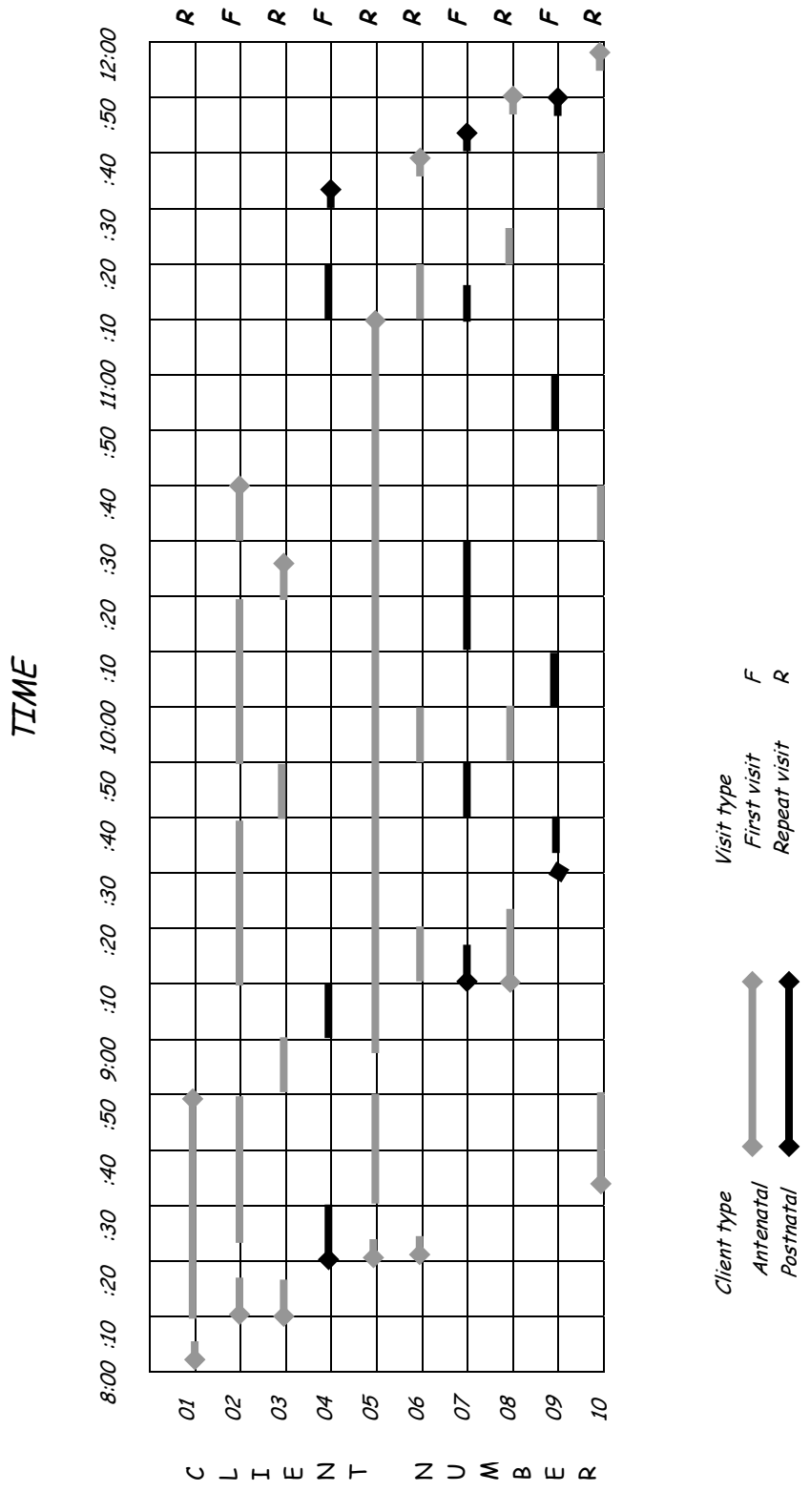
3. For client number 01, choose the color pen or pencil that corresponds to the client type in question. Using this color, make a symbol (for example, an asterisk or a vertical bar) at the points on the graph indicating the time the client entered and left the clinic.

4. Using the same color, draw horizontal lines corresponding to the time the client spent with each staff member. The space between these lines shows waiting time.

5. Using the same color, write the Visit type code, "F" or "R," at the extreme right of the line you have drawn (along the right side of the graph).

6. Repeat steps 3, 4, and 5 for each client in the session.

FIGURE 6-6 Sample Client-Flow Graph (first 10 clients only)



STEP 5
ANALYZING STAFF UTILIZATION

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

1. On a blank sheet of paper, first note the "Summary total contact minutes" in the session from the Client-Flow Chart Summary.

2. Next, calculate the total staff minutes available by multiplying the number of minutes in the session by the number of staff who worked during the session.

Example:

Minutes in the session	x	Staff members	=	Available staff minutes
240		5		1,200

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

Example:

Contact minutes	÷	Available staff minutes	=	Percentage staff time in contact
551		1,200		46%

Creating a Staff-Utilization Graph

Like the Client-Flow Graph, the Staff-Utilization Graph is used to give a clear, visual representation of the 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.

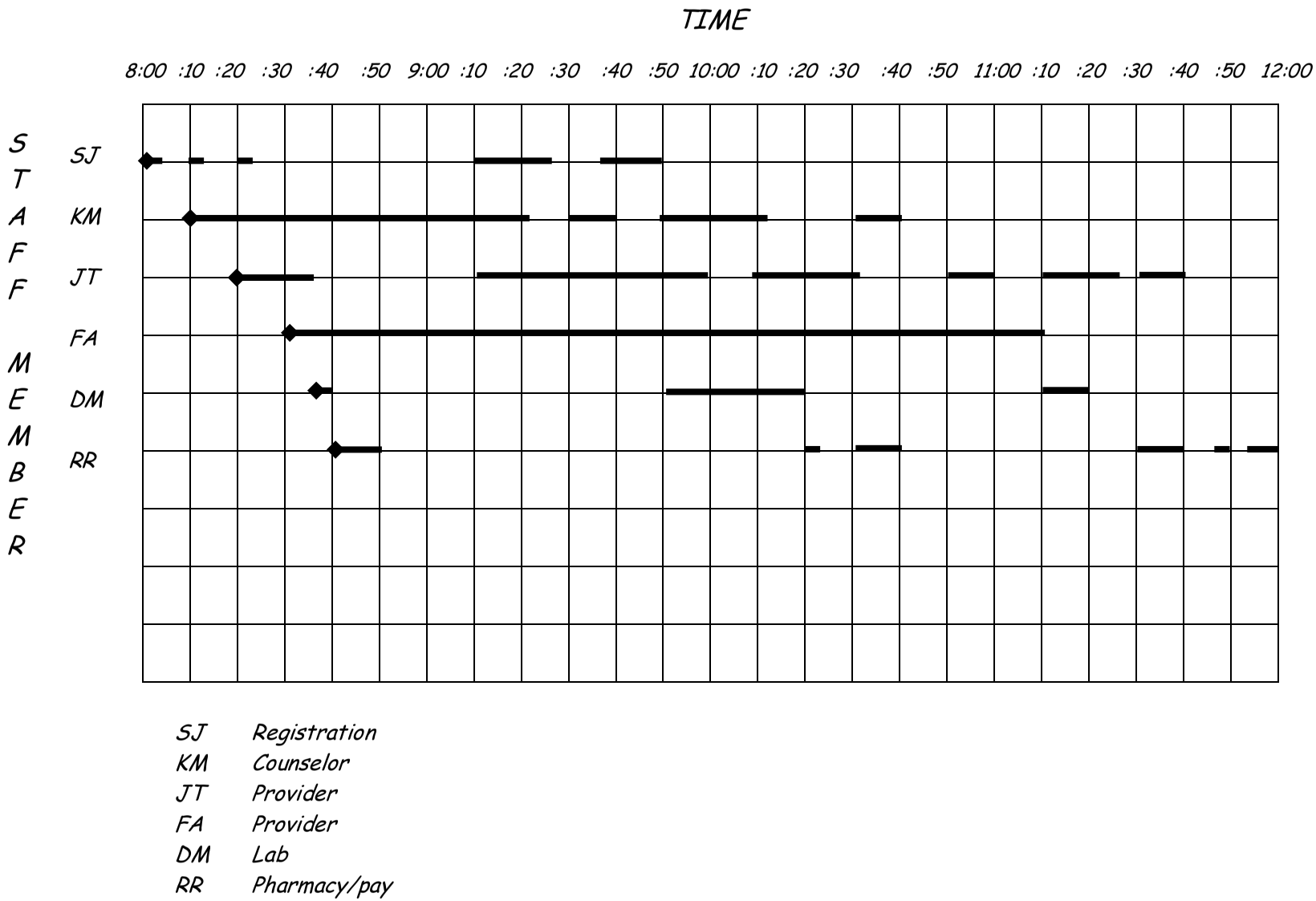
To create a Staff-Utilization Graph (see Figure 6-7), follow these steps:

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- to 10-minute intervals until the time the session ended. Each square of the graph shown in Figure 6-7 represents a 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 beside the staff member's initials that corresponds to the time spent providing service to that client. Spaces between the lines will represent tea breaks, meal breaks, and other activities.

FIGURE 6-7 Sample Staff-Utilization Graph (first 10 clients only)



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 point in the client's visit?
- Can you think of some ways in which services could be reorganized to do this?

Staff utilization

- Are staff members fully utilized in your clinic?
- Are a few staff members doing the major part of service delivery? If yes, 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 the record their findings for presentation at the Action Plan Meeting. They may use the Action Plan format to record the problems, root causes, recommendations, people responsible for implementing the recommendations, and completion dates.

Staff should also be prepared to use the graphs and charts to give a brief presentation about their analysis at the Action Plan Meeting.

Action Plan Development

THE ACTION PLAN MEETING

During the Action Plan Meeting, which is held on the last day of the COPE exercise, the Self-Assessment, Client-Interview, and Client-Flow Analysis teams present their Team Action Plans. The entire group of COPE participants:

- Discusses the problems, root causes, recommended actions, individuals responsible for implementing the actions, and completion dates for the actions
- Revises them, as appropriate, based on the discussion
- Consolidates the findings of the different teams to eliminate redundancy
- Prioritizes the problems and establishes completion dates based on a consideration of criteria, such as safety (the highest priority goes to problems that reduce client or provider safety) or the ease with which the problems can be solved using existing resources
- Writes up the resultant problems and recommendations in a Site Action Plan

MATERIALS AND SUPPLIES

The following materials are needed for the Action Plan Meeting:

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

To record findings:
Flipchart paper
Colored markers
Tape

CONDUCTING THE ACTION PLAN MEETING

Generally, the Action Plan Meeting follows the format outlined below. To encourage full participation, the Action Plan Meeting should be informal, and participants should be as comfortable as possible. For specific facilitation tips for the Action Plan Meeting, see "Facilitating Action Plan Development" on pages A.5 and A.6.

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 of the meeting for the future use of site staff.

At the beginning of the meeting, the facilitator should:

- Thank the participants for their hard work throughout the COPE exercise
- Remind the participants that problems generally occur because the system is not working—that problems are not the fault of any one person
- Remind the participants that COPE is an internal, not external, process. COPE is performed by staff, for staff.
- Point out the positive findings that she or he observed during the exercise, (i.e., the services at the site that are already of high quality) and reinforce that the objective of the COPE exercise is to further improve the quality of services
- Encourage lively discussion without letting the participants argue in a hostile way

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TOPIC 2
PRESENTING FINDINGS

Using their Team Action Plans, team representatives should present their teams' findings and thoughts about the problems at the site, including:

- Each problem identified
- The root causes of each problem
- The person responsible for implementing each action
- The completion date for each action

Before the first presentation, facilitators should ask the participants not to discuss problems that their team identified if the problems were discussed in a previous presentation. Instead, if a problem comes up during another team's presentation, all teams that identified the same

problem should discuss their findings regarding the problem when it is first raised. This ensures that the group won't discuss the same problems more than once and redundancy will be eliminated; the participants can discuss whether there is more than one root cause to the problem; the participants can discuss the relative merits of the different solutions; and the group can use more than one of the recommended solutions, if appropriate.

TOPIC 3
DISCUSSING FINDINGS

After each team's presentation, the participants should discuss the team's findings. To be able to arrive at a workable solution, the participants must first agree on whether something is a problem and on the source of that problem.

If the root causes that the teams present during the Action Plan Meeting are not as specific as they could be, the facilitator should encourage the entire group to use the Multiple Whys method to find more specific root causes (see Figure 4-1 on page 4.5).

The participants should not limit themselves to one solution per problem; problems that have more than one root cause may have more than one solution.

The 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 the discussion without dominating it. One of the main principles of COPE is that staff are far more likely to accept and act upon suggestions that they have made themselves.

TOPIC 4
CREATING THE SITE ACTION PLAN

Through the Action Plan Meeting presentations and discussion, the participants should have arrived at an agreement about each problem and recommendation presented. They should also have prioritized the problems, based on consideration of criteria, such as safety (the highest priority goes to problems that reduce client or provider safety) or the ease with which the problems can be solved using existing resources, and agreed on completion dates that reflect the feasibility and the priority level of each item.
The results should be noted on the flipchart sheets as the Site Action Plan (see Figure 7-1, "Sample Site Action Plan"). The "Problem," "Root Causes," and "Recommendations" should be as specific as possible. Whenever possible, staff, not management, should be assigned responsibility for implementing the recommendations. The staff assigned responsibility for implementing recommendations should represent a variety of types and levels of staff, and their names should be noted on the Action Plan. Finally, the completion date for each task should be realistic.

FIGURE 7-1 Sample Site Action Plan

Problem	Root Causes	Recommendation	By whom	By when
No forum to discuss maternal health stats	*No staff assigned to review stats*	*Form committee to review the new stats*	*Judith Taylor*	*October 19 (one month)*
Some providers not trained in counseling	*Trained staff haven't shared skills w/others*	*Develop on-the-job training*	*Kibogoyo Mzee*	*October 25 (5 weeks)*
Staff routinely perform episiotomies	*Staff not up-to-date on current guidelines*	*Update staff on current guidelines and plan routine refreshers*	*David Masik*	*October 19 (one month)*
Staff don't know how to perform manual removal of placenta	*They haven't been trained to do the procedure*	*Organize training on the procedure and plan routine refreshers*	*Judith Taylor*	*October 19 (one month)*
Some staff don't know how to make chlorine solution	*Only some staff received training*	*Demonstrate to all staff how to make 0.5% solution*	*Fatma Ahmed*	*October 3 (2 weeks)*
No heavy-duty gloves	*Cleaning staff didn't know they needed gloves*	*Use petty cash to buy heavy-duty gloves*	*Sarah Jotto*	*October 3 (2 weeks)*

Either during the discussion or immediately afterward, the facilitator should make a copy of the Site Action Plan (or two copies if an external COPE facilitator is working with a site facilitator) to use for follow-up of the COPE exercise.

TOPIC 5
PLANNING A FOLLOW-UP MEETING

Once the Site Action Plan has been recorded and agreed on by the participants, the main work of the meeting is complete. At this point, the facilitator should inform the participants that a follow-up COPE exercise will be conducted in three to six months and that their site facilitator will let them know the exact date. The facilitator should also tell the participants that the site facilitator and the COPE Committee, if one has been formed (see "COPE Committee" on page 8.2), or Quality Improvement Committee will decide which tools to use during the next exercise.

The follow-up meeting is part of the COPE process. The purpose of this meeting is for staff to monitor and assess their progress in meeting the goals established in the Site Action Plan. Scheduling a follow-up meeting and a return visit by the external COPE facilitator encourages staff to implement their recommendations and motivates them to focus on them during the intervening period. If possible, the experienced COPE facilitator should arrange to return to the site to help the site facilitator conduct the follow-up COPE exercise. Following the Action Plan Meeting, the COPE facilitator should confirm arrangements for the Follow-up Meeting with management and reconfirm the arrangements in a letter.

TOPIC 6
REINFORCING THE POSITIVE

During the Action Plan Meeting, the staff's focus should be on problems at the site. At the end of the meeting, the facilitator should remind staff of some of the positive things about the quality of services at their site so that staff do not end the exercise thinking that the site has nothing but problems. For example, if the exercise revealed that the staff are good at making sure that women who are hemorrhaging receive immediate care, the facilitator should congratulate the staff for that accomplishment.

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

COPE Follow-Up

COPE is based on two 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 new problems will be different from the old ones. Follow-up to COPE has four important objectives:

- Immediate follow-up of a COPE exercise by a facilitator
- Site-level follow-up on the implementation of recommendations
- Periodic performance of follow-up COPE exercises
- Sustained staff involvement in improving the quality of services

IMMEDIATE FOLLOW-UP

The nature of immediate follow-up will depend on whether the external COPE facilitator or the site facilitator does the facilitation.

If the outside COPE facilitator is returning to facilitate the follow-up, he or she should send a letter or memo to the site facilitator or to site management congratulating the site on the successful completion of the COPE exercise and the participation of the site's staff. The COPE facilitator should attach a copy of the Site Action Plan to this letter and should use this opportunity to reconfirm the date of the COPE follow-up exercise. The COPE facilitator should also communicate with the site facilitator periodically to check on the progress being made on the Site Action Plan.

If the site facilitator is going to facilitate the follow-up meeting, he or she may wish to distribute a copy of the Site Action Plan to all staff or to post the flipchart sheets in a prominent place where all staff can review the plan. The site facilitator may also check periodically with those responsible for implementing specific recommendations—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 the implementation. He or she should also instruct the staff responsible for implementing recommendations to let the site facilitator know when they have completed their tasks. The site facilitator should mark completed items on the flipchart and on the Site Action Plan. A week or two before the follow-up COPE exercise, the site facilitator should remind

participants that they will be performing COPE again and that one of the objectives of the exercise will be to review the progress made on the previous Site Action Plan.

COPE Committee

COPE is not a one-time intervention. Identifying problems and coming up with possible solutions through the Site Action Plan is an important first step. Many sites find that it is also helpful to establish a COPE committee. The purpose of a COPE committee is to have a group of staff members who, with the site facilitator, will be responsible for following up on Action Plan progress, planning additional COPE exercises, assisting staff who need help completing tasks assigned in the Site Action Plan, and so forth.

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

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

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

- *The size of the committee.* The committee should be large enough to represent different perspectives, but not so large that it becomes unwieldy (fewer than 10 members is preferable)

- *The composition of the committee.* The committee should be composed of different types and levels of staff members

- *The qualities of committee members.* The committee members should be enthusiastic about improving quality, willing and able to participate actively, and able to communicate easily and effectively with their peers

In addition, once the committee is formed, it should elect a committee chairperson, who will be responsible for scheduling and facilitating committee meetings.

FOLLOW-UP COPE EXERCISES

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

As previously mentioned, the follow-up COPE exercise is usually a good time to introduce Client-Flow Analysis. If your site opts to perform CFA, the COPE exercise may take three days to complete instead of two, depending on how many other tools are used in the exercise.

- All follow-up COPE exercises include an initial follow-up meeting, which includes follow-up on the previous exercise's Site Action Plan, and Action Plan Development for whichever tools are used at the new exercise—Self-Assessment, Client Interviews, or Client-Flow Analysis.

Introductory Meeting/Reintroduction of the COPE Tools

The site facilitator should run this meeting. If the external facilitator is present, he or she should participate only to support the site facilitator.

FIGURE 8-1 Sample Completed Follow-Up Summary Sheet

FOLLOW-UP SUMMARY

Karibuni Clinic at Three-Month Follow-Up

PROBLEM	ROOT CAUSES	RECOMMENDATION	STATUS	COMMENTS
No forum to discuss maternal health statistics	No staff assigned to review statistics	Form committee to review maternal health statistics	*Solved*	*Meets once a month*
Some providers not trained in counseling	Trained staff haven't shared skills with others	Conduct training and plan routine on-the-job training	*Attempted*	*Currently in the planning stage*
Staff routinely perform episiotomies	Staff not up-to-date on current guidelines	Update staff on current guidelines and plan routine refreshers	*Unsolved*	*Cancelled several times—various reasons*
Staff don't know how to perform manual removal of placenta	They haven't been trained to do the procedure	Organize training on the procedure and plan routine refreshers	*Attempted*	*Currently in the planning stage*
Some staff don't know how to make chlorine solution	Only some staff have received the training	Demonstrate to all staff how to make the 0.5% solution	*Solved*	*Everyone has now had a demo*
No heavy-duty gloves	Cleaning staff didn't know that they needed gloves	Provide heavy-duty gloves from petty cash	*Solved*	*Question now is how to maintain constant supply*

If possible, all participants from the previous COPE exercise should participate in this meeting. The facilitator should begin by reviewing the Site Action Plan from the previous COPE exercise, discussing each item on the plan and its implementation. Through this discussion, it may emerge that some items were not problems after all. The participants may also find that some recommendations took more or less time to implement than was allotted or that there was more to the problem than they originally understood. The results of this discussion should be noted on the COPE Follow-Up Summary Sheet (see Figure 8-1). Unresolved items for which a solution seems possible should be incorporated into the next Site Action Plan.

The site facilitator should then reintroduce the COPE quality improvement process and the material presented during the Introductory Meeting from the first COPE exercise (see "How COPE Works" on page 3.5). The facilitator should advise the participants to incorporate unsolved problems from the previous COPE exercise into their discussion during this exercise.

COPE Components

Following the Introductory Meeting, the staff should implement whichever of the tools have been planned for the follow-up COPE exercise. (See "Self-Assessment" on page 4.1, "Client Interviews" on page 5.1, and "Client-Flow Analysis" on page 6.1, as needed.)

Action Plan Meeting

The Action Plan Meeting and the development of the new Site Action Plan should take place in much the same way as in the first COPE exercise (see pages 7.1–7.5). Again, the site facilitator should run this meeting, with the outside COPE facilitator providing support, as needed.

The site facilitator should reemphasize the following:

- Positive aspects of services at the site—e.g., cesarean sections performed well or staff sensitive to family members' need for reassurance.
- 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 help of the site facilitator to ensure that staff have the support they need to provide the high-quality services that clients are entitled to and that quality improvement is an ongoing process
- That staff should set a date for the next COPE meeting

References

Bertrand, J., et al. 1993. Handbook of indicators for family planning program evaluations. Chapel Hill, NC: The Evaluation Project.

Bruce, J. 1989. Fundamental elements of the quality of care: A simple framework. *Working Papers* no. 1. The Population Council.

Dwyer, J., et al. 1991. COPE: A self-assessment technique for improving family planning services. *AVSC Working Paper* no. 1. New York: Association for Voluntary Surgical Contraception.

Family Care International. 1998a. "Maternal mortality." *Safe Motherhood Fact Sheet*. New York.

Family Care International. 1998b. "Good quality maternal health services." *Safe Motherhood Fact Sheet.* New York.

Family Care International. 1998c. "Unwanted pregnancy." *Safe Motherhood Fact Sheet.* New York.

Graves, J., et al. 1981. Computerized patient flow analysis of local family planning clinics. *Family Planning Perspectives* 13(4):164–170.

Huezo, C., and Diaz, S. 1993. Quality of care in family planning: Clients' rights and providers' needs. *Advances in Contraception* 9:129–139.

International Planned Parenthood Federation (IPPF). The rights of the client. Poster created by IPPF.

Lynam, P., et al. 1993. Using self-assessment to improve the quality of family planning clinic services. *Studies in Family Planning* 24(4):252–260.

Martinez, C. F. Do's and don'ts of effective presentations. Paper prepared for the Center for Systems Education, AT&T Communications. Piscataway, NJ: AT&T Communications.

Miller Consulting Group. 1994. *Managing quality through teams: A workbook for team leaders and members.* Atlanta, GA: Miller Howard Consulting Group, Inc.

Rabinowitz, L., et al. 1994. An evaluation of COPE, a family planning self-assessment technique. Unpublished report prepared for AVSC International, New York.

Appendix A

Facilitating COPE

FACILITATING COPE

THE COPE FACILITATOR

The initial COPE exercise is carried out by the site's staff with the assistance of the external facilitator. The trained COPE facilitator helps the staff go through the COPE exercise and trains one staff member to facilitate the site's future COPE exercises. Having a trained site facilitator is essential if the staff are to continue to do COPE on their own.

Ideally, during the first COPE exercise, the external facilitator works with the site facilitator. The site facilitator leads the first follow-up meeting , with support from the experienced COPE facilitator. Thereafter, the site facilitator conducts COPE exercises and follows-up on his or her own, with support from headquarters or other staff members, as needed.

CREATING A COMFORTABLE ENVIRONMENT

It is important to create a comfortable environment for the COPE exercise. The facilitator should:

- Come prepared with the necessary materials and supplies (see Figure 2-2 on page 2.5)
- Arrange the room in an informal style
- Start the meeting on time
- Use training aids (such as flipchart paper, a blackboard, samples of methods) and make sure that all participants can see them
- Make sure everyone can hear
- Encourage group participation in the discussions. Walk around the room instead of staying at the front.
- Establish rapport and let staff members know that the facilitator is on their side
- Be kind and sensitive to staff members
- Relax and be natural

- Try to make the participants feel at ease

- Talk to and address all levels of staff, paying particular attention to nonproviders and ancillary staff

FACILITATING COPE DISCUSSIONS

The facilitator should explain to the participants that the administration requested the COPE exercise and is committed to the concept of staff *self-assessment*. Explain that part of the COPE philosophy is that all staff members can make valuable contributions to this process; therefore, all staff members' comments are valued.

The following facilitation tips will help the facilitator maximize staff participation in the discussions and keep the discussions focused, while maintaining a low profile—that is, not leading the discussion.

Encourage ownership

The most important feature of COPE is its emphasis on *self-assessment.* COPE is not an assessment exercise imposed on the staff by outsiders—staff members consider their clients and the services that they offer them, identify and analyze shortcomings and bottlenecks, and then decide for themselves what they need to do to rectify problems. The facilitator should emphasize this from the beginning.

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 the staff.

Encourage participation

Everyone's participation is important to COPE. The facilitator is there to start things off, but the more staff members participate, the better. The facilitator should establish rapport with and among the staff members and should encourage questions, interruptions, and lively discussion without letting the participants argue in a hostile way.

As a rule, the facilitator should ensure that every speaker is treated with respect. No individual or small group should dominate the discussions: the facilitator should try to involve shy people and staff members who are not used to expressing their ideas in meetings, including ancillary staff (ward boy, maintenance staff, housekeeping staff, gatekeepers, etc.).

Be positive

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

Talk about strengths

The facilitator should encourage staff to talk about their facility's strengths by discussing examples of quality services that they have observed. People are often too modest to mention their positive qualities if they are not asked.

Show enthusiasm

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

Be flexible

The COPE facilitator should always bear in mind that each site has different needs, strengths, and weaknesses. For example, some of the Self-Assessment Guides or questions may be appropriate for some sites and not for others. COPE tools should be adapted for individual site circumstances and needs; COPE will be a different experience every time it is conducted. Wherever possible, the facilitator should discuss this aspect of COPE with the site management in advance of the exercise.

Show empathy

The facilitator should show the participants that he or she understands how they feel about a situation. This helps the 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 the facilitator says.

- *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."

Probe by asking open-ended questions

The facilitator should use open-ended questions to probe the participants if they are having a hard time being specific about problems. Open-ended questions usually begin with "what," "where," or "how." They encourage staff members to participate because to answer them, participants have to think and respond at some length—the questions cannot be answered by a simple "yes" or "no." Open-ended questions can be used to:

- *Start a discussion.* For example, "What do you think about infection prevention practices at this clinic?"

- *Get a member of the team more involved.* For example, "Nurse Obare, what is your opinion about infection prevention practices at the clinic?"

- *Bring a conversation back on track.* For example, "What other information do we need to solve this problem?"

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 restatement of the speaker's message can be introduced by phrases like: "So, in other words...," "It sounds like...," or "Let me make sure I've got this right. Rephrasing can be used to:

- *Clarify what someone is saying.* For example, "It sounds as if you think we are spending too much time discussing infection prevention."

- *Resolve conflicts between participants.* For example, "It sounds as if Dr. Ndete thinks that our infection prevention procedures are adequate, and Nurse Obare thinks there is still some room for improvement."

- *Get at deeper issues.* Some things are hard to speak about. By rephrasing, the facilitator can help participants talk about the real root cause of the problem by using statements like "So, in other words, there is more to this problem than meets the eye" or "Can you think of any other reasons for this problem?"

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. *However, do not name names of institutions or individuals.* It is very important that confidentiality be honored and that 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 that staff members have identified at different sites and the actions they

took to resolve them. It's best if this record does not use specific names or places—just the problems identified and solutions.

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.

FACILITATING ACTION PLAN DEVELOPMENT

When needed, the facilitator should provide assistance to the staff as they develop the Team and Site Action Plans. After the Introductory Meeting, the facilitator should walk around the site and ask teams how they are progressing with the development of their Team Action Plans and assist them if necessary. During the Action Plan Meeting, the facilitator should assist the staff with the Site Action Plan.

During Action Plan Development, it is important to ensure that all participants' voices are heard and to encourage broad discussion of the topics in every category. Staff may have difficulty identifying root causes, developing recommendations, assigning staff members to implement the recommendations, and setting realistic completion dates. If staff experience any of the following problems, facilitators may wish to use some of the questions listed below to guide Action Plan Development discussions.

If staff have trouble identifying the root cause of a problem

- Is this really a problem?
- How is it a problem?
- Does something else lie behind it?
- What do staff think could be the sources of the problem?
- Is this problem a barrier to clients getting good services?
- Will the solutions listed improve the services?

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

- Is this recommendation the best way to solve the problem?
- Is there an easier or more effective way to deal with this problem?
- Is there more than one possible solution?

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

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

If the time allowed to implement a recommendation seems unrealistic

- Is this timeframe appropriate, or should it be changed?

If participants seem uncomfortable with assignments

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

If a problem identified seems vague

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

If some recommendations have been assigned to an outside organization

- Can anyone suggest an alternative recommendation, one that can be implemented on-site by staff?
- Are problems that can be solved by staff assigned to someone in the clinic?
- Who will take responsibility for coordinating this recommendation with the other organization?

If many recommendations are assigned to one individual or organization

- Do you think it is feasible for all these recommendations to be implemented by one person/organization within the specified time?
- Can other staff be assigned to implement some of the recommendations?

Appendix B

Self-Assessment Guides

SELF-ASSESSMENT GUIDE SERVICE CATEGORIES

The Self-Assessment Guides are each divided into five service categories: general, antenatal care, routine labor and delivery care, emergency obstetric care (including postabortion care), and postpartum care (immediate and follow-up). Examples of services in each category are provided below.

General
Services that apply to antenatal, routine labor and delivery, emergency obstetric, and postpartum care, such as infection prevention.

Antenatal Care
- Detection of pregnancy and calculation of due date
- Screening (physical examination, pelvic, fetal assessment, and history) and recognizing complications
- Urine tests for protein and glucose
- Tetanus immunization
- Iron provision
- Malaria and hookworm treatment
- Labs (hemoglobin, blood type, syphilis, gonorrhea, chlamydia, HIV, tuberculosis tests)
- Imaging studies (sonogram)
- Birth plan assistance
- Counseling (antenatal)
- Referrals

Routine Labor and Delivery Care
- Initial obstetric evaluation/assessment
- Recognition of labor, complications, and emergency
- Normal labor management (including maternal and fetal monitoring, labor progress assessment)
- Management of prolonged labor/dysfunctional labor
- Normal delivery (including management of shoulder dystocia and third-stage labor)
- Initial management of routine complications such as dehydration, bleeding, placental retention
- Performance of IV fluid replacement, laceration repair, manual removal of the placenta, bimanual uterine compression, use of oxytocin, methergine, antibiotics
- Immediate newborn evaluation, resuscitation, routine care, immediate breastfeeding
- Stabilization and transfer of care for clients needing emergency obstetric care

continued

Sef-Assessment Guide Service Categories (continued)

Emergency Obstetric Care (including postabortion care)

- Emergency evaluation/assessment
- Recognition of complications and emergency
- Initial stabilization of emergency (such as shout for help, IV, oxytocin, CPR)
- Management of eclampsia, preeclampsia, hemorrhage, obstructed labor, infection, sepsis, ectopic pregnancy, malpresentation, shock, cardiopulmonary arrest
- Performance of assisted delivery, cesarean section, blood transfusion, uterine evacuation, use of diazepam/magnesium sulfate
- Administration of anesthesia
- Management of unexpected surgical complications (such as bleeding or bowel/ bladder perforation)
- Stabilization and transfer of care for clients needing further emergency care

Postpartum Care (immediate and follow-up)

- Assessment, immediately postdelivery, postcesarean, or postabortion, and at follow-up visits for complications (such as check of vital signs, incisional checks, bleeding, uterine firmness)
- Infant assessment and management of complications both postdelivery and at follow-up visits for complications
- Counseling about normal care of mother and baby, breastfeeding, family planning, warning sings, and where to come for medical attention
- Removal of sutures, incisional care, perineal care, breast care, breastfeeding support
- Recognition, management, and/or stabilization of complications and transfer of care for clients needing additional emergency obstetric care

Clients' Right to Information

Clients have a right to accurate, appropriate, and understandable health information delivered through counseling and through educational activities and materials that are available throughout the health care facility.

INSTRUCTIONS

WHO SHOULD WORK ON THIS GUIDE: Staff who provide client-education services, staff who give clients information on pregnancy-related health and the facility's services, and at least one member of the clinical staff

HOW TO WORK ON THIS GUIDE: Read and consider each of the questions in this guide. Ignore any questions that are not relevant to your facility. A "no" answer to any of the relevant questions may indicate an opportunity for quality improvement. Make a note of the questions that you think should be discussed further.

For each question that indicates a need for improvement, and for any problems not covered in this guide, record on flipchart paper: the problem, your recommendations for correcting the problem, who you think should implement the recommendations, and a realistic target date.

PROBLEM CAUSES RECOMMENDATIONS BY WHOM BY WHEN

Note: Some of the questions in this guide ask whether staff share information with those who accompany a client (e.g., partners, family members, or TBAs). In such cases, it is assumed that confidential client information will be shared only at the client's request or with the client's authorization.

General

1. Does your facility prominently display signs in the local language(s), outside of and throughout the building(s), that indicate the location, cost, and hours of maternity or other pregnancy-related services?

2. Do all staff provide clients with the following information concerning your facility's maternity or other pregnancy-related services?

   - What services are available
   - Where and when each service can be obtained
   - How much each service costs
   - Which services are available by referral to another facility, where the other facility is located, and how clients can get there

3. Do staff speak all the local languages, or are interpreters available?

4. Does your facility have sufficient supplies of local-language client-education materials such as posters, pamphlets, videos, and slides on a variety of health topics, such as general health care, antenatal and postpartum care, and infant and child care?

5. Does your facility provide information through health talks and community outreach activities on topics such as general health care, antenatal and postpartum care, and infant and child care?

6. Do staff encourage the following clients, who may be at higher risk for complications in pregnancy and delivery, to deliver in a medical facility and refer them, as appropriate?

    - Women under 17 years of age
    - Women who have had five or more births
    - Women who have undergone cesarean section
    - Women with concurrent medical conditions, such as heart disease, diabetes, and malaria

7. Do clients with reproductive tract infection (RTI)/sexually transmitted infection (STI), including HIV, receive information and counseling on how to care for themselves, how to inform their partners and advise them about treatment, and how to prevent reinfection or transmission to their infants or their partners?

8. Do staff counsel maternal care clients and those who accompany them about the *negative* health consequences of the following practices?

    - Poor nutrition or nutritional taboos for women in the antenatal or postpartum period
    - Acceptance of postpartum bleeding for cleansing purposes
    - Avoidance of colostrom for the infant
    - Female genital cutting (FGC)

9. Do staff inform and counsel antenatal *and* immediate and follow-up postpartum clients on how to care for themselves (e.g., nutrition, routine care of abdominal and perineal lacerations, and postpartum family planning) and their infants (e.g., nutrition, cord care, immunization)?

10. Do staff inform and counsel antenatal *and* postpartum clients on the importance of breastfeeding for the mother and infant (e.g., the value of colostrom for the infant, breast care, and putting the infant to the breast in the first hour)?

Antenatal Care

11. Do antenatal clients and those who accompany them receive information on the following topics?

    - The due date
    - Concurrent diagnoses and treatments

- The importance of having a birth plan that includes arrangements for a skilled birth attendant and emergency transportation
- What to expect and who and what to bring to the facility when they are in labor (for a planned facility birth)
- Safe labor and delivery (e.g., cleanliness, constant attendance, oral hydration)
- The warning signs of complications (fever, heavy bleeding, convulsions, swelling, prolonged labor)
- The importance of seeking medical attention if warning signs occur and where to go for medical attention
- Unsafe traditional practices (e.g., nutrition restriction, allowing unchecked bleeding, avoidance of colostrom)
- The importance of attending follow-up visits

12. Do antenatal clients who plan to deliver at home receive instructions to return to the facility if they encounter any problems in labor and delivery?

13. Do antenatal clients receive information on RTI/STI, including HIV (e.g., how infections are transmitted, how to reduce the risk of transmission to partners and infants, and when and where to go for screening)?

Routine Labor and Delivery Care

14. Do labor and delivery clients receive information on the following topics?

- What will happen to them before, during, and after delivery
- What their pain control options are
- Where they will be cared for within the facility
- How partners, family members, or TBAs may participate in the labor and delivery and where they may stay

Emergency Obstetric Care (including postabortion care)

15. For cesarean sections, blood transfusions, the administration of anesthesia, or other procedures: If the client's condition is stable, do staff explain the following information to her? If the client's condition is not stable, do staff explain the information to her partner, family members, and/or TBA, if available, and to the client once she is stabilized?

- Her diagnosis and her treatment options
- The treatment option that she chooses
- The benefits and risks, including side effects, of any procedure or intervention
- What will happen during the procedure or intervention
- Her right to decide against the procedure or intervention at any time before undergoing it, without sacrificing her right to other services

16. Do clients with abortion complications receive counseling, emotional support, and the following information?

- What will happen to them before, during, and after treatment
- How to care for themselves after treatment
- Where, when, and under what circumstances (including warning signs) to return for follow-up care
- When work and sexual activities can be resumed
- That fertility returns within 11 days after an abortion and that clients who want to prevent pregnancy can begin using a contraceptive method right away
- Where and how to obtain other reproductive health services, including family planning

Postpartum Care (immediate and follow-up)

17. Do postpartum clients and those who accompany them receive information on the warning signs of complications (e.g., fever, heavy bleeding, and severe pain in the abdominal or perineal area) and what to do if they occur?

18. Do postpartum clients and those who accompany them receive information on the warning signs of infant complications (e.g., fever, poor feeding or sucking, difficulty breathing, lethargy, and jaundice) and what to do if they occur?

19. Do staff tell postpartum clients and those who accompany them where mothers *and* infants can obtain care 24 hours a day, seven days a week?

20. Do postpartum clients receive postpartum family planning information and services?

Other Issues You Think Are Important

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Clients' Right to Access to Services

Clients have a right to access to services that is unimpeded by cost, hours of service, location, or physical or social barriers.

INSTRUCTIONS

WHO SHOULD WORK ON THIS GUIDE: At least one person who provides maternal or other pregnancy-related health information, counseling, or services. It may also be useful to include an administrator in this group.

HOW TO WORK ON THIS GUIDE: Read and consider each of the questions in this guide. Ignore any questions that are not relevant to your facility. A "no" answer to any of the relevant questions may indicate an opportunity for quality improvement. Make a note of the questions that you think should be discussed further.

For each question that indicates a need for improvement, and for any problems not covered in this guide, record on flipchart paper: the problem, your recommendations for correcting the problem, who you think should implement the recommendations, and a realistic target date.

PROBLEM CAUSES RECOMMENDATIONS BY WHOM BY WHEN

General

1. Does your facility prominently display signs in the local language(s) at all entrances that indicate where to find the maternal and child health (MCH) or outpatient clinic, the labor and delivery ward, the emergency room, and the maternity ward?

2. Do all clients have access to the following services, either on-site or by referral?

   - Maternal care (antenatal, labor and delivery, postpartum, and newborn)
   - Postabortion care
   - Pediatrics
   - Family planning
   - Gynecology (e.g., fistula repair, Pap smear)
   - Infertility
   - General health (for men and women)
   - RTI/STI, including HIV
   - Laboratory
   - Pharmacy
   - X-ray

3. Can clients and those who accompany them get from the facility entrance to the emergency obstetric evaluation area easily and rapidly, 24 hours per day, seven days per week?

4. Does every client have access to either a provider who speaks her language or an interpreter?

5. Does your facility have a policy or protocol to ensure that all nonemergency maternal care clients who cannot afford services at your facility get the care they need?

6. Do clients with complications receive care immediately, regardless of their ability to pay for services or purchase supplies or drugs?

7. Do all clients have access to maternity or other pregnancy-related services at your facility, regardless of their age, marital or reproductive status, ability or disability, or social or ethnic background?

8. Do staff try to minimize other barriers to health care (e.g., requirements that the client obtain a male family member's permission to receive the service, obtain antenatal care at the facility, have a medical record at the facility, or bring her own supplies or drugs)?

9. Does your unit have access to laboratory, pharmacy, and X-ray services, 24 hours per day, 7 days per week?

10. Do staff understand local customs or traditions related to pregnancy and childbirth and how the facility's response to those customs may affect clients' willingness to come to the facility for care?

Antenatal Care

11. Do staff try to minimize the number of antenatal visits that a client has to make?

12. Do clients have access to antenatal services at times that are convenient? For example, for clients who have difficulty getting to the facility on weekdays, are services available in the evening and on weekends?

13. Do clients have access to the following antenatal services, if needed, whenever the antenatal clinic is open?

    - Detection of pregnancy and calculation of due date
    - Screening (physical exam, fetal assessment and history)
    - Tetanus immunization
    - Iron provision
    - Malaria and hook worm treatment
    - Laboratory services
    - Imaging studies (sonogram)
    - Birth plan assistance
    - Counseling
    - Referrals

Routine Labor and Delivery Care

14. Does your facility provide the following services and the staff necessary to provide them 24 hours per day, seven days per week?

    - Immediate obstetric evaluation
    - Normal labor and delivery management
    - Administration of IV fluids, antibiotics, oxytocin/ergometrine
    - Management of dysfunctional or prolonged labor
    - Management of shoulder dystocia
    - Repair of cervical, vaginal, or perineal lacerations
    - Manual removal of placenta
    - Bimanual uterine compression

15. Does your facility educate or train home birth attendants to recognize complicated labor and refer such cases in plenty of time?

16. If home birth attendants bring clients with labor complications to your facility, do you welcome the clients and their attendants and treat them with respect?

Emergency Obstetric Care (including postabortion care)

17. Do staff evaluate emergency obstetric clients within 15 minutes of arrival and treat them without delay?

18. Does your facility provide early recognition and initial management of the following conditions, 24 hours per day, seven days per week?

    - Shock
    - Hypertensive emergency, eclampsia/preeclampsia
    - Antenatal and postpartum hemorrhage
    - Sepsis or infection (of the uterus, perineum, IV sites, incisions)
    - Abortion complications
    - Obstructed labor

19. Does your facility provide the following services, 24 hours per day, seven days per week?

    - Assisted delivery (vacuum or forceps)
    - Cesarean section
    - Blood transfusions
    - Uterine evacuation
    - Laboratory services (blood type and cross-match, coagulation parameters, hematocrit)
    - Cardiopulmonary resuscitation (CPR)

20. Do women with abortion complications have access to prompt treatment and to information and services to help them achieve their reproductive goals (i.e., becoming pregnant or preventing pregnancy)?

21. For obstetric or other emergencies that your facility is not equipped to handle, do clients have access (in terms of referral, location, cost, and transportation) to a facility that can provide those services, 24 hours per day, seven days per week?

Postpartum Care (immediate and follow-up)

22. On the maternity ward and at postpartum visits, do staff counsel postpartum clients on how to care for themselves (e.g., nutrition and postpartum family planning) and their infants (e.g., nutrition, cord care, and immunization)?

23. On the maternity ward and at postpartum visits, do staff inform clients about warning signs and when and where to seek medical attention if they occur, 24 hours per day, seven days per week?

24. Do clients have access to the following postpartum services, both immediately postpartum *and* at follow-up visits?

    - Routine postpartum and postsurgical care (e.g., monitoring, routine care, breastfeeding support, and care of incisions and lacerations)
    - Routine infant care (e.g., bathing, feeding, cord care, and immunizations)
    - Recognition and management of complications for mother and infant
    - Counseling on care of mother and infant (e.g., breastfeeding, bathing, cord care, warning signs, and where to go should warning signs occur)
    - Postpartum family planning counseling and services
    - Management of complications

25. Do postpartum clients have access to follow-up care (through follow-up visits at home, in the community, or at the facility) at 24 hours, 48 hours, one week, and four to eight weeks postdelivery?

26. Do postpartum clients have access, either on-site or by referral, to surgical treatment for fistula?

27. For mothers of newborns, do staff try to minimize the number of clinic/hospital postpartum visits by scheduling the mother's and the child's visits at the same time?

28. Do women who have experienced an abortion, miscarriage, stillbirth, or neonatal death have access to counseling support?

Other Issues You Think Are Important

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Clients' Right to Informed Choice

Clients have a right to the information and support they need in order to make informed decisions about their health care and to respect for the decisions that they make.

INSTRUCTIONS

WHO SHOULD WORK ON THIS GUIDE: Clinical staff and other staff who provide maternal or other pregnancy-related health information, counseling, or services

HOW TO WORK ON THIS GUIDE: Read and consider each of the questions in this guide. Ignore any questions that are not relevant to your facility. A "no" answer to any of the relevant questions may indicate an opportunity for quality improvement. Make a note of the questions that you think should be discussed further.

For each question that indicates a need for improvement, and for any problems not covered in this guide, record on flipchart paper: the problem, your recommendations for correcting the problem, who you think should implement the recommendations, and a realistic target date.

PROBLEM CAUSES RECOMMENDATIONS BY WHOM BY WHEN

General

1. Do staff give clients the information, counseling, and support they need to make informed decisions about their health care?

2. When clients make decisions about their care, do staff respect their decisions?

3. Do staff systematically obtain a signed consent form, as required, before performing any nonemergency surgical procedure and treatment?

4. Do staff counsel clients who are infected with HIV on how to prevent transmission to the infant (e.g., delivery and feeding practices)?

Antenatal Care

5. Do staff ask clients what delivery practices they would like to follow and, when possible, support their decisions concerning pain control; delivery position; participation of their partner, family member, or TBA; and the handling of the delivered placenta?

Routine Labor and Delivery Care

6. Do staff ask clients what delivery practices they would like to follow and, when possible, support their decision concerning: pain control; delivery position; participation of their partner, family member, or TBA; and the handling of the delivered placenta?

Emergency Obstetric Care (including postabortion care)

7. After treating clients who present with abortion complications, do staff provide the clients with information, counseling, and referrals to assist them in achieving their reproductive goals (i.e., becoming pregnant or preventing pregnancy)?

Postpartum Care (immediate and follow-up)

8. Does your facility encourage women to keep their infants with them in the postpartum ward?

9. Do staff counsel postpartum clients on family planning?

Other Issues You Think Are Important

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Clients' Right to Safe Services

Clients have a right to safe services that are delivered in accordance with guidelines by trained providers who are skilled in routine care, management of complications and emergencies, and infection prevention.

INSTRUCTIONS

WHO SHOULD WORK ON THIS GUIDE: Depending on the services available at the facility, the group working on this guide could include clinical staff from the antenatal/postpartum outpatient clinic, the labor and delivery and postpartum ward, the operating theater, pediatrics, the emergency room, the laboratory, the pharmacy, and gynecology. The group should also include at least one clinician, surgeon, nurse, technical or medical assistant, housekeeper or cleaner, and administrator or manager.

HOW TO WORK ON THIS GUIDE: Read and consider each of the questions in this guide. Ignore any questions that are not relevant to your facility. A "no" answer to any of the relevant questions may indicate an opportunity for quality improvement. Make a note of the questions that you think should be discussed further.

For each question that indicates a need for improvement, and for any problems not covered in this guide, record on flipchart paper: the problem, your recommendations for correcting the problem, who you think should implement the recommendations, and a realistic target date.

PROBLEM CAUSES RECOMMENDATIONS BY WHOM BY WHEN

Note: Because this guide is long, the group working on it should work on this guide only.

General

1. Do staff follow current, written service-delivery guidelines or protocols for each of the maternity or other pregnancy-related health care services provided at your facility?

2. Do staff treat or refer all clients with symptoms of RTI/STI, including HIV, or with disorders of the reproductive tract in accordance with guidelines?

3. Do staff tell each client her due date and give her oral or written instructions on routine care during the antenatal, labor and delivery, and postpartum periods; warning signs and what to do if they occur; and where to go for follow-up care?

4. Does your facility have an effective system for ensuring that supplies are always in stock, instruments are always ready for use, and equipment is always functioning?

5. Do supervisors and staff take measures to ensure that procedures are performed carefully and to minimize the incidence of the following complications?

    - Hemorrhage and organ trauma caused by cesarean section (less than 5%)
    - Infection from cesarean section, IV insertion, and urethral catheter insertion (less than 10% each)
    - Uterine perforation from uterine evacuation of retained products (less than 1%)

6. Does your facility systematically track complications, poor outcomes, and deaths and routinely analyze and discuss reports of complications, deaths, and service statistics?

7. Do meetings about, and reviews of, complications and poor outcomes result in improvements in practice?

8. Do staff record necessary information (e.g., diagnosis and treatment/procedures, labor progress notes, drugs administered, vital signs, and complications) on each client's record before, during, and after care, as appropriate?

9. Is your facility always clean?

10. Do staff members know and follow the infection prevention guidelines necessary to protect themselves and the mother, child, and other health care workers?

11. Does your facility take the following measures to protect the staff from exposure to infection?

    - Follow protocols for use of sharps (e.g., puncture-resistant sharps containers in each client-care area, avoiding needle recapping)
    - Require protective wear (e.g., aprons, eyewear, footwear, gloves, resuscitation bags)
    - Immunize staff, if feasible, against hepatitis B
    - Dispose of medical waste by burning, burying in a deep pit, or using a municipal medical waste disposal service

12. Do staff wash their hands with soap and running water in each of the following situations?

    - Before and after each clinical procedure and client contact
    - After handling waste
    - After using the toilet

13. Do staff change gloves between clients (and with the same client if the gloves become contaminated) and use appropriate gloves in all situations, as follows?

    - Sterile or high-level-disinfected gloves for cesarean sections, vaginal exams with ruptured membranes, manual removal of placenta, and assisted deliveries
    - Clean gloves for vaginal exams and deliveries
    - Heavy-duty utility gloves when cleaning instruments, handling medical or chemical waste, and performing housekeeping tasks

14. Do staff use aseptic technique when performing clinical procedures (e.g., cesarean section, uterine evacuation, IV insertion, Foley catheter placement, manual removal of the placenta, and laceration repair), as follows?

    - Maintain a sterile field
    - Ensure that only essential people are in the operating theater
    - Prepare the client's abdomen or perineum with antiseptic
    - Refrain from shaving the surgical site (for both emergency and nonemergency procedures)
    - Place sharps/scalpels on trays instead of handing them from person to person
    - Wear a gown
    - Scrub hands

15. Do staff process instruments and reusable supplies, as follows?

    - Decontaminate instruments, gloves, and medical waste after every procedure by soaking in a 0.5% chlorine solution (which is always available in every examination room, delivery room, and operating theater)
    - Thoroughly scrub instruments and reusable supplies with a brush and detergent before high-level disinfection/sterilization
    - Follow protocols for timing, pressure, and packing for high-level disinfection/steam, dry, or chemical sterilization
    - Ensure that all items are thoroughly dried and marked with the expiration date before storing
    - Reprocess expired instrument and supply packs correctly and in a timely manner

16. Between clients and after each procedure, do staff clean the area as follows?

    - Wipe down the tables in the delivery room, operating theater, examination room, and infant-receiving area with a 0.5% chlorine solution
    - Decontaminate the floor of the delivery area
    - Remove infectious waste and used supplies

Antenatal Care

17. Do staff screen all antenatal clients for complications, as follows?

    - Check blood pressure and fetal heart rate
    - Screen for urine protein and edema
    - Ask about bleeding, fluid leakage, fetal movement

18. Do staff offer clients laboratory screening and treatment for infections that could affect pregnancy outcomes for the mother or child (e.g., RTI/STI, HIV, malaria, hookworm, and tuberculosis)?

19. Do staff screen clients for anemia and blood type and treat as needed?

20. Has your facility established routine procedures to ensure that abnormal test results are managed properly?

21. Do clients receive the following preventive care in accordance with guidelines?

    - Presumptive treatment for malaria and hookworm (in endemic areas)
    - Supplementation (e.g., vitamin A, iodine, folic acid, calcium)
    - 60 mg elemental iron every day for 100 days before delivery (more for women with anemia)
    - Tetanus immunization during the antenatal period and during delivery

22. Do staff assist clients and their families in developing a safe birth plan that includes arrangements for a skilled birth attendant and emergency transportation?

23. Do staff encourage the following clients, who may be at higher risk for complications in pregnancy and delivery, to deliver in a medical facility and refer them, as appropriate?

    - Women under 17 years of age
    - Women who have had five or more births
    - Women who have undergone cesarean section
    - Women with concurrent medical conditions, such as heart disease, diabetes, and malaria

Routine Labor and Delivery Care

24. Do staff assess the severity of a client's condition within 15 minutes of arrival and immediately stabilize and treat emergency cases?

    - Monitor the mother's and infant's vital signs—every 30 minutes in active labor and every five minutes in the second stage of labor
    - Assess and record labor progress using a partograph or other labor chart
    - Monitor and record any drugs that they administer
    - Ensure that a woman in the second stage of labor is never left alone
    - Practice active management of the third stage of labor (gentle cord traction, oxytocin, uterine massage)

25. Do staff correctly monitor and manage the client during labor and delivery?

26. Do staff perform episiotomies and vaginal exams only when necessary?

27. Do staff correctly perform each of the following procedures when indicated?

    - Start an IV and provide fluids
    - Manage shoulder dystocia
    - Repair a cervical, vaginal, or perineal laceration
    - Remove a placenta manually
    - Perform bimanual uterine compression

28. Do staff identify and manage dysfunctional/prolonged labor (e.g., by using a partograph or other labor chart to follow labor progress and by giving oxytocin when appropriate)?

29. When indicated, do staff administer oxytocin and methergine, using the correct route and dose?

30. Do staff perform neonatal evaluation of all newborns and, when necessary, resuscitate?

31. Do staff provide all newborns with immediate essential care, including warmth, eye care, and cord care?

32. Do staff encourage the mother to breastfeed as soon as possible by putting the infant to the breast immediately after birth?

Emergency Obstetric Care (including postabortion care)

33. Does your facility provide emergency evaluation and stabilization, 24 hours per day, seven days per week?

34. Do staff recognize emergencies, including the following conditions, immediately?

- Shock
- Eclampsia/preeclampsia
- Antenatal and postpartum hemorrhage
- Sepsis or infection (e.g., of the uterus, perineum, IV sites, incisions)
- Abortion complications
- Obstructed labor

35. Do staff, once they recognize obstetric emergencies, immediately and correctly take the following steps, if necessary, to *stabilize* the client?

- Shout for help
- Start rapid infusion of IV fluids
- Start cardiopulmonary resuscitation (CPR)
- Administer needed drugs
- Perform lab tests (blood type and cross-match, coagulation parameters, hematocrit)
- Call in providers who are capable of managing the condition

36. After initial stabilization, do staff immediately and correctly manage *each* of the following conditions?

- Shock (aggressive fluid and blood resuscitation, respiratory support, source identification and management)
- Hypertensive emergency, eclampsia/preeclampsia (as needed, control blood pressure, manage airway, administer magnesium sulfate or diazepam, and promptly deliver the fetus)

- Antenatal hemorrhage (as needed, assess for placenta previa, transfuse blood, and deliver)
- Postpartum hemorrhage (as needed, perform massage/bimanual uterine compression, administer oxytocin/methergine, administer blood, address placental retention and lacerations)
- Sepsis or infection of the uterus, perineum, IV sites, incisions (as needed, administer antibiotics, identify and remove source)
- Abortion complication (as needed, perform uterine evacuation, administer antibiotics, transfuse blood, and assess for perforation of uterus, bowel, or bladder)
- Obstructed labor (perform cesarean section)

37. Do staff correctly perform the following procedures when indicated?

    - Assisted delivery (vacuum or forceps)
    - Cesarean section
    - Blood transfusion
    - Uterine evacuation (preferably using a vacuum instead of a sharp curette)

38. Do staff use the correct indications, route, dose, and precautions (monitoring of urine output, lung exam, respiratory rate, etc.) for magnesium sulfate or diazepam?

39. At your facility, are local anesthesia and vacuum aspiration the standard regimen for the treatment of incomplete abortion?

40. Do staff screen surgery clients for contraindications to surgery by taking their medical history, performing a physical examination, taking their vital signs, and conducting appropriate laboratory tests?

41. Is the operating theater always kept clean and disinfected and equipped with all necessary equipment, supplies, and routine and emergency drugs?

42. Is a reliable supply of blood available for use in the operating theater?

43. Is transfusion blood routinely screened for HIV, hepatitis, malaria, and syphilis?

44. Before surgery, do staff ensure that the client has fasted for six hours, has an empty bladder, has been premedicated (and premedication has been recorded in the client's record), and has been examined by the surgeon?

45. Do staff who administer anesthesia do the following?

    - Use local anesthesia whenever it is possible and safe to do so (e.g., for uterine evacuation, episiotomy, laceration repair, assisted delivery)
    - Use correct doses of the anesthetics and premedications
    - Recognize the signs of anesthetic overdose
    - Respond appropriately if there is an anesthetic overdose (perform CPR and administer drug antidote, as needed)

46. If unexpected surgical complications occur (e.g., bladder injury, bowel injury, excessive bleeding), is a qualified provider available on-site, on-call, or by referral?

Postpartum Care (immediate and follow-up)

47. Do staff assess all clients for fever, vital sign instability, excessive bleeding, and uterine firmness immediately postdelivery or postsurgery, and reassess them every 15 minutes for two hours and periodically for at least 24 hours, if normal, and for 48 hours, if complicated?

48. Do staff recognize and manage complications immediately?

49. Do staff provide routine care for the mother, including perineal care, breast care, breastfeeding support, suture removal, incisional care, and pain relief?

50. Do staff encourage postcesarean section clients to move around as soon as possible?

51. Do staff routinely assess, recognize, and, if necessary, promptly treat newborns with complications such as feeding or respiratory problems, bleeding, jaundice, and infection?

52. Before discharging a client, do staff:

- Check her stability (bleeding, infection, uterine firmness, vital signs)
- Check her ability to walk, eat, urinate, and repeat discharge instructions
- Ensure that she will be accompanied by someone when she leaves
- Give her verbal and/or written instructions about normal care of herself and her infant
- Give her verbal and/or written instructions about the warning signs of complications and when and where to go for medical attention if they occur

53. Do staff check follow-up postpartum clients for signs of complications from delivery and counsel them about breastfeeding and postpartum family planning, as follows?

- Routine postpartum and postsurgical care (e.g., monitoring, routine care, breastfeeding support, and care of incisions and lacerations)
- Routine infant care (e.g., bathing, feeding, cord care, immunizations)
- Recognition and management of complications for mother and infant
- Counseling on care of mother and infant (e.g., breastfeeding, bathing, cord care, warning signs, and where to go if warning signs occur)
- Postpartum family planning counseling and services

54. Does your facility have a system in place to ensure that postpartum clients receive checkups either in the hospital, at the clinic, or at home at 24 hours, 48 hours, and one week postdelivery or postcesarean section?

Other Issues You Think Are Important

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Clients' Right to Privacy and Confidentiality

Clients have a right to privacy and confidentiality during counseling, physical examinations, and clinical procedures and in the handling of their personal information and medical records.

INSTRUCTIONS

WHO SHOULD WORK ON THIS GUIDE: Staff who provide maternal or other pregnancy-related health information, provide direct care to clients (such as nurses, assistants, midwives, doctors, and ward helpers), or are responsible for recordkeeping (including receptionists, gatekeepers, and guards)

HOW TO WORK ON THIS GUIDE: Read and consider each of the questions in this guide. Ignore any questions that are not relevant to your facility. A "no" answer to any of the relevant questions may indicate an opportunity for quality improvement. Make a note of the questions that you think should be discussed further.

For each question that indicates a need for improvement, and for any problems not covered in this guide, record on flipchart paper: the problem, your recommendations for correcting the problem, who you think should implement the recommendations, and a realistic target date.

PROBLEM CAUSES RECOMMENDATIONS BY WHOM BY WHEN

General

1. When staff need to discuss a client's care with other staff, do they respect the client's confidentiality by speaking in a private space so that the conversation cannot be overheard?

2. Do staff tell each client that everything that the client says and all information related to the client will be kept confidential?

3. Do staff respect the client's wishes about whether or not to provide information to partners and family members?

4. Do staff store client records, when not in use, in a secure place with access strictly limited to authorized staff? Are staff careful not to leave records unattended on desktops or in other nonsecure locations?

5. Do staff conduct counseling, history taking, examinations, procedures, and deliveries in a private space so that they are not observed or overheard by others?

6. Do staff respect the client's privacy and modesty during procedures and deliveries?

7. Do staff take measures to ensure that counseling sessions and examinations are not interrupted?

8. When a third party is present during a counseling session, an examination, or a procedure, do staff explain the person's presence and request the client's authorization for it?

9. Do staff keep all laboratory test results confidential?

10. Do staff provide all services in a manner that is respectful, confidential, and private?

Other Issues You Think Are Important

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Clients' Right to Dignity, Comfort, and Expression of Opinion

Clients have a right to consideration for their feelings, modesty, and comfort and to respect for their opinions and decisions.

INSTRUCTIONS

WHO SHOULD WORK ON THIS GUIDE: Staff who provide direct care to pregnant clients (such as nurses, assistants, midwives, doctors, and ward helpers), administrators, staff responsible for supplies, and field/community workers

HOW TO WORK ON THIS GUIDE: Read and consider each of the questions in this guide. Ignore any questions that are not relevant to your facility. A "no" answer to any of the relevant questions may indicate an opportunity for quality improvement. Make a note of the questions that you think should be discussed further.

For each question that indicates a need for improvement, and for any problems not covered in this guide, record on flipchart paper: the problem, your recommendations for correcting the problem, who you think should implement the recommendations, and a realistic target date.

PROBLEM CAUSES RECOMMENDATIONS BY WHOM BY WHEN

General

1. Do staff welcome all clients—regardless of age, marital status, or ethnicity—and those who accompany them and treat them in the way that they would want to be treated under similar circumstances?

2. Do staff understand local customs or traditions related to pregnancy and childbirth and how the facility's response to those customs may affect clients' willingness to come to the facility for care?

3. Do all staff (medical and ancillary staff) treat all clients, including labor and delivery and postabortion care clients, with kindness, courtesy, attentiveness, and respect?

4. Do staff serve nonemergency clients in the order in which they arrive or in order of their scheduled appointments?

5. Do staff try to minimize client waiting time (e.g., by having a nurse or other health professional provide services that don't require a doctor's attention or by organizing records for quick and easy retrieval)?

6. Does your facility offer services in an atmosphere that is comfortable for those who accompany the client, including men?

7. If a client wants her partner, family members, or TBA to participate in discussions about her care, do staff support her wishes?

8. Do staff try to involve men in counseling and information sessions, when appropriate and when clients want them to?

9. Do staff always explain to clients all aspects of the examination or procedures that they may undergo, including why the examination or procedure is needed and what to expect?

10. If staff discuss the client's case in her presence, do they encourage her to participate in the discussion?

11. Do staff respect clients' opinions, even if they are not the same as their own?

12. Do staff perform physical examinations and other procedures (e.g., labor checks, deliveries, cesarean sections) with the client's dignity, modesty, and comfort in mind (including providing clients with drapes or covering, when appropriate)?

13. The list below describes some areas of the facility that clients may use. In your facility, are these areas pleasant and comfortable? For example, is there enough space? Is the space well-organized, clean, well-lit, comfortable, well-ventilated?

    - Toilets
    - Registration, reception, waiting areas
    - Counseling areas
    - Examination and procedure rooms
    - Pharmacy
    - Labor and delivery rooms
    - Maternity wards
    - Neonatal wards
    - Gynecology wards
    - Emergency rooms
    - Operating theaters (reception and operating areas)
    - Recovery areas

14. Does your facility provide clean drinking water and handwashing facilities for clients?

15. Do staff spend time with women who have learned they are infected with HIV and help them to talk about their feelings?

16. Do clients have an opportunity to suggest what the facility can do to provide higher-quality services? For example, does your facility have a suggestion box?

Routine Labor and Delivery Care

17. Do staff try to minimize the client's discomfort and pain during labor and delivery (e.g., by coaching or soothing the client)?

18. Do women in labor receive appropriate and timely analgesia?

19. Do staff allow clients to have their partners, family members, or TBAs present or nearby during delivery?

Emergency Obstetric Care (including postabortion care)

20. Do staff make every effort to ensure the client's comfort and minimize her pain during treatment of abortion complications? For example, do they talk to the client to distract her from her pain or provide analgesia, as appropriate?

21. In the operating theater, do staff keep clients covered (except the incisional area) until exposure is needed?

22. Do clients who undergo cesarean section receive analgesia and IV fluids when appropriate?

Postpartum Care (immediate and follow-up)

23. Do staff allow women to keep their infants with them in the postpartum ward?

24. Do staff encourage and assist women who are having difficulty breastfeeding?

25. Do staff offer counseling and support to women who have had a miscarriage, abortion, or stillbirth or whose infants are born with abnormalities or are otherwise sick?

Other Issues You Think Are Important

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Clients' Right to Continuity of Care

Clients have a right to the services, supplies, referrals, and follow-up necessary to maintain their health.

INSTRUCTIONS

WHO SHOULD WORK ON THIS GUIDE: Staff who provide pregnancy-related care to clients (such as nurses, assistants, midwives, doctors, and ward helpers), administrators, staff responsible for supplies, and field/community workers

HOW TO WORK ON THIS GUIDE: Read and consider each of the questions in this guide. Ignore any questions that are not relevant to your facility. A "no" answer to any of the relevant questions may indicate an opportunity for quality improvement. Make a note of the questions that you think should be discussed further.

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PROBLEM CAUSES RECOMMENDATIONS BY WHOM BY WHEN

General

1. For all services provided, do staff tell clients when and where to return for routine follow-up or for emergency care and that they can return at any time if they have questions or concerns?

2. Do staff schedule follow-up visits with the client's convenience in mind?

3. Do clients who travel some distance to the facility receive information about where they can go in their own community to obtain follow-up services?

4. Do staff give clients information on the warning signs of complications and tell them where to go for immediate medical attention if they experience any of the signs?

5. Do staff take measures to ensure that clients they have referred to another department or facility for services get the care for which they were referred?

6. Do staff know which medication substitutions (e.g., for antibiotics, anticonvulsants, oxytocics, antihypertensives) may be made in the event of a stock-out?

7. Does your facility have a sufficient and reliable inventory of supplies so that clients can obtain medications, contraceptives, laboratory tests, etc., without delay?

8. Does your facility have a system for informing clients of their laboratory test results and scheduling and providing any necessary counseling and treatment?

9. Do staff properly complete clients' medical and health records and include information essential for continuity of care (e.g., due date, complications, procedures and treatments, birth plan development)?

10. Do staff give clients a card to carry with them and record client information on it (e.g., due date, complications, procedures and treatments, birth plan development, name and location of emergency contact)?

11. When clients return for follow-up care, can staff easily retrieve their records?

12. If clients do not return for follow-up care, do staff follow up to find out why?

Antenatal Care

13. Do staff encourage pregnant women who are planning to deliver at home or in the community to seek a postpartum checkup—either from a community health worker or at the facility—at 24 hours, 48 hours, and one week postpartum?

Routine Labor and Delivery Care

14. Do staff encourage all delivering women to seek postpartum checkups?

Emergency Obstetric Care (including postabortion care)

15. Does your facility have transportation to a referral site for emergency clients, 24 hours per day, seven days per week?

Postpartum Care (immediate and follow-up)

16. Does your facility have a system, which may include partnerships with community-based providers, to ensure that all postpartum women receive follow-up care at 24 hours, 48 hours, and one week postpartum?

17. Do staff correctly manage perineal tears and episiotomies, both in the maternity ward following delivery and at the postpartum visit?

18. Does your facility have postpartum family planning methods (tubal ligation, postpartum IUD, condoms, instructions for LAM) readily available, every day, for women who return for follow-up?

19. Do staff always offer clients family planning counseling and methods at the postpartum visit even if the clients do not attend at exactly six weeks?

20. Do staff combine child immunization visits with reproductive health visits postpartum?

21. Does your facility have a working relationship with community health workers, especially TBAs, for referral and collaborative care on normal and complicated postpartum cases?

Other Issues You Think Are Important

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Staff Need for Facilitative Supervision and Management

Staff need supervision and management that value and encourage quality improvement and give staff the support they need to provide high-quality services to their clients.

INSTRUCTIONS

WHO SHOULD WORK ON THIS GUIDE: A cross-section of the staff—representatives from each department within the facility

HOW TO WORK ON THIS GUIDE: Read and consider each of the questions in this guide. Ignore any questions that are not relevant to your facility. A "no" answer to any of the relevant questions may indicate an opportunity for quality improvement. Make a note of the questions that you think should be discussed further.

For each question that indicates a need for improvement, and for any problems not covered in this guide, record on flipchart paper: the problem, your recommendations for correcting the problem, who you think should implement the recommendations, and a realistic target date.

PROBLEM CAUSES RECOMMENDATIONS BY WHOM BY WHEN

General

1. Do your area, regional, and headquarters administrators do any of the following activities to support your facility's delivery of high-quality services?

   - Observe service-delivery practices
   - Review records
   - Organize and/or participate in problem-solving exercises
   - Organize training for facility-level staff
   - Provide constructive feedback
   - Track, and share reports of, service statistics and complications

2. Do staff clearly understand their work roles and responsibilities?

3. Do supervisors organize work shifts so that staff are fully occupied and well-utilized during the entire time they are working?

4. Do supervisors ensure that, for each of the maternity or other pregnancy-related services provided at the facility, staff are assigned responsibility for routinely carrying out the following functions?

   - Giving health talks to clients in the clinic or wards

- Counseling
- Conducting community outreach, including with community health workers and TBAs
- Coordinating supplies and equipment maintenance
- Filing and maintaining records
- Monitoring and supervising staff performance and services on a regular basis
- Coordinating services and referrals with other departments, wards, or institutions

5. Do supervisors ensure that staff are clearly assigned responsibility for the following services, 24 hours per day, seven days per week?

    - Obstetric evaluation
    - Management of normal labor and delivery and postpartum care
    - Management of complications
    - Performance of clinical procedures (including uterine evacuations or cesarean sections)
    - Transportation for cases that cannot be treated at your facility

6. Do supervisors make current guidelines and protocols for maternity care and other pregnancy-related care available to staff and require the staff to know and follow the guidelines?

7. Do supervisors regularly observe service delivery, provide staff with constructive feedback, and recognize staff quality improvement efforts and accomplishments?

8. Do supervisors provide staff with opportunities to discuss or communicate problems they are experiencing?

9. Do supervisors formally solicit staff participation in quality improvement (e.g., through a quality improvement committee with regularly scheduled meetings or regular staff meetings that address quality improvement issues) and use the staff's input to improve quality?

10. Do supervisors encourage staff to obtain client feedback on the quality of services?

11. Do supervisors ensure accurate and timely recordkeeping and reporting by all staff?

12. Do supervisors and staff routinely review and discuss records, reports, and other documentation to identify and discuss ways to improve services?

13. Do supervisors and staff take measures to ensure that procedures are performed carefully and to minimize the incidence of the following complications?

    - Hemorrhage and organ trauma caused by cesarean section (less than 5%)
    - Infection from cesarean section, IV insertion, and urethral catheter insertion (less than 10% each)
    - Uterine perforation from uterine evacuation of retained products (less than 1%)

14. Does your facility have protocols for reporting complications that arise from procedures performed at the facility (e.g., delivery, cesarean section, blood transfusion)?

15. Does your facility have an audit/case review system to monitor and review major and minor complications that occur?

16. Do supervisors encourage staff to respect and collaborate with their colleagues, including TBAs, community health workers, ancillary staff, and staff from other departments?

17. Do supervisors support strong links between the facility's different departments? Do they, for example, encourage interdepartmental information sharing and referral (among pediatrics, the laboratory, and the pharmacy)?

18. Does your facility have guidelines for referring clients for preventive services including reproductive health and family planning?

19. Does your facility have clear referral protocols for occasions when staff are not equipped to deal with a health problem?

20. Does your facility have a system to ensure emergency preparedness by routinely doing the following?

    - Checking emergency drugs for availability and expiration date
    - Ensuring that emergency equipment is working
    - Preparing a portable emergency tray or trolley with equipment, drugs, and supplies and making it available in client care areas
    - Displaying emergency protocols on wall charts
    - Reviewing emergency protocols with staff through discussion and periodic rehearsals

Other Issues You Think Are Important

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Staff Need for Information, Training, and Development

Staff need knowledge, skills, and ongoing training and professional development opportunities to remain up-to-date in their field and to continuously improve the quality of the services they deliver.

INSTRUCTIONS

WHO SHOULD WORK ON THIS GUIDE: A cross-section of the staff—representatives from each department within the facility

HOW TO WORK ON THIS GUIDE: Read and consider each of the questions in this guide. Ignore any questions that are not relevant to your facility. A "no" answer to any of the relevant questions may indicate an opportunity for quality improvement. Make a note of the questions that you think should be discussed further.

For each question that indicates a need for improvement, and for any problems not covered in this guide, record on flipchart paper: the problem, your recommendations for correcting the problem, who you think should implement the recommendations, and a realistic target date.

PROBLEM CAUSES RECOMMENDATIONS BY WHOM BY WHEN

General

1. Does the administration ensure that sufficient numbers of trained staff are on-site to provide all maternity or pregnancy-related services?

2. Do staff clearly understand their professional roles and responsibilities?

3. Are staff, including new staff, familiar with service-delivery guidelines and protocols for the services they provide, including routine care and management of complications and emergencies?

4. Do all staff know where and when maternal health services are available at the facility?

5. Do clinical staff know how and where to refer clients for health information and services that are beyond their area of expertise or are unavailable at your facility (e.g., RTI/STI, family planning, infertility, and fistula repair services)?

6. For clients with complications or emergencies that your facility is not able to manage, do staff know how to refer and arrange for transportation to a higher-level facility, 24 hours per day, seven days per week?

7. Do staff know when, how, and in what documents to *record* the following client information?

    - Diagnosis and treatment/procedures, including surgeon's notes
    - Progress notes (e.g., labor progress)
    - Drugs used
    - Vital signs
    - Complications

8. Do staff have access to all service-delivery evaluation or assessment reports?

9. Do staff know which service statistics, records, and reports your facility monitors and why?

10. Does your facility have a system in place for identifying and addressing the training needs of staff?

11. Does your facility provide in-service orientations, updates, and training sessions to increase staff knowledge and skills related to all aspects of maternal or pregnancy-related care, including infection prevention?

12. Does your facility invite community health workers and TBAs to attend training sessions or provide them with separate in-service updates and orientations?

13. Does your facility have a system in place for monitoring whether staff correctly apply and maintain newly acquired skills?

14. Do all staff understand and implement your facility's policies and protocols regarding the following?

    - Referring (within and outside of the facility)
    - Managing emergency situations
    - Recordkeeping
    - Reporting complications and deaths
    - Ordering supplies and drugs
    - Repairing and maintaining equipment
    - Improving client relations (e.g., involving partners, family members, and TBAs in care and supporting nonharmful traditional practices)

15. Do staff have the knowledge and skills they need to inform and counsel clients on the following topics?

    - Antenatal care, including birth planning
    - Labor and delivery
    - Postpartum care
    - Infant care
    - Breastfeeding

- Postabortion care
- RTI/STI, including HIV
- Clinical procedures (e.g., cesarean section, uterine evacuation, manual removal of placenta, blood transfusion, administration of anesthesia)
- Family planning

16. Have all staff who counsel clients about clinical procedures observed the performance of those procedures?

17. Do clinical staff know how to perform the examinations required for the services they provide?

    - General physical (cardiac, lung, skin, breast, distal pulse)
    - Vital signs (blood pressure, heart rate, respiratory rate)
    - Fetal assessment (heart rate, growth, and pregnancy dating)

18. Do laboratory staff have the training necessary to conduct the diagnostic tests they are expected to perform?

19. Do staff know the early signs of complications during pregnancy, during labor, and postpartum?

20. Do staff know the protocols for *immediate* response to complications and emergencies?

21. In places where female genital cutting (FGC) is prevalent, are staff familiar with the practice and able to manage its health consequences?

Antenatal Care

22. Do staff know how to screen clients by medical history and physical exam for estimated due date and complications (including urine screen and fetal assessment)?

23. Do staff know how and when to provide iron supplementation, tetanus immunization, and malaria and hookworm treatment?

24. Do staff know how to help clients and their families develop a safe birth plan?

Routine Labor and Delivery Care

25. Do staff know how and when to monitor the vital signs of the mother and infant during labor and delivery?

26. Do staff know how and when to perform vaginal exams to monitor labor progress?

27. Do staff know how to recognize and manage dysfunctional/prolonged labor?

28. Do staff know how to manage normal delivery, including active management of the third stage of labor?

29. Do staff know how and when to do the following?

    - Start an IV and provide fluids
    - Administer oxytocin and methergine/antibiotics
    - Manage shoulder dystocia
    - Repair a cervical, vaginal, or perineal laceration
    - Remove the placenta manually
    - Perform bimanual uterine compression

30. Do staff know how to evaluate and manage newborns (e.g., resuscitate, if necessary; keep the infant warm; and provide eye and cord care)?

Emergency Obstetric Care (including postabortion care)

31. Do staff know how to recognize and manage complications and emergencies?

32. Do staff know the correct indications, route, dose, and toxicity monitoring for magnesium sulfate and diazepam?

33. Do staff know how and when to perform the following procedures?

    - Assisted delivery (vacuum or forceps)
    - Cesarean section
    - Blood transfusion
    - Uterine evacuation (preferably with vacuum instead of sharp curette)

34. Do staff know how to recognize and manage abortion complications (with local anesthesia, vacuum aspiration, antibiotics, fluids, and blood, as needed)?

35. Do staff know how to administer and monitor anesthesia correctly and safely? Do they know how to manage anesthesia-related complications?

36. Do staff know how to perform CPR?

Postpartum Care (immediate and follow-up)

37. Do staff know how to assess clients postdelivery, postcesarean section, and postabortion and at follow-up visits for vital signs, bleeding, uterine firmness, and infection?

38. Do staff know how to manage or refer postdelivery and follow-up clients with complications?

39. Do staff know how to provide routine care for the mother, including perineal care, breastfeeding support, breast care, suture removal, and incisional care?

40. Do staff know how to assess, recognize, and manage neonatal complications immediately postdelivery and at follow-up visits?

Other Issues You Think Are Important

41. _____

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42. _____

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43. _____

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Staff Need for Supplies, Equipment, and Infrastructure

Staff need reliable inventories of supplies, instruments, and working equipment and the infrastructure necessary to ensure the uninterrupted delivery of high-quality services.

INSTRUCTIONS

WHO SHOULD WORK ON THIS GUIDE: A staff member who provides pregnancy-related care to clients (such as nurses, assistants, midwives, doctors, and ward helpers), an operating theater nurse, a staff member who works in supplies and purchasing, and a staff member who has budgeting authority to change the items and quantities ordered

HOW TO WORK ON THIS GUIDE: Read and consider each of the questions in this guide. Ignore any questions that are not relevant to your facility. A "no" answer to any of the relevant questions may indicate an opportunity for quality improvement. Make a note of the questions that you think should be discussed further.

For each question that indicates a need for improvement, and for any problems not covered in this guide, record on flipchart paper: the problem, your recommendations for correcting the problem, who you think should implement the recommendations, and a realistic target date.

PROBLEM CAUSES RECOMMENDATIONS BY WHOM BY WHEN

General

1. Does your facility have systems in place to do the following?

   - Monitor inventories of supplies (including client-education materials)
   - Monitor amounts and expiration dates of drugs
   - Store drugs and supplies in accordance with guidelines
   - Monitor and maintain or replace equipment

2. Does your facility's infrastructure always include the following?

   - A reliable supply of clean water
   - An uninterrupted power supply
   - Adequate lighting in examination, procedure, and operating areas
   - Adequate amounts of clean, sturdy, and functional furniture throughout the facility
   - Clean, comfortable, well-ventilated rooms
   - Storage cabinets for supplies (including client-education materials) and equipment
   - Stretchers and wheelchairs
   - Emergency transportation, available 24 hours per day, seven days per week

3. Over the past three months at your facility, have maternal care services been uninterrupted by problems with infrastructure, supplies, drugs, or equipment?

4. Does your facility have adequate registers and records (e.g., labor and delivery register, duty calendar, contact list, obstetric admission records)?

5. Does your facility have an accessible supply of client-education materials (e.g., brochures/pamphlets, wall charts, posters) in the local language(s)on antenatal care, postpartum care, breastfeeding, and infant care?

6. Do staff have access to current, written service-delivery guidelines, charts, posters, and job aids for the services they provide, including clinical treatment and management of emergencies?

7. Does your facility have the necessary supplies, equipment, and infrastructure to follow infection prevention guidelines (e.g., handwashing facilities, cleaning materials, gloves, waste buckets, sterilization equipment, chlorine, detergent, chemicals for high-level disinfection/sterilization of instruments)?

8. Does your facility have all of the functioning equipment needed to perform examinations in the antenatal clinic, labor and delivery room, operating theater, and postpartum ward, as follows?

    - Adjustable light
    - Blood pressure apparatus and stethoscope
    - Fetoscope
    - Weighing scale
    - Speculum

9. Does your facility have all of the expendable supplies needed to provide services in the antenatal clinic, labor and delivery room, operating theater, and postpartum ward, as follows?

    - Antiseptic solutions and soap
    - Gauze
    - IV infusion set and fluids (tubing and needles)
    - Hypodermic needles and syringes
    - Suture and suture needles
    - Dressing supplies (bandages and adhesive tape)

10. Does your facility have a stretcher or wheelchair available at the entrance and evaluation areas to transport emergency clients to the correct area?

11. Does your laboratory have the supplies and functioning equipment needed to test, fix (preserve), analyze, and transport the specimens it takes for testing?

Antenatal Care

12. Does your facility have adequate supplies of drugs for iron supplementation, malaria, hookworm, and tetanus immunization?

Routine Labor and Delivery Care

13. Does your facility have the following kits ready in the labor and delivery and operating areas?

    - Delivery kits
    - Assisted delivery kits
    - Cervical/vaginal laceration repair kits
    - Neonatal resuscitation kits
    - Cesarean section kits
    - Uterine evacuation equipment

14. Does your facility have protective wear for providers (e.g., eyewear, footwear, aprons, gloves, caps, and face masks)?

15. Does your facility have the following drugs available in the labor and delivery and operating areas, as appropriate:

    - IV solutions
    - Oxytocics (oxytocin, ergotomine, misoprostol)
    - Antihypertensives (labetalol, hydralazine)
    - Anticonvulsants (magnesium sulfate, diazepam)
    - Pain medication (anesthetics, analgesics: paracetamol, pethidine)
    - Antibiotics
    - Antiemetic (phenergan)

16. Does your facility have equipment and supplies for warming and resuscitating infants and for routine eye and cord care?

Emergency Obstetric Care (including postabortion care)

17. Does your facility have the following basic equipment in the operating theater?

    - Operating table with stirrups, steps, and Trendelenberg capability
    - Instrument table or instrument tray (trolley)
    - Adjustable light (hanging or standing)
    - Portable suction apparatus (electric or manual/foot-operated) with suction tubes and nozzles
    - Anesthesia machine and equipment (e.g., endotracheal tubes, face mask, laryngoscope)
    - IV stand
    - Revolving stool

18. Do all client care areas have supplies for IV fluid resuscitation?

19. Does your facility always have a supply of safe blood (i.e., that has been tested for HIV, hepatitis, malaria, and syphilis) and all supplies necessary for blood transfusions?

20. Are the following emergency equipment and supplies for CPR available in the evaluation area, labor and delivery room, and operating theater?

    - Manual resuscitator (Ambu-bag)
    - Face mask
    - Oxygen cylinder with flow meter and flow valve, volume meter, cylinder key, and tubing (easily moveable, such as on a stand with wheels)
    - Oxygen
    - Suction machine with tubing and traps
    - Nonflexible suction catheter (size 18)
    - Flexible suction catheter
    - Oral airways (90- and 100-mm sizes)
    - Nasopharyngeal airways (28 and 30 sizes)
    - Lubricant
    - Tourniquet
    - Blood pressure apparatus and stethoscope
    - Battery-operated flashlight
    - Intubation equipment and electrocardiogram if trained personnel available (laryngoscope, endotracheal tubes)
    - Supplies (oxygen, IV fluids and infusion sets with large caliber needles and tubing, suture and suture needles, Foley catheter, and drainage bag)
    - Emergency trolley to carry CPR equipment and supplies

21. Are the following emergency drugs for CPR and obstetric emergency available in the evaluation area, labor and delivery room, and operating theater?

    - Adrenaline
    - Atropine sulfate
    - Dextrose
    - Diazepam
    - Diphenhydramine (Benadryl) or phenergan
    - Ephedrine
    - Flumazenil or physostigmine (only needed if using benzodiazepines such as diazepam)
    - Naloxone (only needed if using narcotics)
    - Lidocaine
    - Magnesium sulfate (injection)
    - Ergotomine (injection)
    - Oxytocin (injection)
    - Misoprostol (tablets)
    - Labetalol or hydralazine (injection)

Other Issues You Think Are Important

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23. _____

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24. _____

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Appendix C

Obstetric Admission Record Review

OBSTETRIC ADMISSION RECORD REVIEW*

Site: _____ **Date:** _____ **Reviewer:** _____

Select obstetric records at random. Check each record for notes/information on each of the checklist items. Complete the second part of the table only for those records that indicate, for question 12, that there was a complication.

CHECKLIST ITEM	RECORD NUMBER										TOTAL
1. Date and time of admission											
2. Date and time of delivery											
3. Diagnosis (normal labor, eclampsia, infection, etc.)											
4. Vaginal exam details**											
5. Vital signs (BP, temperature, heart rate)***											
6. Mode of delivery											
7. Fetal heart beat											
8. Birth weight											
9. Client's condition at discharge											
10. Baby's condition at discharge											
11. Date and time of discharge											
For complications only (e.g., cesarean sections and blood transfusions)											
12. Complication											
13. Description of management											
14. Start and end time of procedure											
15. Medications and dosages											
16. Informed consent form signed by client and doctor											

** Noted every four hours in active first-stage labor .
*** Noted every 30 minutes in active first-stage labor and every five minutes in second-stage labor.

Reviewers' Comments:

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* Use additional pages as necessary

Appendix D

Client-Interview Form

CLIENT-INTERVIEW FORM

Site:_____ **Date:**_____

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

1. Why did you come to this facility? Is this your first visit or a return visit?
2. Did you get what you came for? If not, why not?
3. What information did you receive?
4. Were you instructed to return for a follow-up visit? If yes, was an appointment scheduled?
5. Were you referred to someone else for other services? If yes, why?
6. What was the best thing about your experience during this visit?
7. What was the worst thing about your experience during this visit?
8. Would you return here for services? If not, why?
9. Would you refer your friends or relatives here?
10. What do people in the community say about the services provided at this facility?
11. Can you suggest specific ways that we could improve services at this facility?
12. Is there anything else you would like to tell us?

Interviewer notes:

Appendix E

Client-Flow Analysis Forms

CLIENT REGISTER FORM

Client number:_____ Client's time of arrival:_____

Type of client:_____ Type of visit:_____

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

Comments: _____

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CLIENT-FLOW CHART*

Site: _____ **Date:** _____

Client number	Time In	Time Out	Minutes at the site	Contact minutes	Waiting minutes	Type of client	Type of visit	Comments

Client type:
- A Antenatal
- P Postpartum

Visit type:
- F First visit
- R Repeat visit

* Use as many pages as necessary

CLIENT-FLOW CHART SUMMARY

Site:_____ **Date:**_____

Page number	Total number of clients	Total minutes at the site	Total contact minutes	Total waiting minutes
Page 1				
Page 2				
Page 3				
Page 4				
Page 5				
Summary Total				

Average number of minutes at the site per client: _____

Average number of contact minutes per client: _____

Average number of waiting minutes per client: _____

Average percentage of time in contact with a provider: _____

Average percentage of time waiting to see a provider: _____

Appendix F

Action Plan Follow-Up Summary Form

FOLLOW-UP SUMMARY

PROBLEM	ROOT CAUSES	RECOMMENDATION	STATUS	COMMENTS