

1 Introduction

Traditionally, teaching and training in the health sector of Nepal have depended largely on the rote system of learning with the emphasis on the acquisition of theoretical knowledge. As such, training has been very much a vertical affair with separate training courses for different cadres, priority given to targets and numbers rather than performance and quality. As a result a sustainable improvement in the quality of services has been slow to emerge. Training has come to represent for some an opportunity to supplement otherwise inadequate salaries; consequently the very purpose of training, i.e. improving service delivery, has often been overshadowed by the more pragmatic need to enhance income. Recently there has been growing popularity and commitment by all partners involved, both donor and government, to look more at team building, supportive supervision to newly trained staff as well as the institutionalisation of follow-up measures.

One approach to improving service delivery has been to adopt more participatory and learner-centred approaches, which involve listening to and using the experiences of participants as well as incorporating a higher proportion of time on skills learning and practical issues. Given the new impetus of worldwide moves to health sector reform, the strengthening of district health systems and decentralisation, we now have more than ever the opportunity to develop partnerships at every level in order to build up the quality of service delivery at local levels.

2 Whole Site Planning to Improve Generic Primary Health Care (PHC) Services

The concept of whole site planning and training was initially applied by Access to Voluntary and Safe Contraception (AVSC) in its Client Oriented Provider Efficient (COPE) approach. Developed to improve the quality of female sterilisation, it was later expanded to address wider reproductive health issues at service delivery level by working with the whole team, on site and not only identifying barriers to good service delivery, but also, jointly, seeking workable solutions (Dwyer *et al.* 1991). Since COPE is being successfully used

Partnerships and Participation

Synthesising Methods to Improve the Quality of Planning and Training for Primary Health Care Services at District Level in Nepal

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already in Nepal in the field of reproductive health and since the concept was considered to be congruous with Primary Health Care Providers' (PHCPs) own philosophy and approach to Human Resource Development, it was felt that some of the components and approaches could be modified to address the broader range of primary health care issues. Together with the whole team and on site approach, COPE also allows for client involvement through exit interviews. These interviews were also retained to keep service users central to the process, but in a modified format. Where the original COPE approach relied upon written self-assessments, and fairly lengthy interviews, our adaptation includes more visual methods to make it acceptable and accessible to even the moderately literate, since literacy is a significant issue in Nepal's future development (UNDP 1998).

3 Incorporating Participatory Methods in Health Training

Participatory Learning and Action (PLA) is a natural derivative of the more research-oriented Participatory Rural Appraisal (PRA) and is used frequently in the field of community development as a method of increasing control and ownership of local communities in their own services (Schoenhuth and Kievelitz 1994). PLA is chiefly about increasing local participation and developing approaches to self-help together with all the stakeholders. To this end many novel approaches to community work have been developed based on principles of increased visualisation and interaction. Although, in Nepal PLA has generally been used more in the forestry and environment sector than the health sector, we felt that the principles were well matched with COPE and could be extremely effective. Accordingly, the synthesis of methods involved a revised and reduced set of questions for client interviews and a new approach to self-assessment with the inclusion of six PLA elements:

- Creative team building
- Skills mapping
- Transect walk
- Colour-coded activity ranking
- Indicators
- Photographic monitoring

These simple and entertaining exercises served a dual purpose. One was to provide crucial information with which the team could plan realistically. The second was to remove the dangers of the process being seen as 'just another training' or as an 'academic' exercise, as is frequently the case with more classical class-based training.

4 Who Participates?

The Health Posts were originally targeted as sites with the greatest potential for positive change and the best equipped to provide good quality PHC services, given adequate support. In both PHCP districts there are fewer than twenty health posts, which makes it viable to reach all sites within a year.

Accordingly, all the health service providers are invited to participate, from Health-Post-in-Charge to the health post/clinic/hospital support staff, as well as the peripatetic staff. In addition, those who rent premises on the health site compound are also invited, for example tea-shop keepers or private pharmacists. The district supervisors are also considered to be key to the process in that their supervisory role is often under-utilised, although they have a budget for the same. Finally, in Nepal there are Health Post Management Committees (HPMCs) whose members comprise senior health post staff, the local village development chairperson, the local most senior teacher, a ward member and the female community health volunteer. The committee's function involves management and support to the facility in terms of repair and maintenance, drug supply and administrative support for which it holds a small budget. Members from this committee were also included in the COPE Participatory Learning and Action (COPEPLA) team.

5 The COPEPLA Process

Since the process is designed to take place on site, it is vital that activities take place around clinic times in order not to disturb service delivery. This has the advantage that the process can reinforce the importance of the clients' needs and delivery of services as paramount. Involving all site staff from doctor to sweeper, as well as supervisors and members from the HPMC has positive results in terms of collective responsibility and an increased understanding that all staff are interdependent. The six

elements of the COPEPLA process are described below.

5.1 Creative team building

The creative team-building component was considered important, as many health sites are hierarchical and there is often a limited sense of 'team work'. The exercise takes place on the first day to demonstrate practically the value of a team approach. Participants are split into small teams and provided with certain rudimentary materials and the objective to build a structure within a certain time frame with the materials, where each item is given a nominal 'price'. In one Health Post, Benighat, in Dhading District, the outcome of 'build a monument' proved highly useful at the final planning stage: not only was the most stable and efficient monument made in the shortest time but it also used the least resources.

When it came to action planning we were able to demonstrate clearly that 'lack of resources' does not automatically constitute a problem, since the least efficient tower used the most resources and yet the most stable used the least. The winning monument was constructed after a period of discussion to arrive at consensus on how it should be built, while the least successful model had been constructed with ongoing and divergent inputs from the different team members. The feedback from this exercise proved highly instructive to all participants as well as causing much hilarity in the workroom.

5.2 Skills mapping for the team

To reinforce the idea of working as a team, the visual skills mapping exercise is designed to emphasise the different contributions that team members make, by representing their different skills in picture format. If one individual's picture is removed, the skills s/he offers also disappear and the team fails to function as efficiently as before. This shows how the different members of the team can complement each other and allows individuals to appreciate the contribution that each person can make.

5.3 Transect walk

Before the transect walk takes place participants are asked to think about the sort of service they would expect to receive if they became ill and approached

a health professional. Once completed individually, emerging issues are then discussed in smaller groups. Thereafter, the issues are clustered in the whole group and subsumed under the key headings of quality, for example: environment, technical competence, logistics and supply, communication skills, infection control and management issues. Participants are then asked to draw a simple ground plan of all the rooms and ground space managed by the health post. Two observation groups are formed with the chiefs and HPMC members in one and the less senior staff members in the other, so as to reduce the level of influence or potential domination of the junior staff by the more senior. Each group starts at a different point and makes a tour of the whole site with notebooks, marking down the strengths and weaknesses of the site. They finally come together and discuss the situation. This activity is very valuable in the development of the action plan, since the reality of a site is impossible to ignore when it is straight in front of the participants!

5.4 Prioritising with colours

Since there were so many activities noted it was felt that to gain a truly democratic idea of what the different constituents of the team considered important, each individual would be given the opportunity to make their own decision and the collective result would be worked on. Subsequently a colour coding system was developed in line with clinical systems where red means urgent, yellow means under observation and green means OK for now. This was done with coloured pins but simple colour pens could be used. By enabling everyone to voice their opinion and engage in meaningful discussion, this method created safety for quieter participants by not putting anyone uncomfortably in the limelight. After all the pins were stuck to the board it was easy to see which items took precedence and which could wait.

5.5 Indicators in the action plan

In developing the action plan we decided to include indicators to enable the staff to understand the requirements and desired output of any selected activity. In discussing the indicators they were able to appreciate that 'regular meetings' were not sufficient as outcome indicators, but rather that the effect of the meeting is what should be measured. In

this way we were able to achieve such measurable indicators as 'decontamination solution available and used'. Indicators were deemed necessary in order to focus people's minds on the actual desired outcomes of their selected activities.

5.6 Photographic monitoring

The concept of 'photovoice' has been explored elsewhere (Wang 1998) and was chosen to maximise the visual aspect of this COPEPLA. In this case the photovoice performs two functions: 1. If participants are shown how to use the camera, they are able to photograph things that they themselves, rather than the facilitator, see as significant; and 2. The resulting photographs provide an attractive and compelling account of change from the inception of the COPEPLA process through its various stages of change and can provide good tools for process monitoring. Thus, in one site where the toilets were blocked, the waste was overflowing in the compound and the dressing room was far from perfect, pictures were taken as a reminder of action required.

During follow-up, further pictures were taken to demonstrate improvements or new complications. One site had instigated the use of an oil drum to burn infectious waste as the incinerator was inaccessible in the rainy season. However, the drum was placed next to the incinerator that of course also became inaccessible in the rainy season! Such visual reminders provide stimuli for the participants, service providers and users alike, in that they act as reminders of achievements. The photos will be displayed in the waiting room at the end of the first year as a collage to inspire all.

6 Issues of Sustainability

Sustainability is core to the success of any development programme and it is with this in mind that our participants represent such a broad spectrum. The district supervisors, for example, have a brief to supervise health posts and a budget to support the activity, but in practice this rarely happens. Likewise, the HPMC has a management function and a budget, but its role remains largely theoretical. Through the COPEPLA we are hoping to create an opportunity to expand partnerships between local and District level by activating these systems through their involvement in the process. The

process itself can demonstrate that good quality health services depend as much on good management and supervision as they do on clinical expertise, as well as the importance of the client perspective in quality service delivery. Given the high staff turnover in the health system, this approach also contributes to a longer lasting institutional memory.

By including all stakeholders, we have endeavoured to 'influence upwards' and to provide opportunities for the positive lessons learned to be shared at district level and ultimately central level. Certain HPM members, the village development chairman for instance, represents their village interests at broader district-wide meetings and so can advocate on behalf of the method wherever it is successful. Our past experience with local PLA initiatives has shown that, unless the district health system is involved in the improvement of the site, the change and enthusiasm will remain only at a local level and will therefore quickly lose its impetus.

Generally the health sector is highly verticalised. This means that planning or training is often the domain of clinicians alone. Preliminary results show that broadening the scope for partnership results in an openness and acceptance of managerial responsibility that have hitherto been lacking; perhaps this is because the HPMC members were so rarely involved. Where proof of sustainability is so often discussed in terms of financial issues, our preliminary outcomes have shown that the HPMCs have been willing and able to co-fund activities that they have identified jointly in the action plan, if not the whole fund. In one site, for example, waste management was seen as a priority, and a pit was dug and built according to accepted specifications. The materials for this were provided by the committee and the labour by the local villagers.

7 The Value of COPEPLA in Addressing Issues of Gender and Equity

Nepal is predominantly patriarchal and the staff patterns within the health sector clearly reflect this (Figure 1). The lower down the pay and authority scale, the higher the proportion of women (Butcher 1997). Furthermore, it is precisely at this level that the bulk of PHC work is expected to be delivered.

Only women are encouraged to work in the health sector as volunteers. In addition, when one considers the national literacy rate of 39% (25% for women, 55% for men) any whole site approach including all levels of staff must appeal to a common denominator to avoid further marginalisation of already under-represented populations.

While the process encourages the team approach, if there is no 'team spirit' to start with, three or four days is insufficient to establish it. However, by using more visual methods we were able to minimise domination by male and literate participants. Women and sweepers felt more comfortable with visual material and more able to participate in methods which did not depend on a high level of literacy or large group presentations. By the end of the four-day period the whole team was balanced in its talking time and output. In addition, the inclusion of photographic monitoring encouraged participants to use the camera. The fact that the women were coached and able to take shots was highly and evidently appreciated since such 'technical' matters are generally seen to belong to the male domain.

The client and community interviews were conducted by the team themselves as well as the Health Post Management Committee members. However, since the clients were largely women and the staff and HPMC members largely men, some imbalance was possible. It is difficult to know what the solution to this problem is apart from a strategic effort at policy level to ensure that it is the female HPMC members who attend. Other suggestions have been made (Adriance 1999) that these interviews should reach out to the community served by the health post, especially where formal health services are heavily underused.

8 Outcome of COPEPLA with Regard to PHC services

Does COPEPLA work in addressing the vast area of PHC? The model is still in its early stages and is not beyond further modification, nevertheless the outcome is highly encouraging.

By opening up the questions, general themes of importance have emerged. Fusing the methods has had the effect of diminishing gender and power imbalances and producing actions that are

beneficial to all. In one site, the main topic for the female clients was the need for chairs to sit on in the waiting room. These were supplied a few weeks later by the HPMC. Through the client interviews it became clear that the non-clinicians were getting different responses. In several cases the women said that they had not understood the instructions given to them by the doctor. Because of the initial emphasis on team-building and shared responsibility, we were able to address this and develop a simple feedback loop after the doctor's consultation with the patient. Infection control was also noted as an area in need of improvement. Already at the end of one COPEPLA, workers in the clinic had joined forces with the nurse to write simple guidelines for sterilisation that were attached to the wall for future reference.

It is not only the women health workers, but also the clients, who are more empowered as a result of this method and are therefore more committed to getting involved in change. An example of this can be seen in the need to develop a safer more hygienic method of waste disposal. Waste management was identified through the transect walk as an urgent priority and subsequently a proper pit was constructed for the disposal of infectious waste and a simple oildrum for the burning of papers and melt-down of syringes and needles. The renovation and rehabilitation of the toilet was also given 'priority for action' status. Discussions were held that clearly highlighted the urgent if basic need of developing visual aids/posters to instruct local people how to use the clinic toilet; i.e. to use water not stones or sticks to clean themselves with. The issue of human waste is generally taboo and rarely covered so practically in standard training courses, although in terms of primary health care delivery it is of paramount importance. This system naturally depends on the cooperation of all those active on the health compound, including the woman who runs a small cafe on the premises.

9 Conclusion

In the few sites covered so far, it emerges, not surprisingly, that the most successful sites are those where the Health-Post-in-Charge is a 'champion of change' (World Bank 1998). Where there is generally low motivation to begin with and a low commitment to innovation, COPEPLA can have only a

limited impact. However, where champions of change are present, the potential for change is significant. In one month, one site completed its action plan, erected a photographic account of the status and began to make practical changes. According to the Health Action Model (Tones 1984) the intention to change is a large precursor to actual and sustainable change occurring. From our preliminary attempts it is clear that with a little encouragement and assistance to identify what is possible, rather than what is not, this intention becomes crystallised and action follows soon after.

Like many training approaches, the quality of the result may well reflect the quality of the facilitator. In this process there is a very real need for critical assessment, so that facilitators are able to question the validity of actions chosen or results perceived where there are potential problems. Accordingly, in one site, there was much discussion about incinerators. But it became clear that no-one fully comprehended the true purpose of incinerators and, furthermore, that actions were applauded for their own sake rather than for their contribution to improving quality or effectiveness. Without constructive criticism there is the danger that the

process falls into a self-congratulatory exercise where no real improvements are made.

Follow-up is of paramount importance if the method is to succeed. The facilitator has an ethical responsibility once a team has been encouraged, to continue to support its endeavours, but with regular supportive supervision slowly to distance him/herself when the site is ready to operate on its own through the whole cycle of planning, implementing and replanning. The inclusion of HPMC members and district supervisors means that there is a sustainable system left behind where those legally responsible for the management of the site are included and empowered with a simple and replicable approach to problem solving.

Preliminary results suggest that the COPEPLA process encourages broader partnerships in health, shared financing and demonstrable outputs. By tapping into existing structures, the process serves to strengthen the existing health system. While working with single sites may take longer initially, evidence suggests that in the long run it is a more effective way of producing better quality services, which are responsive to the health needs of the community.

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