COPE® for Reproductive Health Services:
A Toolbook to Accompany the COPE® Handbook

ENGENDERHEALTH
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Preface

In 1994, the International Conference on Population and Development (ICPD) in Cairo adopted the following definitions of reproductive and sexual health (UN, 1995):

“REPRODUCTIVE HEALTH is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.”

SEXUAL HEALTH aims at “the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.”

As readers of this volume are likely all too aware, on a global scale there are many challenges to attaining the state of reproductive health described above. The day-to-day realities of women’s health are more accurately reflected by these data:

- At least 100 million women in the developing world have an unmet need for family planning (Bongaarts, 1997).
- By the end of 2001, 40 million adults and children were living with HIV or AIDS (UNAIDS, 2002).
- Twenty million unsafe abortions take place each year, 95% of them in the developing world, and complications of unsafe abortion kill at least 78,000 women every year (FCI, 2000).
- Complications arising during pregnancy and childbirth cause the deaths of more than one-half million women every year, the vast majority in the developing world, and in the least-developed countries the lifetime risk for maternal death is one in 16 (WHO, 2001b).
- While the worldwide annual number of live births has stabilized at around 131 million per year, the number of women dying each year as a result of unintended pregnancy has increased (Daulaire et al., 2002).
- In the developing world, nearly 380,000 new cases of cervical cancer are identified every year (Ferlay et al., 2001).
- Over the next decade, 600 million girls will become adolescents, the largest such group of young women in human history (Daulaire et al., 2002).
These figures reveal major challenges for providers of health care services. They indicate the very real difficulties that women and men face in gaining access to quality services to meet their reproductive health needs.

Since the 1994 ICPD in Cairo and the 1995 United Nations (UN) Fourth World Conference on Women in Beijing, the field of population has turned its focus toward a more comprehensive approach to reproductive and sexual health needs in a more integrated fashion. The shift to integrated reproductive health services has included an increased focus on the rights of clients, on the quality of care, on informed choice, and on gender sensitivity. What is equally important is that this shift incorporates a greater recognition of clients' broad, interrelated sexual and reproductive health needs and of the changes required throughout the health care system to meet those needs. This newer perspective involves:

- **Redefining service provision** to include following a holistic, quality, client-oriented approach; assuring that services are youth-friendly, male-friendly, and gender-sensitive; and ensuring a rights perspective (human rights, women's rights, and reproductive rights). A sexual and reproductive health approach involves assessing the interrelationship between clients' needs, as well as promoting awareness among clients of their bodies, reproductive cycles, and sexuality.

- Importantly, linking clients to comprehensive care encompasses the need for comprehensive services, but does not imply that every site must offer all services. It may simply involve adapting or revitalizing those already in place or establishing a referral system. Above all, it involves an awareness of the interconnectedness of clients' health care needs.

- In addressing underlying issues, providers should be sensitive to clients' needs that may lie beyond what they initially express during a visit, understanding and addressing as much as possible the interpersonal and social issues that may underlie a client's health care decisions and that may be determinants of poor health. With a reproductive health approach, providers tend to be more aware of and sensitive to the context of decision making, including poverty and economic dependence, cultural influences, beliefs and practices, and gender-based power imbalances (e.g., the threat of violence or coercion).

Since 1988, in collaboration with partners in developing countries, EngenderHealth has been developing and refining COPE®, a staff-driven process to improve access to and quality of services. COPE, which stands for “client-oriented, provider-efficient” services, was originally developed for family planning services. It has been adopted in an ever-increasing number of countries, organizations, and health care facilities and has, over time, been adapted for use with other health care services. This version of the COPE toolbook has been adapted to help providers consider the broader reproductive health needs of their clients.
Acknowledgments

COPE, which originated as a quality improvement process for family planning services, was developed by EngenderHealth* with the aid of a grant from Mrs. Jefferson Patterson and with support from the U.S. Agency for International Development (USAID). As noted in the acknowledgments to the handbook COPE: Client-Oriented, Provider-Efficient Services: A Process and Tools for Quality Improvement in Family Planning and Other Reproductive Health Services (1995), “AVSC International has been developing and refining the COPE technique since 1988.... This evolution continues as we and our colleagues find better ways to work in our joint efforts to improve the quality of services for clients.” The COPE tools for reproductive health included in this book are part of that evolutionary process and have been made possible by support from USAID and from the British Department for International Development.

Many individuals and organizations around the world where COPE is now used contributed to EngenderHealth’s development of this new toolbook. In particular, we thank the staff of all institutions and sites that have provided feedback on this COPE toolbook, which focuses on a broad set of reproductive health issues.

Special mention is due to the management, staff, and clients of the following organizations and institutions that helped us think through these revisions:

- The Family Planning Association of Tanzania (UMATI)
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- The Family Planning Association of Kenya
- The Ministry of Health, Kenya
- The Christian Health Association of Kenya
- The Directorate of Family Planning, Bangladesh
- Concerned Women for Family Planning, Bangladesh
- World Vision, Bangladesh
- Urban Family Health Partnership, Bangladesh
- Rural Service Delivery Partnership, Bangladesh

In addition, we thank colleagues from JHPIEGO’s Maternal and Neonatal Health Program and from PRIME II.

Within EngenderHealth, the current and former staff in New York and in field offices who have contributed their expertise are many more than we can name individually, but you know who you are and we express our deepest thanks. A few EngenderHealth staff in New York were charged with the final writing of these guides, with comments and suggestions from their colleagues, guided by the staff of the Quality Improvement Team and with contributions from the Clinical Services, HIV/STI, and Maternal Care/Postabortion Care teams and from field staff. Michael Klitsch, Karen Landovitz, Anna Kurica, Margaret Scanlon, and Virginia Taddoni were responsible for the editing, design, and production of this toolbook.

Last but not least, we should make special mention of the contributions of Grace Wambwa and former staff member Pamela Lynam, without whose vision, patience, and persistence we would not have been able to produce this document.

* Before 2001, EngenderHealth was known as AVSC International.
About COPE

COPE is an ongoing quality improvement (QI) process used by health care staff to assess and improve the quality of care that they provide. Two assumptions inform the COPE process:

- 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.
- 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 clients’ rights and three staff needs that are implicit in these two assumptions (see Figure 1, page 2). The rationale is that the more these rights are honored and these needs are met, the higher the quality of care will be.

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 QI 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 and about their contributions to the facility and to the health of their community.

About This Toolbook

The COPE process has four tools—Self-Assessment Guides, a Client-Interview Guide, Client-Flow Analysis, and the Action Plan. 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.
Figure 1. The Rights of Clients and the Needs of Staff

The Rights of Clients

**Information:** Clients have a right to accurate, appropriate, understandable, and unambiguous information related to reproductive health and sexuality, and to health overall. Information and materials for clients need to be available in all parts of the health care facility.

**Access to services:** Clients have a right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, or sexual orientation.

**Informed choice:** Clients have a right to make a voluntary, well-considered decision that is based on options, information, and understanding. The informed choice process is a continuum that begins in the community, where people get information even before they come to a facility for services. It is the service provider’s responsibility either to confirm that a client has made an informed choice or to help the client reach an informed choice.

**Safe services:** Clients have a right to safe services, which require skilled providers, attention to infection prevention, and appropriate and effective medical practices. Safe services also mean proper use of service-delivery guidelines, quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

**Privacy and confidentiality:** Clients have a right to privacy and confidentiality during the delivery of services. This includes privacy and confidentiality during counseling, physical examinations, and clinical procedures, as well as in the staff’s handling of clients’ medical records and other personal information.

**Dignity, comfort, and expression of opinion:** All clients have the right to be treated with respect and consideration. Service providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, even when their views differ from those of service providers.

**Continuity of care:** All clients have a right to continuity of services, supplies, referrals, and follow-up necessary to maintaining their health.

The Needs of Health Care Staff

**Facilitative supervision and management:** Health care staff function best in a supportive work environment in which supervisors and managers encourage quality improvement and value staff. Such supervision enables staff to perform their tasks well and thus better meet the needs of their clients.

**Information, training, and development:** Health care 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 services they deliver.

**Supplies, equipment, and infrastructure:** Health care staff need reliable, sufficient inventories of supplies, instruments, and working equipment, as well as the infrastructure necessary to ensure the uninterrupted delivery of high-quality services.

COPE is a staff-driven process that combines both an approach and a set of tools. EngenderHealth’s first COPE handbook, published in 1995 (COPE: Client-Oriented, Provider-Efficient Services), was focused on family planning. But clients around the world expect quality in all health services, and family planning services are not isolated from other types of health care. Over time, providers have expressed the need for such tools for other health services, so the COPE process and set of tools have since been adapted for use in other health services (see Figure 2).

**Figure 2. COPE Toolbooks: Addressing a Range of Health Services**

In addition to this toolbox, the following COPE toolbooks are currently available:

- **COPE: Client-Oriented, Provider-Efficient Services: A Process and Tools for Quality Improvement in Family Planning and Other Reproductive Health Services** (1995)
- **COPE® for Maternal Health Services: A Process and Tools for Improving the Quality of Maternal Health Services** (2001)
- **COPE for Child Health: A Process and Tools for Improving the Quality of Child Health Services** (draft, 1999)
- **Community COPE: Building Partnerships with the Community to Improve Health Services** (2002) (This is a variation on the COPE process.)

Most of the above toolbooks are currently being revised for use in conjunction with the new edition of the COPE Handbook. In addition, new toolbooks on such topics as adolescent reproductive health care and services related to HIV and STIs are being developed.

In 2003, EngenderHealth revised the original handbook to include additional information about how to conduct COPE and began producing a set of accompanying toolbooks, of which this is the first. In this document, EngenderHealth has adapted the COPE tools to address a full range of topics reflecting a reproductive health approach to services.

Since EngenderHealth’s first COPE handbook was published, health care staff and managers have repeatedly asked for the tools to be expanded to include other aspects of reproductive health services besides family planning. In response, EngenderHealth produced this document for managers, supervisors, and COPE facilitators who wish to involve service providers and other staff in the QI process. Among the reproductive health topics addressed in the tools are:

- Antenatal care
- Labor and delivery
- Postpartum and newborn care
- Postabortion care
- Family planning
- Reproductive tract infections, including sexually transmitted infections (STIs)*
- HIV and AIDS

* For more information on reproductive tract infections, including sexually transmitted infections, see EngenderHealth, 2003.
These content areas are addressed through each of the COPE tools. There are 10 self-assessment guides for reproductive health services, each based around the 10 clients' rights and staff needs (see Figure 1 and explanation, below).

This volume also contains a Client-Interview Guide, a Client Record-Review Checklist and Surgical Record-Review Checklist, and forms needed to conduct a Client-Flow Analysis. A brief overview of the COPE process, including a description of each of these tools, is presented below. For a detailed explanation of the COPE process and of the use of each tool, please refer to the COPE Handbook, the reference and “how-to” manual that accompanies this toolbook.

**Implementing COPE**

**Getting Started**
Before conducting COPE, facilitators should read through the COPE Handbook in its entirety and become familiar with the process and the tools. The initial COPE exercise takes 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 a Client-Flow Analysis. (For an overview of the COPE process, see Figure 3.)

**The Facilitator**
When the decision is made to implement COPE at a facility for the first time, the facility administrator 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 with 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. With the assistance of the external facilitator (if needed), the site facilitator will be responsible for all subsequent COPE exercises at the site.

**Preparing for a COPE Exercise**
Through site visits or correspondence, the external facilitator should use the time leading up to the initial COPE exercise to:

- Build consensus with key managers about the importance of QI
- Orient site managers to COPE
- Gather information about the site
- Instruct management on selecting staff participants and a site facilitator for follow-up COPE exercises
- Schedule the COPE exercise
- Prepare materials for the exercise

† For more information on men's reproductive health services, see AVSC International, 2000.
Figure 3. COPE at a Glance

**Self-Assessment Guides**

**Self-assessment teams:**
- Schedule meeting and pick a team member to present Team Action Plan
- Meet to review self-assessment questions
- Conduct self-assessment and record review
- Prepare Team Action Plan: identify problems and root causes, recommend actions, assign responsibility for actions, and establish completion dates

**Client Interviews**

**Interview team:**
- Meets with facilitator to review interview instructions and obtain interview guide
- Conducts interviews
- Prepares Team Action Plan: identifies problems and root causes, recommends actions, assigns responsibility for actions, and establishes completion dates
- Picks a team member to present Team Action Plan

**Client-Flow Analysis (CFA) (for follow-up exercises)**

**All participants:**
- Meet with facilitator to review CFA instructions
- Establish entry points
- Assign team members to: distribute Client Register Forms at entrances, collect Client Register Forms before clients leave, and present findings at the Action Plan Meeting
- Number Client Register Forms
- Track client flow
- Prepare summary sheets, charts, and graphs
- Analyze client flow and staff utilization
- Meet to prepare Team Action Plan: identify problems and root causes, recommend actions, assign responsibility for actions, and establish completion dates

**Action Plan Meeting**

**Facilitator and all participants:**
- Discuss strengths
- Discuss Team Action Plans: problems, root causes, and recommendations
- Consolidate and prioritize problems
- Develop site Action Plan with problems, root causes, recommended actions, staff responsible for actions, and completion dates
- Form COPE Committee
- Schedule follow-up

**Introductory Meeting**

**Facilitator:**
- Describes quality in real terms
- Explains COPE components

**Facilitator and all participants:**
- Form teams
- Assess progress on previous action plans (if a follow-up exercise)

**Site Preparation**

**Facilitator:**
- Orient key managers
- Selects and orient site facilitator
- Prepares materials and room
- Selects participants

**Follow-up**
For follow-up COPE exercises, the external or site facilitator should schedule the exercise, prepare the materials, and help the administration select staff participants.

The Introductory Meeting

Each COPE exercise begins at an Introductory Meeting, during which the COPE facilitator explains COPE to all of the participants and the participants form teams to work with each of the tools (detailed below).

The Four COPE Tools

COPE uses four tools—the Self-Assessment Guides, the Client-Interview Guide, the Client-Flow Analysis, and the Action Plan. The COPE tools are practical and easy-to-use data collection and analysis forms that are designed to be flexible, so that each site can adapt them to meet its particular needs. These tools are as follows:

- **Self-Assessment Guides.** After COPE participants form teams, each team is responsible for reviewing one or more of the 10 Self-Assessment Guides. Each guide consists of a series of questions related to the quality of reproductive health services (based on international standards and guidelines) in the context of one of the clients’ rights or staff needs identified as critical to high-quality care (see Figure 1). The team members review the questions during their normal workday and decide which questions reveal a problem that they have observed or experienced at their site. Depending on the size of the facility and the number of staff reviewers, one or two team members also review between 10 and 20 client records (and between 10 and 20 surgical records, where applicable), using the Client Record-Review Checklist and the Surgical Record-Review Checklist to identify strengths and weaknesses in record keeping. After going through the self-assessment questions individually or as a team, the team members meet to discuss the problems they identified, determine their root causes, and recommend solutions, 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 how to conduct the self-assessments and record reviews can be found in the **COPE Handbook** (page 38). (See Figure 2 for a list of the COPE toolbooks that are currently available, covering a range of health services.)

- **Client-Interview Guides.** Although the number of interviews 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). The client interview team conducts informal individual interviews with clients who have completed their clinic visit, using the client interview form as a guide. Using open-ended questions, the interviewers encourage each client to discuss his or her opinions about services received, 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 how to conduct the client interview can be found in the **COPE Handbook** (page 39).

- **Client-Flow Analysis (CFA).** The purpose of the CFA is to identify the amount of time that clients spend waiting and the ways in which staff are utilized, so as to remove bottlenecks and improve the use of staff time. CFA team members track the flow of each reproductive health 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. The Client Register Form is used to track clients from the time they enter the clinic until the time they leave, by recording each contact they have with a provider and its duration. One or two team members then complete the Client-Flow
Chart and the Client-Flow Chart Summary. 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 how to conduct the CFA can be found in the COPE Handbook (page 74).

Action Plan. When COPE participants have completed the self-assessment, the client interviews, and the 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 that lists:

▲ Each problem identified
▲ The root causes of the problem
▲ The actions recommended to solve the problem
▲ The staff members responsible for implementing the recommended actions
▲ The completion date for each action

A more detailed description of how to develop an Action Plan can be found in the COPE Handbook (page 40).

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 Action Plan Follow-Up Form to assess their progress in solving the problems in the Action Plan from the previous exercise. CFA may be conducted at the first follow-up exercise, particularly if client waiting time or staff utilization were 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 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 can be found in the COPE Handbook (page 55).

If no QI 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.