CONTENT

1. Background

In terms of quantity, the coverage of basic health facilities in Nepal is sufficient, but basic population health indicators remain alarming. One reason for this is that local people do not use the public health facilities. Services at the Health Posts are affordable or even free of cost, so why are they not utilised?

Imagine your child is sick, and has been losing weight dramatically. You have visited the traditional healer but the situation has not improved. Eventually, you decide to seek professional help. Because you cannot afford a private doctor, you walk two hours to the nearest Health Post. On arrival you find a crowd of people, there is no space to rest, and no drinking water available. Patiently you wait your turn, with the crying baby in your arms. After several hours you are relieved to be called to see the health worker. He examines the baby briefly, administers an injection and tells you to come back the next day. You still do not know what is wrong with your child as you start the long walk home…

The situation may not be quite as bad as this in all health institutions, but most health facilities in Nepal suffer from poor overall physical conditions, and unsatisfactory communication between Health Post staff and clients. A well-run local health facility has the potential to improve the local health situation significantly, and the provision of quality health care services is the basis for mutual trust between staff and clients. As a part of community life, the Health Post can play an important role in creating awareness about health related matters.

To improve the quality of health services at delivery level, the GTZ - Primary Health Care Project (PHCP - now HSSP-PHC[1]) pioneered a new approach in early 1999. Taking inspiration from the Client Oriented Provider Efficient (COPE) process, which has been proven as an effective tool for improving the quality of service delivery in reproductive health services, a new model has been

developed through work done by Kate Butcher and Pitambar Dunghana: COPE/PLA. It combines key components of COPE with Participatory Learning and Action (PLA) methods.

The main objective of COPE/PLA is to improve both the supply and the demand side of the local health system, through enhanced involvement of all key stakeholders. In addition, it recognises the need to maximise the use of local resources rather than depending on external funds. The approach focuses on teamwork and creative problem solving.

COPE/PLA involves the Health Management Committee and the Health Facility staff, including peons. Experience shows that COPE/PLA is an effective tool for helping the team to assess and recognise their own strengths, weaknesses and potential, for empowering service users to take part in the process of service quality management, and for improving the interaction between providers and clients.

After conducting COPE/PLA for more than 2½ years in Health Posts in the districts of Dhading and Siraha, the main visible impacts are:

- Improved drug management and rational prescription of drugs
- Improved service provider - patient communication
- Improved measures for infection prevention and waste disposal
- More efficient management of human resources
- Improved maintenance of facilities
- Greater participation of the community in planning and management
- Increased gender sensitivity
- Improved mobilisation of resources

The most relevant proven impact is that the number of patients has increased dramatically.

[1] In January 2000 the Health Sector Support Programme (HSSP) was launched, integrating the projects: Primary Health Care Project (PHCP), Reproductive Health Care Project (RHP), Physical Assets Management Project (PAMP) and Community Based Drug Management (CBDM).

This document shares the concept of COPE/PLA, the experiences gained and lessons learnt while implementing the approach in Nepal. We strongly believe that COPE/PLA is replicable, not only in Nepal but in many other developing countries worldwide. We have therefore tried to compile all relevant information and tools to enable others to successfully follow this approach.

2. A brief introduction to the public health system in Nepal

2.1 General problems and constraints

The high infant mortality rate of 77.2 per 1,000 live births[2] and the high maternal mortality ratio of 539 per 100,000 live births are indications that the health system is not meeting the needs of women and children in particular. Furthermore, Nepal is one of only three countries in the world where life expectancy for women (57 years) is lower than for men (58 years). This suggests a considerable degree of social discrimination against women. Average life expectancy shows marked regional variations (74.4 years in Kathmandu and 37.4 years in Mugu district in the Mid-Western Region).

Nepal's topographical features, the large number of settlements with little or no infrastructure, the harsh climate in some areas and the caste-based social structure all have a significant influence on the country's health situation. Widespread poverty and poor health care services are also reflected in the nutrition status and vaccination rates among children. 53% of children are classified as chronically under-nourished. National vaccination programmes designed to reduce child mortality reach only about 60% of children.

There has been a steep increase in communicable diseases such as HIV/AIDS, tuberculosis and malaria. The spread of HIV/AIDS is most pronounced among migrant workers in districts along the Indian border and among injecting drug addicts in urban areas.

[2] Human Development Report 2001, UNDP

Demand for public health services is low in spite of the poor health indicators. While there are socio-cultural reasons for this, there are also signs that the present system is not meeting people's needs, least of all the needs of the poor. The following are some of the interrelated factors responsible:

- government funding is not sufficient to provide satisfactory health care;
- government spending tends towards an increase in expenditure on secondary and tertiary care at the expense of primary health care;
- the private sector little to offer in the way of primary health care, moreover, the responsible government authorities have no control over this sector and its growth;
- the health system is unable to carry out the most urgent supervisory and quality control tasks satisfactorily; and is not yet sufficiently decentralised
- the quality of medical and paramedical staff is inadequate and there are too few of them, particularly in remote areas;
- high turnover of staff jeopardises the continuity of care in public health care institutions;
- the supply of drugs is not assured and not in line with needs;
- the buildings and equipment of health facilities are poorly maintained and many of them are not in a usable condition.

Frequent changes of government and the resultant political instability have also impeded the implementation of necessary reforms in the health sector.

2.2 The public health system at local level

There is great diversity in both the demand and the supply side of the Nepalese health sector. The 'Terai', in the South of the country, is a flat and tropical region, which faces different problems from those experienced in the hilly and mountainous parts, where accessibility is often a problem.

The public health system is structured along the same lines as the government administration structure, with five regions, 75 districts and almost 4,000 Village Development Committees (VDC). The Ministry of Health (MoH) is responsible for planning and supervision in the health sector, and the Department of Health Services (DoHS) is responsible for implementing the national health policy. It still operates in a highly centralised way. Responsibilities and authorities are not yet clearly defined for the different levels of health personnel, which leads to poor co-ordination and unsatisfactory implementation.

Primary Health Care is provided by Primary Health Centres (PHC), Health Posts (HP) and Sub-Health Posts (SHP) and District Hospitals. Health Posts were selected as implementation sites for COPE/PLA because they have the greatest potential for positive change and are best equipped to provide good quality primary health care services at local level.

In Nepal, Health Posts (HPs) cover 4 to 8 VDCs, depending upon the population density of the area. On average, each Health Post serves a population of about 20-30,000 people. The ideal staff composition of a Health Post is as follows:

1 Health Assistant
1-2 Auxiliary Health Workers (AHW)
1 Assistant Nurse Midwife (ANM)
1 Administration Assistant
2 Peons

3. An introduction to COPE/PLA

Traditionally, teaching and training in the health sector in Nepal have been associated with the acquisition of theoretical knowledge. Training has been very much a vertical affair with separate training courses for different cadres, and priority given to targets and numbers rather than performance and quality. As a result, a sustainable improvement in the quality of health services has been slow to emerge. Training has increasingly become an opportunity to supplement inadequate salaries with allowances. In the last years there has been growing

commitment by both donors and government to focus on team building, and participatory and learner-centred approaches. Given the new impetus of world-wide moves towards health sector reform, the strengthening of district health systems and decentralisation, we now have more opportunities than ever before to develop partnerships at every level, in order to build up the quality of health service delivery at local level. COPE/PLA is not just another training module. Its activities focus on improving the quality of generic primary health care services at the site level by involving the whole team and other stakeholders.

3.1 What is COPE?

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 on site with the whole team. COPE is a relatively simple technique for improving quality of care. It encourages and enables service providers and other staff at a facility to assess the services they provide jointly with their supervisors. Using different tools, they identify problems, find the root causes, and develop effective solutions. COPE is results-oriented and cost-effective. It does not require large investments of time and does not disrupt service delivery, because some activities are conducted as staff carry out their routine work.

The COPE tools include:

- A series of self-assessment guides
- Client-interview guides
- Client-flow analysis
- Action plan

Since COPE is being successfully used in Nepal and since the concept was considered to be congruous with the GTZ-HSSP philosophy and approach to

Human Resource Development, it was felt that some of the components could be modified to address a broader range of primary health care issues.

Where the original COPE approach relied upon written self-assessment and fairly lengthy interviews, the HSSP adaptation includes more visual methods in order to make it acceptable and accessible to even to those who are only moderately literate.

3.2 What is PLA?

Participatory Learning and Action (PLA) is a derivative of the more research oriented Participatory Rural Appraisal (PRA), which is often used in the field of community development as a method of increasing the control and ownership of local communities over services delivered[3]. PLA is chiefly about increasing local participation and developing approaches to self-help with all stakeholders. Although in Nepal PLA has generally been used more in the forestry and environment sector, we felt that it could be also effective in the health sector.

3.3 The combination of COPE and PLA: COPE/PLA

The synthesis of methods needed 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 walking
- Colour coded activity ranking
- Indicator development
- Photographic monitoring

[3] Schönhuth and Kievelitz: 1994

These simple and entertaining exercises serve a dual purpose: on the one hand to provide crucial information, which enables the team to plan realistically and on the other hand to minimise the risks of the process being seen as 'just another training' or an academic exercise.

Since the process is designed to take place on site it is vital that activities take place during clinic times in order not to disrupt service delivery. The advantage of this is that the process can reinforce the concept of client needs and delivery of services as paramount. The involvement of all site staff - from doctor to sweeper - as well as members of the Health Management Committee has positive results in terms of collective responsibility and an increased understanding of the interdependence of all actors.

Case study:

COPE/PLA and the Mahadev Bensi Health Post in Thakre/ Dhading District

When we entered the Mahadev Bensi Health Post in Thakre for the first time, we were greeted by a mess! First, our tall training co-ordinator was caught in a spider web. Taking a closer look at the facility, we found an old rusted kit tank lying on the floor for keeping used syringes, bandages and cotton balls. A mobile tray with a wash basin was kept in the corner of the dressing room without any disinfecting solution or even water. Some rusted forceps and knives were half immersed in a boiler. Entering the storeroom, we found large cupboards filled with medical equipment, dressing sets and delivery kits - obviously untouched for some time. Two other rooms were completely empty, yet the office of the Health Post incharge was utilised not only for administration but also for service delivery, and as a common room.

The Health Management Committee had been in place for a long time but was evidently non-functioning. The members not only failed to provide patients with a clean environment but also did not even meet regularly. In fact, they have not held a management meeting for two years. Within the Health Post, the working relations among the staff were not supportive of smooth delivery of health services. As a result, the number of patients was very low, since no-one expects to receive adequate treatment in a filthy place. Clearly it was time to improve the situation, time for COPE/PLA.

On request, we conducted a four-day COPE-PLA workshop. At first it was very difficult to achieve full participation of all staff members. Some were busy with other work, and support staff were insecure about interacting with senior staff members. However, the entertaining exercises and different steps of COPE/PLA gradually drew the attention of the participants. By the third day, the trainers had created an atmosphere in which staff and HMC members were able to discuss the urgent and sensitive topics in a

constructive manner. On the fourth day they came up with an action plan for the following months.

Four months later…

When the COPE/PLA trainers came back for a follow up they could hardly believe their eyes. The Health Post building and the compound looked neat and friendly, with curtains on the windows and doors. On the outside wall the team also noticed a new sign informing the public about the health services available. Inside, the job responsibilities of each staff member were displayed in a way which everyone could understand. According to the action plan, available rooms and space had been re-planned and allocated for different services i.e. mother and child health room, delivery room, patient check-up room and an administrative table.

The overall standards of hygiene had improved dramatically within this short time: The former rusty kit tank had been replaced, disinfectant solution was available and used, separate bins for combustible waste and a safe disposable box for syringes and broken glasses were in place. The staff members proudly informed the team about the newly introduced waste management system. Combustible waste from the health facility was burned regularly and non-combustible waste and glass was buried in a deep pit.

Not only visible improvements had been made, also many changes in management. A new Health Management Committee, with 40% women members, had replaced the former idle committee. Its first action was to regularise and institutionalise meetings. Very soon health awareness activities were organised in different communities, and in return for these efforts the villagers gave their support in providing repair and maintenance services for the health facility. Local communities put pressure on their elected local bodies to release the budget for construction of a building for reproductive health services and staff quarters. The new committee also managed to annul the proposed transfer of one staff member working in the area of reproductive health by directly addressing the Department of Health Services.

We were impressed by the active role played by the female members of the new Health Management Committee. In only one year they had mobilised mothers groups for environmental health activities and were able to generate additional local funds. Due to their engagement poor people now have access to health services free of cost and victims of road accidents are also supported.

The COPE/PLA team was keen to see whether the improvements in the overall management of the Health Post had produced an impact on health service seeking behaviour. Members were surprised to learn that the number of patients had almost doubled in four months. People were even willing to pay a registration fee of three instead of former two rupees, because of the improvement in quality of services, and the awareness that generation of more funds for medicine and other logistic supplies was necessary.

The first COPE/PLA session was held in October 2000. Coming to Mahadev Bensi regularly we are delighted to see that one year later, the enthusiasm of the staff and management committee has not vanished and the patients and villagers are still supporting and utilising **their** Health Post.

4. Putting COPE/PLA into practice

This chapter describes the COPE/PLA process as it is currently in practice.

4.1 COPE/PLA orientation for the district health team

Before conducting the first COPE/PLA session in a district, it is essential to orient the district health team on the approach to ensure their commitment and support. The District Health Teams in Nepal usually consists of:

- District Health Officer (DHO)
- Public Health Officer (PHO)
- District Supervisors
- Public Health Nurse
- Family Planning Assistant
- Statistical Assistant

In a one-day orientation, the team is familiarised with the approach and the tools of COPE/PLA, and roles and responsibilities are clarified. The master trainer facilitates the orientation, which has the following main topics:

- Concept of quality health services
- COPE/PLA approach
- Target groups
- Tools and processes
- Selection criteria for health facilities
- Roles and responsibilities of the district team

The district supervisor then carries out a need assessment in the health facility, and informs the District Health Officer of the outcome. The DHO requests technical assistance from supporting agencies, or conducts the workshop through the local district health staff. The DHO also communicates the process to interested health management committee members, and finalises the date for implementation.

4.2 The site: Health Posts

All staff members of a Health Post, from the in-charge to the peon and including the field workers, are invited to the four-day workshop. In addition, those who rent premises on the health site compound, such as teashop keepers or private pharmacists, are also invited. Members of the Health Management Committee and the district supervisors are also involved. The HMC comprises senior health post staff, the local VDC chairperson, the most senior local teacher, a local entrepreneur, a ward member and the female community health volunteer. Its function is the management and support of the facilities, for which it holds a small budget. The involvement of the district supervisor is essential, because he can assist the Health Post staff to put the action plan developed into practice, and to access the necessary support from the District Health Office.

4.3 The Facilitators

Two to three facilitators are needed for COPE/PLA and the follow-up workshops. As with many other training approaches, the quality of the result depends on the quality of the facilitator. In the COPE/PLA process there is a 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. Without constructive criticism there is a danger that the process may fall into a self-congratulatory exercise, with no real improvements being made.

4.4 Practical elements of COPE/PLA

The different elements build on each other, and therefore the sequence should not be changed. A detailed outline of a COPE/PLA four-day session is given in the curriculum. The whole session starts with an ice-breaking game to introduce participants to each other. Sharing expectations and the general objectives of the workshop follows this. The COPE/PLA exercises are simple, entertaining, participatory and accessible even for the non-literate.

4.4.1 Role-Play: Orientation to the COPE/PLA concept and process

The role-play is an excellent method of becoming familiar with the COPE/PLA approach and sensitising participants to problems by changing their perspective. Selected players receive a 'role card', so that one acts as a health worker and another as a patient; the other participants watch the scene. The play is followed by a plenary discussion. Based on this the facilitator explains the concept of quality health services, and together with the participants develops elements of these services and deduces common client rights and provider needs. Finally, the facilitator points out how COPE/PLA can help to reinforce progress towards quality health services in the facility.

4.4.2 Introduction and Discussion: Quality of Health Services

Based on the role-play, the facilitator introduces the issue of Quality Health Service. Participants are asked to express what kind of service they would expect to receive if they were sick. Their responses are discussed and grouped as client rights. Participants are then asked how these can be met. Typical answers to the question of expected services are:

- Proper diagnosis and medicine for complete treatment
- Friendly behaviour of health workers
- Clear information about the use of the prescribed medicine

Quality of Health Services

Clients have the right to:

- Information
- Access
- Choice
- Safety
- Privacy and confidentiality
- Dignity and comfort
- Continuity

Providers have a need for:

- Good supplies and site infrastructure
- Good management and supervision
- Information, training, and development

Examples of agreed definitions of quality health service read as follows[4]:

- Quality service is the sort of service staff members would want to receive or would want their spouses, their parents and children to receive

- Quality is about meeting client needs and allowing staff to work more efficiently

- Quality improvement requires ongoing attention - it is not attained by one meeting or one training session, but should become a part of daily work

- A service that is delivered in a safe way by a competent provider in a friendly and clean environment using appropriate equipment with sufficient information[5]

From the role play and discussion, leading to agreement about elements of quality services, it soon becomes clear that this can be reached only by working in a team in which everybody is committed to improve the situation in the facility.

The module on Quality of Health Services is the core part of COPE/PLA because it sets the general targets. The targets are specified through different self-assessment exercises. In the following session the participants become familiar with the tools and components of COPE/PLA, and learn how these help to identify strengths and problems. Our experience shows that if the COPE/PLA concept and approach is not clear to the participants they are hesitant and reluctant to be open and honest in the self-assessment tasks.

[4] Source: AVSC International - COPE, 1995
[5] Source: Health Quality Assurance in Nepal, Health Institution and Manpower Division, Kathmandu, Nepal 1996

4.3.4 Client Exit Interviews

A common opinion voiced among service providers is that the clients are illiterate and cannot articulate the distinction between a quality service and a poor service. However, often the exit interviews revealed that clients have a clear vision and expectation of the health services.

From the selected pilot sites, clients considered the most important elements of a good service as:

- cleanliness and hygiene on site
- prompt service
- fair service
- useful information about the cause and possible prevention of the problem
- sufficient consulting time with the service providers

The purpose of the interviews is to obtain relevant suggestions and feedback from clients and community members. The client interview consists of open and closed questions. (see annex 1 for example)

Together with the self-assessment, the interviews form the baseline data, which are later used in problem prioritisation, and during the follow-up workshops.

4.4.4 Creative team building

The team building component is considered very important as many health teams are hierarchical and there is often a limited sense of teamwork. For most Health Post teams it is the first time they have closely interacted with each other, especially with the support staff. The exercise takes place on the first day, to demonstrate in practical terms the value of a team approach.

- **Tower Building Game**

During the first workshops conducted in the early years, HSSP realised that team building is very difficult among staff members and management committees, because of the entrenched hierarchy, which prevents the development of a co-operative working atmosphere. Eventually, we found the 'Tower Game' to be the most effective way of developing team spirit. Participants are split into small teams and given the task of building a tower out of the material provided. Each material has a certain price, so the cost of each tower can be assessed afterwards. The team whose tower is most stable made in the shortest time by using the least resources is the winner. This exercise has proven to be highly useful at the final planning stage. When it comes to 'action planning' we can demonstrate clearly that 'lack of resources' does not automatically constitute an insoluble problem.

- **Skills mapping**

To reinforce the idea of team work, the 'skills mapping exercise' follows the “Tower Building Game”. It is designed to visually emphasise the different contributions which team members make, by representing their different skills in picture format. If the picture of one individual is removed the skills s/he offers also disappear and the team fails to function as efficiently as before. This shows how much the different members of a team can complement each other and allows individuals to appreciate the contribution each person can make.

4.4.5 Self-Assessment

The self-assessment is the most important part of COPE/PLA and the key to ownership, because the assessment is not done by 'outside experts'. The staff and the committee members themselves identify what kind of services they offer and analyse the shortcomings and bottlenecks. They are not told how to overcome the problems, but must decide this for themselves. This should be emphasised right from the beginning of the workshop, as participants should not

feel that the facilitators are judging them. It is therefore one of the principles of HSSP to conduct COPE/PLA only when requested by the health facility and the Health Management Committee. HSSP has developed some guiding questions for the facilitator (see annex 2), which are handed over to the Health Post afterwards, to be used as a check-list on quality health services (which is of course in Nepali language).

- **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. Participants draw a simple ground plan of all the rooms and ground space managed by the HP. Two observation groups are formed with the chiefs and HMC members in one group and the less senior staff members in the other. This division is made to reduce the level of influence or potential domination of the junior staff by the more senior. Before beginning the walk the participants are requested to be honest and focus on quality health issues. Each group starts at different points and makes a tour of the whole site with notebooks marking down the strengths and weaknesses of the site. Each group critically assesses different sections of the health facility as well as the compound, water resources, toilet and waste deposit facilities. It is important to not only focus on problems, but also to explicitly point out positive things such as 'emergency service is available 24 hours', 'new community drug shop on the compound' or ' well-managed herbal garden'.

After the walk, which takes about 2-3 hours, the group finally reunites and discusses the findings. Thereafter, the issues are clustered by the whole group and grouped under the key headings of quality, i.e: environment, technical competence, logistics and supply, communication skills, infection control and management issues. This activity is very valuable in the development of the action plan, since the reality of a site is impossible to ignore when placed in front of the participants.

4.4.6 Prioritising the Problems

All problems identified in the transect walk and from the interviews are displayed on a board. Participants are asked about severity and urgency of the problems and possible resources and time frame needed to solve them. Five coloured pins are provided to each participant for prioritising the constraints. Red means 'urgent', yellow means 'under observation' and green means 'OK for now'. This can also be done with coloured pens. After all the pins have been stuck onto the board, it is very easy to see which items need urgent action. On the basis of this prioritisation, the action plan will be developed.

4.4.7 Action Plan Development

Development of a four-month action plan concludes the COPE/PLA workshop. The format is not fixed, participants can adjust it according to their needs. Below is an example of such a plan:

Action Plan: Kalyanur Health Post, February to May

Problem	Action	Time Frame	Respon. Person	Indicator
HP compound is dirty	Construct a waste disposal pit	2nd week of March	D. Gurung	Pit constructed and in use
Patients do not know what services are offered in the HP	Provide complete information about available services: - display available services on a board	Regularly update	Health Post Incharge	Community is informed and requests services

- **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 but that the outcome of the meetings is what should be measured. In this way we were able to achieve such measurable indicators as 'decontamination solution available and used'. Indicators are necessary in order to focus people's minds on the actual desired outcomes of their selected activities. A detailed action plan is given in annex 3.

4.4.8 Photographic monitoring

The concept of photovoice[6] was chosen to maximise the visual aspect of COPE/PLA. It performs two functions: 1) by learning how to use a camera participants are able to photograph things which they themselves perceive as significant, rather than following the facilitator's ideas and 2) the resulting photographs provide an attractive and compelling account of change from the inception of the COPE/PLA process though its various stages of change, and can provide good tools for process monitoring. Thus at one site, where the toilets were blocked, waste was overflowing in the compound and the dressing room was far from perfect, pictures were taken as a reminder of the 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, which of course also became inaccessible in the rainy season! Such visual reminders provide a stimulus for service providers and users alike. The photos can be displayed as a collage in the waiting room at the end of the first year, as an inspiration for all.

[6] Wang 1998

4.5 COPE/PLA follow-up

Once the COPE/PLA approach has been initiated in a health facility, and handed over to the local stakeholders, it becomes a continuous process. In the initial stages, every three to four months the health management team arranges a date for a follow-up session with the trainer. After a few sessions, the management team is able to conduct these without the trainer. The elements and objectives of the workshops are as follows:

- Evaluation of the success of the last action plan
- Identification of unsolved problems and their causes
- Identification of new problems and adjustment of priorities
- Revision of the action plan

The participants of the workshop are all the members of the health management committee and the Health Post staff. The Health Post incharge is usually the co-facilitator.

The follow-up is of paramount importance if the method is to succeed, and should be held every three to four months. The facilitator has an ethical responsibility, once a team has been encouraged to begin working with this approach, to continue to support its endeavours with regular supportive supervision, and to slowly distance him/herself when the site is ready to operate independently.

5. Issues of sustainability

Sustainability is critical to the success of any development programme. Through COPE/PLA we hope to create an opportunity to extend partnerships between the district and local level by involving the district supervisor and the HMC.

The COPE/PLA process demonstrates that good quality health services depend as much on good management and supervision as they do on clinical expertise,

and the importance of including the client perspective in quality service delivery should not be overlooked. Given the high staff turnover in the health system this approach also contributes to a longer lasting institutional memory.

By including all stakeholders, a bottom-up approach is established providing opportunities for the positive lessons learnt to be shared at district and ultimately central level. Certain HMC members, like the VDC chairman, represent the village at district meetings, and can thus advocate the method. Our past experience with local PLA initiatives has shown that unless the district health system is involved, enthusiasm will remain only at local level and therefore quickly lose its impetus.

The outcomes of COPE/PLA have further shown that the HMCs involved are willing and able to co-fund or even completely fund activities which they have jointly identified in the action plan. At one site, waste management was seen as a priority and a pit was built according to accepted specifications. The materials were supplied by the HMC and labour was provided by the local villagers.

In Dhading district, the District Health Development Board found COPE/PLA so useful, that they have decided to extend it to all remaining Health Posts, which are not yet covered, within one year. These activities will be financed out of the district's regular budget with some additional sources of funding.

Knowledge Transfer through COPE/PLA

One important result of COPE/PLA is the provision of ante natal check ups (ANC) in several Health Posts, as the example from a Health Post in Lahan illustrates. During the COPE/PLA session the staff and HMC members realised that ante natal care should be offered regularly, but the HP was not in the position to fill the vacant post required to offer this service.

Due to human resource constraints, the HP was only able to provide the services of an ANM (Assistant Nurse Midwife) for 1 day per week. As demand increased the ANM needed support. The solution was a wider rotation system, using MCHWs (Mother and Child Health Workers) from a number of nearby Sub Health Posts to support the ANM for a month at a time each. As there is no provision for an ANM in SHPs, they are not able to offer antenatal care, but with this arrangement the MCHWs were able to learn from the ANM and then utilise their new basic knowledge at their own SHPs.

6. The value of COPE/PLA in addressing issues of gender and equity

Society in Nepal is predominantly patriarchal, and this is clearly reflected in the staff patterns within the health sector, as the proportion of women increases significantly at the lower end of the pay and authority scale. It is also noticeable that women are encouraged to work in the health sector as volunteers. In addition, when one considers the national literacy rate (for women this is only 25%), any whole site approach which includes all levels of staff must be pitched at an appropriate level in order to reach everyone and avoid further marginalisation of already underrepresented groups. In COPE/PLA, this was achieved by using visual methods, which minimised the domination by male and literate participants. Women and support staff felt more comfortable with visual materials, which did not depend on a high level of literacy or large group presentations. and were thus more able to participate in activities

7. Limitations

The process encourages a team approach but this requires willingness and a certain degree of established team spirit, which takes more than three or four days to establish.

Where there is low motivation and a low commitment to innovation COPE/PLA can have only a limited impact. However where 'champions of change' are present the potential for change is significant.

The aim was to cover all main Health Posts in the two districts of Dhading and Siraha, but this was not achieved because of several factors:

1) Time and personnel constraints in the districts: conducting COPE/PLA requires the presence of all staff members and the Health Management Committee, and it was often not possible to find dates suitable for all. Some

Health Posts are not fully staffed, especially in the remoter regions of the districts, and in such facilities it is not possible to use COPE/PLA .

2) Follow-up: regular follow-up is essential to ensure success with COPE/PLA, but this is time consuming for all parties - the Health Post staff, HMC members and facilitators. Also, the follow-up requires 2-3 experienced facilitators, and only a limited pool of these is available and affordable.

8. Conclusion

The COPE/PLA process encourages broader partnerships in health. By tapping into existing structures the model serves to strengthen the existing health system. Working with single sites may take longer but in the long run it is a more effective way of producing better quality health services which are responsive to the health needs of the community.

COPE/PLA provides an opportunity to identify the strengths and weaknesses of a health facility. It provides a forum and the inspiration for interaction, problem identification and problem solving among staff and management committee members.

In general peons are not included in internal discussions and meetings, but COPE/PLA provides an opportunity for them to participate and contribute to the improvement, especially in the area of infection prevention and waste disposal.

The transect walk was been found very practical by participants, enabling them to more fully understand the facilities and equipment at the Health Post. They learned about the working areas of their colleagues, and became more aware of the importance of each other’s work. Thus COPE/PLA increases the motivation of staff. However, continuous follow-up and support from the DHO and the management committee is essential to maintain this.

A training programme is always an extra burden for staff. Conventional training programmes have limitations in their design and potential for addressing the practical requirements of service providers, because they are often conducted in isolation from the real work environment. Since COPE/PLA is conducted within the working environment staff are able to see the immediate positive impacts of the training.

It is essential that COPE/PLA is conducted within the health facility during opening hours. If an outside venue is used it is not possible to address the real problems. This approach also ensures that the delivery of health services is continued.

The supervisor from the District Health Office should regularly monitor and support the site staff. It is therefore important that the supervisor participates in the workshop whenever possible.

Annex 1

Client exit interview

The facilitator hands out a guiding questionnaire, which is as follows:

When did you visit this Health Post last time?

Why did you come to the Health Post today?

Did you get the services you expected? If not, why?

Have you been given information about the services available in this facility?

Can you explain to us how to use this medicine/ contraceptive? (show sample of prescription/ instruction leaflet)

What do you like best about this Health Post?

What do you like least about this Health Post?

What suggestions do you have to help us to improve the services in this Health Post?

Is there anything else you would like to tell us?

Annex 2

Self-assessment guiding questions

Client-Provider relationship

1. Do all staff members know which services are offered in this facility and in the closest referral facility?

2. Is your facility as active as possible in informing clients about other related services?

3. Are there enough educational activities/ information on various health topics to engage patients while they are waiting?

4. When a patient/ client is provided with medicine or contraceptives is s/he told:

- How to use it?
- Potential side effects?
- Potential complications and how to identify them?
- Management of side effects?
- Required follow-up?
- Re supply?

5. Do staff ask the clients whether they have understood the information regarding treatment? Are they asked whether they have additional questions?

6. Do staff try to minimise the number of visits the patient has to make?

7. Does the facility provide appropriate choices in the health service, i.e.:

- Counselling and physical examination form male/ female health workers as appropriate
- Referral services available
- Treatment regime

8. Is there private space where the clients will not be seen or overheard during examination/ communication with the health worker?

9. Do staff respect confidentiality?

10. Is the access to client records strictly controlled?

11. Are clients treated the way you would want to be treated?

Technical quality

12. Do staff think they get enough guidance, back-up and updates?
13. Are staff able to get technical support when needed?
14. Are staff well informed about the potential reaction to medicines they dispense?
15. Are disposable needles and syringes used whenever possible?
16. Are reusable instruments sterilised or highly disinfected before being used?
17. Is contaminated waste disposed in a safe way?
18. Do staff uses antiseptic techniques when performing injections, IUD insertions etc.?
19. Are needles and sharp objects placed in safe containers?

Physical Infrastructure and environment

Are there hand washing facilities?
Is the facility in general clean?
Is there a toilet on the site, which can be used by clients and providers?

Logistics, supply, equipment

Are all medicines and contraceptives within the expiry date?
Does the facility have enough supplies to offer services on a regular basis?
Do staff feel that the equipment is in a good condition?

Management, administration, reporting

Do staff routinely report and review clinical practices
Are there regular staff and HMC meetings and a functioning documentation system?
Is supervision considered adequate?
Does the HMC/ DHO provide constructive feed back?
How does the community feel about the Health Post?

Annex 3: Abbreviations

ANM	Assistant Nurse Midwife
COPE/PLA	Client Oriented Provider's Efficiency - Participatory Learning and Action
DDC	District Development Committee
DHDB	District Health Development Board
DHDF	District Health Development Fund
DHMP	District Health Master Plan
DHO	District Health Office(r)
DHS	Department of Health Services, MoH
EHCS	Essential Health Care Services
FCHW	Female Community Health Worker
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit/ German Technical Cooperation
HA	Health Assistant
HMC	Health Management Committee
HMG/N	His Majesty's Government of Nepal
HP	Health Post
HPIC	Health Post in Charge
HSSP	Health Sector Support Programme
INGO	International Non Government Organisation
LSGA	Local Self Governance Act
MCHW	Maternal and Child Health Worker
MoH	Ministry of Health
NGO	Non Government Organisation
NGOCC	Non Government Organisation Coordination Committee
NHTC	National Health Training Centre
PHC	Primary Health Care (Project)
PHC	Primary Health Centre
PLA	Participatory Learning and Action
RH	Reproductive Health
SHP	Sub Health Post
SHPI	Sub Health Post In Charge
TA	Training Assistant
TBA	Traditional Birth Assistant
TOT	Training of Trainers
TTBA	Trained Traditional Birth Assistant
TWG	Technical Working Group
VDC	Village Development Committee
VHDB	Village Health Development Board

Annex 4: References

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