COPE a Qualitative Evaluation

Background

COPE is a set of tools and a process, initially introduced by AVSC International to enable staff to improve the quality of services within a health facility. Piloted in Nigeria and Kenya in 1989, COPE was initially used to improve services for family planning. Since then, the application of COPE has been expanded to include Reproductive and Child Health.

“COPE” stands for 'Client Orientated, Provider Efficient' and aims to improve quality of services by meeting both the rights of the client, as well as the needs of the staff.

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<th>Rights of the Client</th>
<th>Needs of the Provider</th>
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<td>1) Clear information</td>
<td>1) Good supplies and working environment</td>
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<td>2) Choice of birth spacing method</td>
<td>2) Good management and supervision</td>
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Since June 1999, COPE has been introduced in 10 Health Centers in Kampong Trach and Angkor Chey Operational Districts in Kampot Province, Cambodia. The objective was to improve the quality of all services at Health Center level. Provincial and Operational District level health staff were trained by RACHA to facilitate the introduction of COPE at selected Health Centers.

Staff at these Health Centers were shown how to conduct three COPE components:

- **Self Assessment**
  This component uses questionnaires related to clients rights and providers needs. The questionnaires ask staff what problems prevent the services at the Health Center from being of a better quality for the client and more efficient for the provider.

- **Client Interviews**
  This component also uses a questionnaire and encourages staff to ask clients their views about the quality of services at the Health Center.

- **Action Plan**
  An action plan is formulated using information identified through the Self-Assessment and Client Interview components. The action plan states why there is problem, its solution, who is responsible for implementing the solution, and by what time this should be completed.
A monitoring visit was conducted by both RACHA and Ministry of Health staff in December 1999, the results of which were incorporated into the methodology of this evaluation.

**Objectives of the Evaluation**

The objectives of this evaluation are:

1) Identify areas where COPE has and has not been effective in improving the quality of services at Health Centers in Kampong Trach and Angkor Chey districts. Where possible highlight the reasons why.

2) Assess the impact of COPE on staff perceptions of roles and responsibilities within the Health Center, including their relationships with Health Center Chiefs, and staff from Operational District and Provincial level.

**Methodology**

This evaluation utilized qualitative methods to gather data. This was to enable the evaluation team to identify the areas where COPE had and had not been effective, based on the opinions and experiences of the staff members involved.

At the direction of RACHA staff, Focus Group Discussions were used within the evaluation. Focus group discussions use a small group of participants (approximately 5-6 persons), who discuss a topic among themselves. The session lasts about two hours, and a facilitator guides the discussion to keep the participants focused on the topic at hand.

Focus groups allow a topic to be discussed within a group context, and this helps to minimize exaggerated or false reports of affect/non affect from the respondents. The disadvantages of focus groups are that, unlike an in depth interview, the facilitator is often unable to request specific information from one participant, either because the group is still talking, or because it would detract attention away from the other participants, thus stopping the flow of discussion. As the discussion should only involve participants talking together about a specific topic, the facilitator can only guide the discussion rather than ask specific questions to individuals.

The facilitator strives to systematically collect information that it is focused on a particular issue. However skilled the facilitator is, participants can often disturb the outputs of a focus group, for example by not completing sentences, repeating the same answer or comment for each topic, or providing opinions but not being able to support them with evidence. It must be remembered that, as a qualitative method, focus groups seek to elicit the perceptions and opinions of participants, and they do not need to provide any evidence to support their opinions. No follow up data collection was conducted to conclusively make the link between staff perceptions of progress/impact and quantitative indicators of progress.

As COPE was implemented in 10 Health Centers within Kampot province, the majority of staff involved with COPE also participated in the focus group discussions.
Although staff members work together at the Health Center, it was felt appropriate to have separate groups for men and women. This would enable the evaluation team to identify whether there had been any gender bias with the impact of COPE.

The discussion groups were organized according to their status within the health system:

1) Provincial / Operational District supervisors (1)
2) Health Center Chiefs (1)
3) Health Center Staff - general (3)
4) Midwives (1)

Participants were selected at random according to the above criteria. The selection of staff was conducted by the evaluation co-ordinator, Dr Sol Sowath - Chief of Provincial MCH, as well as RACHA by staff. This allowed a fair selection, but also ensured that inappropriate participants were not selected within a focus group.

The focus groups were held at the high school in Angkor Chey District town from 7 – 10 August, and were conducted by an external evaluation team including a focus group facilitator and a note-taker/transcriber.

To illicit information necessary to conduct the evaluation, focus group participants were asked to discuss the following subjects relating to COPE:

- COPE Tools
- Rights of Clients
- Needs of Providers
- Supervision and Management
- Attitudes and Relationships
- Participant Perceptions of COPE

Due to a miscommunication, focus groups held at the beginning of the evaluation were poorly attended by staff from Health Centers in Kampong Trach Operational District. Despite this, enough participants attended to be able to conduct an informal, albeit small, focus group discussion. Most focus groups were lively but participants often did not listen to the questions posed by the facilitator, but gave information they felt was more relevant. Participants often used examples to present their opinions.

Focus groups discussions were translated into English by the facilitator and note-taker, to ensure that the context of answers was correct. As focus groups are not a quantitative method of data collection, the results from the group discussions were desegregated by finding both the commonalities amongst opinions within each group, as well the extremes of opinion and attitude. The final analysis presents all opinions, and will state the degree of support for each one. As there are no baseline indicators relating to staff perceptions before COPE, this evaluation report has relied solely on the participants perception of changes that have occurred as a result of the introduction of COPE.

Where participants' comments are presented in this report, most have been grammatically altered although the meanings have remained the same. Where it has not been possible to amend comments, effort has been made to ensure that the reader can understand them.

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As meeting the rights of clients is an integral part of COPE, the evaluation team also decided to conduct a small number of informal interviews with members of the community (both clients and non-clients) living within 2 km of the Health Center. The questionnaire used in the interviews was structured and brief. The aim of the interviews was to gather the views of the local community, for those who use the facilities, and for those who do not. The team thought it possible to gather information from the community about the possible impact from COPE.

A total of 11 clients and 10 non-clients were interviewed at random at two Health Center locations in Angkor Chey District. Although the questionnaires were short, the interviewers spent approximately one half hour with each respondent.

Summary of Findings

This section presents the summary of findings from the focus group discussions and community interviews.

COPE Tools

Self Assessment

Most staffs utilize the first exercise, “Self Assessment.” They find it useful in identifying their own needs, as well the resources/materials they lack to provide effective services. Staff members were also pleased that they were able by themselves to identify their own problems, and then discuss the solutions with other staff members.

Within the focus groups, most staff members were able to identify two of the needs according to the definitions of COPE.

Some staff stated that they had not realized their needs before COPE, and that the questionnaire was a useful guide to do this. Others were aware of their needs and problems before COPE, but either did not know how to address them, or else were not allowed. The Self-Assessment component, and COPE as a whole, provided the means by which staff feel they are now able to address their needs by themselves.

First, it was reported that Health Centers were not provided with a full copy of the questionnaire for each staff member. As a result, staff are given different sections of the questionnaire to fill out on clients rights and needs of providers. This may be a good practice depending on whether the sections are rotated equally (or fairly), each time staff fill them in. Also, it is important members are able to contribute equally to the preparation of the action plan. It also needs to be discussed as to whether each staff member should be filling out a complete copy of the questionnaire.
Second, it was mentioned that there had been some difficulty with the translation of words within the questionnaire, and that although this issue had already been addressed some staff may still be having difficulty in fully understanding the meaning of some questions. It is essential to clarify this issue to ensure full impact from the component, and identify which questions staff may skip or misread.

**Rights of Clients**

Most staff were clearly aware of clients rights and related these to changes in their own work practices. This was seen within the focus groups, as staff showed they could relate information from the interviews to the problems of the Health Center as a whole. As a result, rather than looking only at their own needs, staff became aware that to improve services they must also address the needs and wants of the clients. This link was apparently not clear before COPE.

**Client Interviews**

Although difficult for the client, the staff seemed to welcome 'negative' comments, and from the comments received at the focus group discussions, they were even happier if they were able to address the negative comments successfully.

By addressing what clients want, the staff members themselves have realized that the client is more likely to come back, as well as encourage other people to visit the Health Center. This promise of increased clients and income was particularly appealing to many Health Center staff.

The main effect from finding out what the client likes and does not like is that staff in general have tried to become more friendly and informative. This is a relatively simple request from clients and has been easily solved. If staff lack knowledge, some have requested extra training, although many staff still rely on Operational District staff to identify their training needs. Other changes for many Health Centers has been not only to set specific working hours, but ensure that staff come to work on time and that clients are not waiting a long time for services. Also, that the system of waiting for services is fairer, and that clients who arrive first are also seen first. These changes were made as a result of client complaints, and clients are apparently happy with the results.

Not as successful have been the requests for the Health Center to have longer opening hours. For some Health Centers this has been possible, but where client numbers are not so high, the cost benefit ratio of providing services, considering the low salary and that many staff get extra income from private practice, means that some Health Centers cannot meet this need of the clients.

Several interviews with non-clients showed that they do not go to the Health Center as it is only open for a few hours each morning, from Monday to Friday. However, the fact remains that they know for sure that the Health Center is providing services at a certain time, and that it would be open for them if they went at the right time. Of course people cannot determine when they will be sick, but knowing that the health center is usually open at...
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certain hours represents an improvement from the time when clients complained that they would never know if staff would be at the Health Center.

While staff members are implementing positive changes within their Health Centers, the evaluation team recognized that there is a limit to what can be changed while the salaries of Health Center staff remains low. The presence of private clinics, managed by staff from some Health Centers, is likely to reduce the impact of any quantity changes in increasing client flow to the Health Center.

Regardless of whether the staff members find the client interview useful to improve their Health Center, there are still some locations which do not conduct them. This could be because the Health Center does not have enough clients to interview, or that clients do not want to be interviewed. Both these issues were raised in the focus group discussions.

For Health Centers that do conduct client interviews, staffs continue to face problems in getting the 'real' answers from clients. Many clients are friends of the staff, or else live in the same village or communes and do not want to criticize the Health Center. Although some staffs have overcome this by ensuring confidentiality, there still remains a fear of retribution against either the staff member involved or against the client.

This is not an isolated problem for COPE, rather it is a problem visible nationwide. The 'fear of retribution' could be alleviated, as clients are more able to trust the staff and can see positive changes being implemented. Or it may be that a different way of conducting client interviews is needed to allow clients to feel secure enough to express their opinions.

This would first require training staff to conduct interviews in a more informal and participatory manner. Asking questions in a wooden fashion, as some staff are currently doing, is not the best way to get a good response from the client. The questionnaire itself could also be reformatted to ensure staff aren't simply reading the questions. Alternately, staff could post signs around the Health Center informing the clients that the staff want to hear their opinions to improve the services provided for them. This way, the client is given advance warning that they may be asked to give their opinions about the services offered at the Health Center, and is not suspicious or afraid when approached.

These proposals to improve conducting clients interviews will not solve all the problems that some staff are currently having, but they may help ease the difficulties and staff can finally receive the information that they require.

All staff that participated in the focus groups stated that they had implemented changes in order to make the client happier. In the interviews with non-clients however, some of the reasons they stated for not going to the Health Center are changes that have already occurred, for example, friendly staff, effective medicine and good services. Whilst clients may be complimenting staff for their improvements, these changes may not be reaching other village/commune members. Alternately, it could be that the villagers we interviewed have had previously bad experiences at the Health Center, and are thus relying on their experiences from before.

Despite this, if improvements in service quality are to be translated into increased client flow, a way needs to be found to inform those villagers of how the Health Centers
involved are trying to meet the needs of the people, and what changes have already been made. It might also be useful, although not strictly part of the COPE component, for staff to talk informally to non-clients and find out why they do not come to the Health Center.

The final COPE component 'Action Plan', is again being used by all Health Centers in its correct format. There was a general consensus that if there was no action plan, activities would either not get completed, or else no one would take responsibility for their implementation. The issue of nobody wanting to take 'responsibility' without incentives appeared a significant problem for Health Centers before COPE was introduced.

In most Health Centers the action plan is on the wall for staff to see and check for deadlines. Staff mentioned that this has helped to clarify their roles and responsibilities within the Health Center, and staff are now more willing to take on the responsibility of implementing an activity, provided there are adequate resources and support from other staff members. Again, improved co-operation between Health Center staff has been central to the process of improvement.

Findings showed that for the action plan, staff would first try to solve the problems using resources from Health Center financing. Examples included buying curtains for more privacy. If the amount were too great, then the Operational District would be asked to assist. If the resources were still not located, provincial staff would be approached, and as a last resort, RACHA. Both RACHA and MEMISA have provided Health Centers with materials that were too expensive for either Health Center or Operational District. RACHA has provided resources to improve the structure of the Health Center, whilst MEMISA has provided batteries for lights. Although overall the action plan has had many positive outputs, staff members remain realistic about the problems they have not been able to solve, stating that some problems just don't have an immediate solution.

**Supervision and Management**

Most Health Center staff stated that as the Health Center Chief is responsible for all activities, he/she is also responsible for the management of COPE. This view was supported by Health Center Chiefs. They sometimes stated that staff members would not be able to manage COPE themselves. It was generally accepted by all groups that there should be one leader, but not overall consensus that it should be the Chief who manages the system of COPE. In some Health Centers, the ‘regular’ staff are the managers of COPE. Currently the system of implementing COPE within the Health Center seems successful, but may be somewhat limiting to the Health Center overall, if the Health Center Chiefs are directing all activities themselves.

The COPE meetings in most Health Centers are held once a month. They are held separately from the normal Health Center meeting and most staff members are aware of the different objectives for the two meetings. This has helped to clarify and maintain the COPE process. In the Health Centers where the two meetings are held together, care should be taken to ensure there is enough time to cover both activities, as well as not confuse the issues. The normal meetings (planning, reporting) take enough time already, and to add COPE may mean that one activity is neglected.
Several participants noted changes in the style of supervision since the introduction of COPE, although it is difficult to say whether this is as a direct result of COPE. In recent years there have been many positive changes in the approach to supervision nationwide. Staff mentioned that supervisors no longer blame them for mistakes, and instead show staff the correct way and encourage them with their work. Staff members are no longer as afraid of supervisors, and are more likely to talk with them about their mistakes, knowing that they will be shown how to not make the same mistakes again.

Some supervisors were not happy with the amount of time they spent for COPE, stating that they must do their regular Health Center supervision as well as that for COPE. Most Health Center staff, however, were satisfied with the amount of supervision they received for COPE, although this does range from one and a half hours, to one day. Staff members seem more concerned that Operational District staff will address their requests for training and materials, rather than having them come to supervise at the Health Center. Supervisors also mentioned that their job had become easier. Rather than being plagued with problems, as had happened previously, staff have now addressed many by themselves. This can only help to improve the relationship between the two.

**Attitudes and Relationships**

Firstly, many Health Center staff feel they are no longer afraid to give feedback both to their colleagues, as well as to the Health Center Chief. In some instances, staff will even give feedback to the supervisors if they feel they did something wrong. Secondly, roles are clearer as a result of the action plan, as well as increased o-operation and discussion between staff members. This extends to replacing staff in the Health Center if they are absent, although there is recognition that some low-skilled staff members are not able to this. Health Center Chiefs mention that they are less likely to force staff to implement activities, again easing possible tensions within the Health Center.

Health Center staff stated that in relation to their work, they now have a clearer idea of what they should be doing. Before, staff seemed frustrated and unmotivated. Staff members have been able to identify this, and now have the means to address it. Motivation and encouragement from undertaking the COPE components has central to the improvements already made for both clients and providers.

In relation to clients, staff often mentioned that before COPE, they did not care about the client and that as a result of the interviews, have both changed their approach to their interactions with clients, as well as implemented changes within the Health Center to make the clients happier.

Although the relationship between Health Center and Operational District had not been bad, staff felt that with COPE, Operational District staff were more receptive to listen to and help solve their problems. Knowing that the staff are using a system to identify problems and solutions has given more confidence in meeting the requests from the Health Center. Because confidence has increased on both sides, Health Center staff are not as wary and afraid of Operational District staff as they were before. Operational District staff also mentioned positive affects within their workplace, stating they now co-operate better with their colleagues if they are asked to by the Health Centers.

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“A Qualitative Evaluation of COPE”

“COPE has had a very positive affect on the relationship of all staff involved.”
Conclusions

General comments about how COPE has affected quality improvement within the Health Center incorporated many of the issues already covered. Some participants could not link changes directly to COPE, but admitted that COPE has played some part in this.

Overall, the main results identified were:

- **Staff** have become more confident in their roles and are able to identify problems by themselves.
- **Staff** members have started to work together when solving problems, and are now able to give feedback and support to each other, rather than blame each other for mistakes.
- **Staff** members involved with COPE recognize that improving services does not always require financial support. Basic improvements in service provision at the Health Centers have been implemented with minimum cost.
- Health Centers are becoming more independent and can locate resources by themselves, rather than from Operational District or Non Government Organizations
- Health Centers have reacted positively to the needs of the clients and implemented changes accordingly.
- Basic improvements at the Health Center have had significant impact on improving services for clients
- There are limitations on the level of quality improvements that can be attained in relation to increasing the flow of clients
- Relationships between all staff involved with COPE have become increasingly based on feedback, co-operation and mutual support

Staff members stated they would continue with the COPE components, as they cannot envision a better working process without them. As there has been limited involvement by RACHA, there is no reliance on financial support, and COPE supervision from Operational District staff is mixed with the monthly supervision. COPE as a process to improve Health Center services is already sustainable, and been fully accepted by the majority of staff. The current enthusiasm of staff needs to be maintained by continued and active support from Operational District staff.

In terms of forward planning, it was suggested by several participants that they would like to see a workshop for all Health Centers implementing COPE (in Kampot, Pursat and Siem Reap provinces) in order to share experiences. This could ultimately be extended to include other Provinces or Health Centers that have shown an interest in implementing COPE.
ANNEX 1

- Results –
Focus Group Discussions
Results - Focus Group Discussion

This section presents details from the Focus Group Discussions. For analytical purposes, the data have been sorted by topic. To ensure confidentiality, where comments and opinions have been included, the names of individuals and their groups have not been shown, although where one group as a whole has stated differing views, it has been necessary to identify this group. In general, most groups did provide similar opinions in response to the questions.

COPE and Quality Improvement

As an introduction and general warm-up, the participants discussed the notion of quality improvement. This ultimately led to a discussion about COPE and its components.

Participants of each focus group had a clear notion of both COPE and Quality Improvement in general. The prominent opinion was that COPE focuses on both the needs of the provider and that of the clients, and this enables a better working process within the Health Center.

Participants tended to use the word “COPE” as an umbrella for all the components they undertake in their Health Center. For example, a respondent would say 'COPE creates the good working process', or 'COPE allows us when we have a problem to find the solution,' rather than talking about the specific work they have done themselves to improve services. All regarded 'COPE' as the means by which they are able to improve services.

Two people in each group were able to give nearly an exact definition of COPE. Some examples include:

- COPE is the improvement of services, focusing on clients and effective providers
- COPE means to make the Health Center better, to make clients happier and provide effective and good quality services
- COPE allows us to know clearly about our roles, so the Health Center has a good working process
- COPE means to improve quality of Health Center services – COPE has taught us not to make so many mistakes e.g. improve environment like a garden, or have a sign at the front door

When asked how COPE works, participants in each focus group were clear about the involvement of identifying problems and their solution within the COPE component:

- COPE reminds us of the problems and needs in the Health Center e.g. lack of materials. We meet together, discuss the problem and find a solution
- COPE trains us how to make a plan, and to make the problem and solution in this plan
- With COPE we learn to identify the problem, to solve it, and put a date by when it must be implemented.
While explaining about COPE, most participants were able to mention at least one of the three components – Client Interview, Self-Assessment and Action Plan without prompting by the facilitator. Offering examples for client interview was particularly popular. The focus groups with midwives, Health Center Chiefs and OD/PHD were able to mention all 3 tools directly, and OD/PHD also discussed the other tool not currently utilized - Client Flow Analysis.

As a result of the discussions about COPE, participants were asked to give their own opinions and experiences of the three COPE components, 1) Self-Assessment 2) Client Interviews 3) Action Plan. Many participants often talked simultaneously about the three components, and for the purpose of analysis, comments made for each component have been put into different sections. However, the fact that participants would often mention one or two components at the same time showed us that they do not view each component by itself, rather as different components of a final result, this being improved quality of services.

**Self Assessment**

Participants in each Focus Group were clear about the role of Self-Assessment, and how it is used to improve services at the Health Center. Some examples include:

- **We use Self Assessment to find the mistakes, and use it to identify what we need to do, e.g., have night duty at the Health Center**

- **Self-Assessment is good and we can find out what is wrong for ourselves – e.g. we should start work at 8am but we arrive at 9am. We should respect the work hours**

- **Self Assessment is good as it is a democratic way, and the staff can do by themselves and make a decision, and we do not need to force them**

- **It is important for us to find the problem and to make the solution e.g. for immunization, before when we took the syringe container it did not keep the syringes from being damaged due to the bad roads. After we found the solution - we need to have a more compressed container for syringes when we go out on outreach.**

The OD / PHD\(^1\) group were very clear to explain about the sections for rights of clients and needs of providers within the Self Assessment questionnaire.

When discussing Self-Assessment, each focus group except one also described the Client Interview component, but not necessarily at the same time. Participants who did mention each component implied that both were necessary to fully understand the problems of the Health Center.

All participants were enthusiastic when discussing the Self-Assessment questionnaire, and all said they found it useful for improving their work. Several participants in each group mentioned that they were pleased to be able to find the problems by themselves.

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\(^1\) OD / PHD refers to the focus group held with participants from Operational District and Provincial Health Departments
The focus group with OD / PHD however raised other issues. Initially some of the Operational District staff and many of the participants had difficulty understanding several of the questions, mostly due to translation errors. This apparently has now been solved, although some participants are still not clear about answering some questions. As one supervisor stated, the staff will read through the questionnaire at the time of the meeting rather than preparing beforehand. This of course would affect the aim of the meeting that should instead be focused on making the action plan. This issue was not raised by the other focus groups and it is not clear whether they still use the questionnaire for guidance.

A second issue raised was that copies of the questionnaires were only given to two or three staff members in each Health Center rather than to all members. As a result the questionnaire is often separated, and different sections given to each staff member. For example, they separate the sections for rights of clients and needs of providers. The staff members would then take turns to read the questions.

Needs of Providers

As addressing the needs of providers is a central part of the COPE component, participants were encouraged to discuss if and how their needs have been addressed through the COPE component:

When participants were asked about their needs, no focus group was directly able to give the three needs associated with the COPE components –

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

However, most participants were able to mention their needs in the Health Center and included at least one or two of the needs stated above:

- Good management should solve all needs of staff. Managers should help them to find the problem and solution
- We request training for ourselves
- We need materials and equipment
- Good knowledge and information
- We request for blood pressure equipment and dustbins as we do this by ourselves. Before COPE we didn't care

One need consistently mentioned was of a higher salary; an issue which cannot be addressed by the COPE component alone, but instead represents a problem for the Ministry of Health in general.

When participants were asked if they had been aware of their needs before the COPE components, their answers were two fold. Firstly, for those staff who were aware of the needs before the introduction of COPE, they were not clear on how to address them:
Before COPE I know my needs, but not clearly
I know my needs, but I am not allowed to address them

Other staff simply were not aware of what they needed, or had waited to be told by the Operational District. Some of their comments include:

We wait for the top to tell us and then we will do. If not, then we don't do anything
Operational District arranges our training, it is not at our request
Before COPE we didn't know our needs

Since the COPE components, the responses from participants are positive for identifying and addressing their needs. Either staff stated that they still wait for the Operational District to request for training and that there has been no change, or that the staff themselves are now more aware of what they need and, when necessary, will request themselves:

We identified that some staff did not give information to the client and needed training
I will go to train in Ante Natal Care at my own request
Each staff must know clearly about each section of the Health Center, and must be trained to be multi skilled

The majority of participants were aware that the COPE components gave them the opportunity to realize their needs, rather than providing them only with material resources to improve services.

When the group with OD / PHD were asked about their needs, they responded that they still need technical support for COPE, and that more money is needed to conduct COPE supervision. Currently supervision is conducted during the Operational District supervision and staff request a separate supervision time. This is discussed further in the section for supervision and management.

Client Interview

As with the Self-Assessment component, all participants responded enthusiastically when asked to talk about the Client Interview.

Participants from all groups were aware of the client interview component, and what it is used for. Over half the participants from each group stated that they found the interviews useful to improve the services at the Health Center, but were keen also to point out the difficulties they have when conducting them.

We want to know attitude of Health Center – do we make clients happy or angry?
We talk to the client to improve ourselves
Before we do not know ourselves. Only people from outside can know our faults, and so we can improve ourselves.

Rather than talk about the process of interviewing clients, several participants in each group preferred to share the ideas that they had gathered from the clients regarding their Health Center. It is positive to see that not all these opinions are in praise of the staff, and that some clients will give honest feedback:

- **We have night duty and they (the clients) are happy**
- **If we cannot provide medicine and cheap price they (the clients) are not happy. If they don’t get the injection they (the clients) are not happy**
- **If the client tell us that the staff come to work late, we discuss and change the work time to the need of people**

There were several difficulties associated with the Client Interview component that were raised by participants of two focus groups. The first difficulty relates to the willingness of the client to share his opinions with the Health Center staff. Concerns were raised that clients are afraid to say the negative thing in case blame is attached to a specific staff member. Furthermore, Health Center staff are living in the same village or commune as many of their clients. This again could make it difficult for clients to give ‘neutral’ answers.

- **The client interview is a good component but there are difficulties. It is difficult to get the real answers from the client, and the client and staff know each other – clients should provide real answers**
- **Most clients do not dare to tell truth as they may be seen as an informant if they say something bad**
- **The interview is difficult as the client does not want to blame us in front of other people – they are afraid as it will affect the staff**

To overcome this problem, several participants stated that they tell the client that the interview is a secret, and that they will not tell anybody what the client said.

Alternately, other participants stated that it was easier to conduct the interview because the client was a friend of theirs. In this case, according to one focus group, the staff do not use the interview questionnaire but instead ask informal questions to them.

Two participants complained that some clients do not want to complete the questionnaire, or that the client must hurry back to their work, and so say only a few words.

- **They don’t want to speak, only say a few words and hurry home. But we still use the interview every day**
- **Clients complain that the interviews take too long, and that next time they will go to a private clinic**

One participant stated that they do not use the client interview in their Health Center, and rely only on information from the Self-Assessment component. This corresponds with
information from another focus group in which three participants stated that some Health Centers do not get the information from the clients, only from themselves (Self-Assessment). Participants from this same group also stated that staff will often forget to conduct the interview until the day of the COPE meeting. In recognition that Health Center staff are genuinely interested in client interviews, a participant from the OD / PHD group suggested encouraging more staff to conduct client interviews, but that only one problem from a client need be addressed during a COPE meeting.

Another issue raised by the focus group for OD / PHD, was that Health Center staff are not skilled enough to conduct the interview effectively. Although at least three supervisors stated that they have attempted to encourage better communication, Health Center staff still have a tendency to read each question from the questionnaire without looking up at the client when he or she responds:

- The staff have no interview skills, they only read out the questions
- I saw them interview at beginning of the component, but they read each question on the form and not look at informant – this is not good communication

One final issue that was identified during the focus group discussions was that several participants seemed confused about the difference between the client interview component, and the normal procedure of recording a client's medical history.

**Clients**

As ensuring the rights of clients is also a central part of the COPE components, participants were again encouraged to discuss the involvement of clients, and how they have been affected since COPE was implemented.

Most staff were aware of the rights of clients, the most recognized ones being:

- Friendly environment (14 participants)
- Provision of reliable and effective services (6 participants)
- Information / advice (6 participants)

Other rights mentioned included confidential service for clients (3), available supplies of medicine (1), and the freedom to express opinions (2):

- Right for received services, information, selection their need
- Keep confidentially for them, safe, comfortable,
- Right to express their opinion about the attitude of the Health Center staff, and confidential service e.g. client have STD don’t want us to tell anybody
- Need to get safe and suitable place, select what service they want

A regular comment mentioned by participants was that if the Health Center caters more to the needs of the client (in relation to the points above), then more clients will come to receive services at the Health Center:
More work more clients, more money and we are happy

More money for the Health Center is good relationship and communication with client they come again

According to the participants, the clients’ involvement with COPE is only through the Client Interviews. The information received from this is used to try and improve the services for them. Sometimes the staff admit this is not possible, for example one participant stated that clients want to visit the Health Center at the weekends. As the staff do not work weekends, and do not get a high salary, staff cannot meet the needs of these clients. For other needs, for example, a friendly environment, this is easier for the staff to solve, and the majority of staff stated that they are now friendly to the clients:

When clients come to the Health Center, I am friendly to them

Some staffs’ attitude is bad, others are good – this is normal. There is change now otherwise the client will not come to the Health Center

Clients have improved us

The reaction from the clients to changes made by the staff, according to the participants, has been quite positive. Each focus group was able to provide examples of where some clients have become happier with the services they receive:

The clients are happy as the staff are friendly and the service is cheap

The clients said they wanted to go to rice field as well as the Health Center, so we came to work at the Health Center early and now they are happy

One client needs medicine every day for high blood pressure but he complained that he couldn’t afford to pay each day. Afterwards we discussed this problem with Operational District, and now we allow the client to pay only twice a month, and now he is happy

Action Plan

All participants were aware of the action plan and understood how to prepare it. Each focus group confirmed that Action Plan meetings are held with all Health Center staff together, and utilize information from either the Self Assessment component, Client Interviews, or both. Participants also knew that at least one person is selected to implement a solution to a problem within a set time period (or deadline).

The action plan should come from Client Interview to see what Health Centers lack, as well as from Self-Assessment component. The staff make the plan for action and have to follow it

We must state what we want to do and put a deadline for it. If we are on outreach one person must stay behind at the Health Center. Before we would all go out whenever we could, and no one would take responsibility for, and no one would care for the clients at the Health Center.
All staff participate. We have one chief for COPE to make the action plan. We put problem and solution, and the date by which it should be solved.

Several staff acknowledged that without the action plan, activities would either not get completed, or no one would want to take the responsibility. Some comments include:

- **If we have no action plan we cannot work**
- **If we make the action plan we are able to do our work. Before we cannot complete the work as we forgot some of the activities**
- **When we plan, we implement by our roles. If we have no plan, we do not know how much we have to do**

Health Center staff find the problems and try to solve them by themselves, using resources available at the Health Center for example, user fee financing. All participants stated that if a solution cannot be found or it is too expensive for the Health Center staff, the Health Center Chief would contact the Operational District staff for help. For example:

- **I know the problem - we don’t have a water well. We will request to the Operational District if we cannot find the solution**
- **We mostly take resources from Health Center finance to solve problems, but sometimes also from the Operational District**

One participant stated that she could not implement some solutions as her salary was too low and she must work elsewhere.

When asked how they implement their plans the participants referred to examples of their own:

- **We set up a policy for daily disease and have now reduced the fee**
- **We stated what our working hours are**
- **We did not have enough curtains, so we were able to solve here**
- **We put up a time sheet for who was responsible for buying materials**

When asked whether their action plans had been successful, at least half of all participants stated that their plan had been successful. Other comments included:

- **Yes successful, we had a leaking roof and RACHA fixed it, and we were also given a battery for lights.**
- **Some activities are not successful, and some problems just cannot be solved**
Supervision and Management

In this section, participants were asked about the management and supervision systems for the COPE components, and whether these have changed since the introduction of COPE.

In five groups, at least one participant in each (but from different Health Centers) stated that the Health Center Chief is the manager of COPE. In the focus group for Health Center Chiefs, all agreed that the Chief manages the components, and is the person responsible for delegating responsibilities. When stating this, the chiefs related their role as manager of COPE to that of being Health Center Chief in general, and either that a leader is necessary for planning and implementation, or that staff do not have the necessary skills.

- Health Center chiefs can only manage COPE, staff can never do it
- Chiefs lead, if not then the deputies will lead
- Staff cannot manage COPE
- We need one leader, if not they will not listen to each other. They will listen to the powerful one
- One family has a mother and a father and a child. If we let the child make the solution, it may not be as good as the mother or father.

When discussing the Client Interview, there was a mixture of feelings between whether this is the responsibility of the Chief or all staff, as seen in the dialogue below:

Participant A: 'Interview should be for Chiefs only as clients may say the bad thing. Other sector staff may write the wrong thing and do not know what to improve'

Participant B: 'All staff should be interviewer as we take all ideas and put together. For chiefs maybe some clients are afraid as he has power'

At least two participants stated that in their Health Centers, the 'normal' staff (that is, not the Health Center Chief) are the managers for COPE.

All participants were aware of the management system for implementing COPE, using the Government structure:

Health Center ——— Operational District ——— Provincial Health Department

If a problem cannot be solved at the Health Center level, they will refer it to the Operational District level. If the Operational District level staff cannot provide a solution, they will in turn refer the problem to the Provincial level staff. All stated that they will try their best to solve the problems themselves first. This was corroborated by the OD / PHD group, which stated that the Health Centers are not as reliant on Operational District support as they were before. As staff were more able to solve their problems, the Operational District staff were not as inundated with problems as they had been on previous supervision visits.

When asked whether the COPE meeting was the same as a normal Health Center meeting, the majority of participants agreed that the two meetings were different. Only two
participants prepared the action plan within a normal Health Center meeting. The difference between the meetings was explained as:

1) Heath Center meeting – planning, reporting for activities

2) COPE meeting – Review and make new Action Plan

   At the COPE meeting we find the problem. The staff meeting is for planning

   At the normal meeting we discuss activities and report back

   The meetings are different because COPE will solve the problems, and the normal meeting is planning for the Operational District

Each focus group reported on the system of supervision, and stated that they receive a supervision visit by Operational District staff once a month. This visit is tied in the standard Operational District visit to supervise all sectors in the Health Center. The time spent for the whole visit ranged from one and half hours to one day if the supervisor had many Health Centers to cover. Health Center staff said that they were happy with the amount of time that supervisors spent with them.

One participant in the group with OD / PHD were initially not so happy with the time spent to supervise COPE:

Sure we had difficulties because COPE supervision is implemented at the same time as our Operational District supervision. Normally we would spend a day to supervise COPE, but we don’t have a per diem for this work. So we must implement together with our Operational District work. We have a lot of work to do already which causes difficulty for us to do the COPE component. However later on, we don’t have so much difficulty any more because the Health Centers understand more about COPE.

Several participants stated that the style of supervision has changed in recent months, although this was not specifically related to the introduction of COPE.

   Supervisors now do not blame, only improve us and give feedback

   There are changes. Now they are more polite. Before they were like a tiger

   Before when they came to do supervision they would only find the mistakes of Health Center Chief and put it in their list. Now if they see mistakes they correct us and give a deadline by which we much change

   Before when we saw them we were afraid, as they would evaluate and give us a low score

   Now we welcome each other better than before. COPE has changed this for the better.
Attitudes and Relationships

To assess the impact of COPE on the relationships between the staff involved, the focus groups were asked whether they felt their attitude to work, as well as relationships with colleagues had been affected since the introduction of COPE.

There were many different opinions given for how relationships have changed since the introduction of COPE, but all comments given were again positive.

The main affect for Health Center staff was that they are now not afraid to give feedback for the activities of other staff members. The former environment of 'blame' has been replaced by feedback if there is a problem. Secondly, participants stated that now they are clear about their roles within the Health Center, and that staff (or staffs) are now taking responsibility for activities.

- It is different, we work within different roles now and we are clear
- It is different and we can co-operate between ourselves
- Now we share our mistakes, and give each other feedback

Thirdly, staff stated that where possible, they are now happier to replace each other within the Health Center, for example if there are outreach activities and one person needs to remain at the Health Center. This was also related to some staff requesting to become multi skilled.

- Now sometimes we can replace each other within the different sectors
- Now we fit together at the Health Center

For the relationship between Health Center staff and Health Center Chiefs, the comments again related to being able to give feedback to the Chief, rather than before when they would have been afraid due to his/her status:

- It is better than before – if the Chief did something wrong the staff were afraid to give feedback. Now the staff will give feedback when they are not clear. Before, everything was top down and now it is bottom up
- Now the Health Center staff dare to show their opinions, as they have more self confidence
- Even in front of Health Center chief, staffs did not dare to raise their opinions. They mostly just listened to him. After COPE was implemented, they know their duties and roles so they are not scared anymore

Health Center Chiefs also felt that their work had become somewhat easier as staff were more willing to implement activities. By increasing the involvement of staff more in the planning of activities, this has also helped to improve the general working process:

- The implementation was not good before as everything was ordered from the top
Now the staff do whatever they feel happy to do. Before we had to force them to do what we wanted.

As already seen in previous sections, the involvement of clients in the COPE component has enabled staff to become more aware and reactive to their needs. Although the most visible change has been the staff becoming friendlier to clients, staff have also been implemented changes to keep clients happy:

- **Before COPE, the staff didn't talk to the client. The client talked to the staff but received no reply. COPE changed this.**

- **Before, many staff have the private practice so came to work late. Now, as the patient said they waited a long time, staff are asked to come to work on time.**

- **Before we didn't care for the clients. After COPE we know our functions, and what we need to do for the client.**

The final relationship which has been affected by COPE is that of Health Center staff with OD / PHD. Although no participants stated that the previous relationship had been bad, the general consensus was that Operational District staff are more receptive to their problems, and that Health Center staff are not as afraid of their visits as they had been previously:

- **Before having COPE, the Provincial level did not work hard to provide us with materials, but now they work hard to give materials to us.**

- **Before we are afraid of them. If we did something wrong, we were afraid to say and did not tell them what we needed. Now we have changed and have the right to advocate. When they are wrong we also give them feedback, so now we are not afraid.**

One OD / PHD participant even stated that he had set up a COPE process at the Operational District technical meeting to enhance the working environment. Another participant commented that he is now more willing to co-operate with other sections at OD / PHD to help the Health Center (as seen below):

*We have better relations than before. Staff in every section in the Health Center help each other to search for and solve the problems. And the relationship between Health Center level and Operational District is good. For example, when I conduct supervision, the Health Center will raise some problem related to filling birth spacing form and ask Operational District to train them. I am not in charge of this unit, but I take their proposal and bring it to the birth spacing unit at the Operational District and find out if there is a possibility to train the staff. It is different from before when we might have refused their proposal because it was not strictly our duty. Now we try to send all the proposals to Provincial level.*

**Participant Perceptions of COPE**

As a summary section for the focus groups, participants were asked to give general opinions about COPE, and whether they felt it had been effective to improve quality of services in the Health Center. This section was intended to collect other information that had not been mentioned by participants before, and gave participants the opportunity to show how they felt about COPE. Again most comments were positive, although there was some dissent:
For the Health Center staff:

- COPE helps us find our weak points. It can improve our work through transparency. We can say directly that there is a problem and what we need to change it.

- We think that COPE is good if we need something. We can discuss the problem, find the responsible person as well as identify the time for its completion. Before we did not have a work plan – now we respect each other and ourselves during the time we work.

- Before COPE I am bored and I hate my work as I have no money. But when we learn COPE we learn it is important, and it is not what I thought it would be.

- Before COPE we didn't care if somebody completed the activities or not

For Clients:

- The attitude of the staff is more friendly now

- There is shorter waiting time now for clients – first come first served now – before it was not like this

- We have discipline and skills, and the clients can believe in us

Other participants claimed either that there had been no improvements (2 people), or that the improvements and changes in their work could not solely be linked to COPE, focusing impact also on their own experiences of work in general:

- It seems difficult to say. I don't know if it is the impact of COPE or the impact of our experiences that gives us the knowledge to make a plan and respect the time. I mean our attitude has changed. We can say COPE has had an impact for change, and we also can say that other work experiences have had an impact in changing our attitudes.

- Working gives us more and more experiences. We cannot say if it is only because of COPE.

- If we say COPE has had an impact on our work, does it mean that other Operational Districts that do not have COPE cannot work?

One issue that had only been raised briefly before, was that staff felt they had more independence when identifying problems and solutions within the Health Center, by working as a team and asking for help when needed. This corresponds with comments from OD / PHD who have witnessed this occurring:

- Since COPE, they now know that all problems are their common problems. Before they only raised problems to the Chief

- They know how to work in groups now – search and solve together

- Before staff raised problems which were difficult to solve. Now they can identify the problems that can be solved
COPE has had an impact as it is a system to improve quality. We don’t need to lead the staff directly. COPE allows us to become partners to help us work. Without COPE we might be working alone.

Financial support that participants stated they had received, apart from monthly supervision, was as a result of the staff identifying the solutions to their problems, but not being able to fund the solutions. In these cases, if the Operational District or Provincial staff were also not able to locate the resources, RACHA provided resources to some Health Centers. This included: 1) a new roof  2) batteries (when there is no electricity – night duty) 3) beds  4) equipment 5) water well. Material support was apparently not given unless asked for, and deemed necessary. As one participants commented:

COPE has supported us for ideas, and to make us understand and take care with the client better than before. But for material support, we have received only a little.

All participants recognized that COPE does not provide them with ‘extra resources’, and although several participants mentioned that they would prefer RACHA to provide a salary, the general consensus was summed up by one participant in the following statement:

COPE supports what we need e.g. materials and supplies, but not money as it is knowledge that is provided. If they give us money we would have no ideas and knowledge, and we would lose money

Participants were asked whether they would continue with the COPE components if RACHA support was stopped. The results again were two fold. Firstly, all Health Centers stated that they would continue, albeit with continued support from Operational District and Provincial staff. Secondly, as participants saw RACHA as having a limited involvement in the COPE components, they saw little difference if they RACHA continued support or not. In total, 20 participants stated they would like to continue with the components.

Their comments to support this are as follows:

☞ My idea is that if COPE withdraws the Government should help the Operational Districts to solve the problems raised by Health Center, and then COPE can withdraw.

☞ If we are talking about the incorrect way for clients, we have been doing this for too long and our education was also bad.

☞ If we do not agree together, we cannot do anything

☞ If we throw COPE away, sometimes we cannot have good implementation of our work

In terms of COPE being a sustainable tool for the Health Centers, the response again was again very positive, backed up by examples of the reasons how and why:

☞ COPE belongs to us and the clients together

☞ Even if I retire I will train to the next generation to implement COPE and will not throw it away

A Qualitative Evaluation of COPE
I will continue the COPE components because we have been implementing COPE for one year (since August last year till this August) and Health Center and Operational District staff can now solve the problems by themselves. We have not depended on the Non-Government Organization that created this program.

There is one lesson for our lives that the trainer provide to us and it is a good lesson as before we don’t know, now we know.

Recommendations

Participants were asked if there was anything that they would like to change with the COPE components. The majority of responses from Heath Center staff were either that they were happy and did not want to change anything, or that they had no ideas to give. Comments for change that were given, were mostly related to the management of COPE.

Comments include:

- COPE meetings should be every 3 months, not every 2 months.
- If it is possible, RACHA should invite Operational District staff from the different districts or provinces to have a study tour and exchange or share experiences.
- I want the day of COPE supervision separate from Operational District supervision because we only have a short time to do both.
- There should be organized workshop for the final year evaluation amongst the three provinces to share experiences and evaluate our common work.
- I suggest that RACHA should continue supporting COPE because we are still technically weak.
ANNEX 2

- Results –

Community Interviews
Results – Community Interviews

This section presents the findings from the interviews with members of the community. Data has been sorted by question, and presented in a similar fashion to that of the Focus Group Discussions.

Client Interviews

The majority of clients (6) interviewed had been going to the Health Center for more than one year, although most of these were visits once in a while rather than on a regular basis. Four clients have started going there within the last six months, whilst the remaining client receives outreach services. Only four clients go to the Health Center on a regular basis, mostly for medical problems which require daily medication – high blood pressure and skin diseases were commonly mentioned.

When asked why they use the facilities at the Health Center, most respondents stated they go because they are sick. Others stated that the services were cheap, and also that the Health Center is conveniently close by. Four clients stated that they like to go there because they are given effective medicine and the staff are friendly. Other reasons included not having to wait long for clients, and the cheap price of services:

☞ The staff are friendly, we have good relation and they do not use their power over us. Also it is cheap
☞ I don’t have to wait too long and the staff are my friends
☞ When we are sick we go there and get effective treatment

When asked if there was anything they did not like about the Health Center, two respondents mentioned that when they require injections, they must pay extra as there are no supplies in the Health Center and staff must go and buy the medicine from the market. One client did not like the environment around the Health Center and wanted to see a garden, whilst another client mentioned that if there is only one person in the Health Center, they cannot provide all the services:

☞ They tell us that if we want to get better they must inject us. They then buy the medicine from outside to inject us
☞ When some staff are not there e.g. pregnancy check, the other staff cannot do it as they do not have the skill and we must pay 2000 Riel for nothing. If we met with the skilled person it would be good.

Most respondents had not noticed any changes at the Health Center, but stated that they do not go often to the Health Center anyway. One client stated that there is more medicine now.
Respondents stated that it is important for them to have the following at a health facility (in order):

1. Friendly staff (3)
2. Enough medicine (2)
3. Good services (2)

When asked whether the staff at the Health Center had interviewed them, all respondents stated that they had been asked about their medical history only.

Non Client Interviews

Five respondents went to the Operational District Health Center to receive services, and four respondents went to private clinics. For the private clinics, all but one used the same staff from the Health Center.

The respondents stated that they did not use the Health Center for the following reasons:

- Private is more effective (4)
- Health Center staff won’t give injections (3)
- Health Center not open (2)
- Health Center only for non serious disease (2)
- Waiting a long time (1)
- Not enough medicine (1)

Comments from respondents include:

- If we use Government Health Center we get better in 1 month. If we use the private we get better in 15 days
- The Health Center only give 2-3 tablets and not give injection
- The Health Center only work 8-11am so if we are sick outside this time how can we go?
- It is easier to buy the medicine from the Health Center staff At the Health Center we must go on time, pay 2000 Riel and not get better

Only two respondents mentioned that they liked the Health Center being so close to the village.

When asked what changes they would like at the Health Center respondents stated that wanted effective medicine (3), a doctor (2), good medical supply (2), that the Health Center is open 24hrs (2) and for the staff to be friendly (1).

- We want to have the services if the Health Center staff regularly come to the Health Center as we don't want to go far away
- The private clinic is not so better as it is more expensive than the Health Center
- We want to have the good medicine which is effective and I don’t want to go far
Respondents also stated that they felt it important for the staff to be friendly (3), and that the Health Center be open for longer hours.