Strategic Mapping: A Consensus-Based Approach to Strengthening Program Implementation

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A Consensus-Based Approach to Strengthening Program Implementation

Advance Africa

USAID
FROM THE AMERICAN PEOPLE

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A Tool for Consensus-Building to

Strengthen Program Implementation

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Acknowledgements

Advance Africa first introduced the Strategic Mapping Tool in Senegal in 2001 where Management Sciences for Health (MSH) has been playing an essential role in strengthening family planning and reproductive health (FP/RH) programs. Since that time, the tool has been used to revitalize FP/RH programs in Angola, Benin, Rwanda, and Senegal. This guide reflects the experiences of users and facilitators in these countries.

The authors would like to acknowledge and thank the World Health Organization for *The Strategic Approach to Improving Quality of Care in Reproductive Health Services*. The Strategic Approach inspired various stages of development of the Strategic Mapping Manual.

This edition of the Strategic Mapping Tool has evolved from the work of its original developers with more recent contributions from experts who provided insights into the final version. Issakha Diallo, Advance Africa Project Director, guided the development of the Strategic Mapping Tool throughout the process, with ongoing input from Nina Pruyn. Significant contribution was provided by the original developers: Jeanne Brown (who led the initial development), Belkis Giorgis, Nagbandja Kampatibe, Youssouf Ouedraogo, Lauren Pindzola, and Agma Prins. Berengere de Negri made major technical contributions to the recent version. Saul Helfenbein contributed his vision and technical comments. Elvira Beracochea coordinated the development of this edition which was written by Linda Tawfik. Samantha Ender edited the manual and, with Nina Pruyn, conceptualized and developed the Strategic Map. Lori Wieder produced the graphic designs. We would like to thank the following individuals who were involved in the original mapping exercises in Angola, Rwanda, and Senegal: Kwame Asiedu, Miho Sato, and Susan Veras.

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Contents

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CPR	Contraceptive Prevalence Rate
FP/RH	Family Planning/Reproductive Health
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MSH	Management Sciences for Health
PMTCT	Prevention of Mother-to-Child Transmission
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United National Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

Preface

Implementing family planning and reproductive health (FP/RH) programs in sub-Saharan Africa has become an increasingly complex challenge for program managers. The purpose of family planning has been expanded and refocused over the last few decades. Reproductive health is a new challenge in the context of HIV/AIDS. New approaches to managing programs in the short-term are increasingly useful.

Planning for the short-term (a year or less) requires a flexible approach such as that provided by Strategic Mapping. Strategic Mapping gives FP/RH programs the tools that allow them, in a short period and at low cost, to assess the performance of, or specific aspect of, a project or program in order to identify gaps and opportunities for repositioning their programs.

Managers today, in all fields including public health, are swamped with massive amounts of data and information. It is difficult to filter and select that which is necessary to make the right decisions at the right time. When we recognize that the ultimate goal of any decision is its effective application and successful outcome, we will understand that it is crucial to ensure the full involvement of the potential stakeholders in decision-making. The real challenge is finding the most effective ways and means to involve a maximum number of stakeholders in decisions and deliver expected results in a timely manner.

The situation for public health managers is more complicated. Public health is a field in which no one alone, even the most talented and qualified person, can deliver expected outcomes. In addition, public health managers must deal with unstable political and social environments in many countries, particularly in Africa. Program managers in these countries experience frequent changes in their workplaces, at times losing their jobs, due to high turnover of key decision-makers, including ministers and executive directors. These changes often require rapid changes in management strategy.

Success in public health outcomes absolutely requires team work with a multi-sectoral and multidisciplinary approach. No single specialty can cover the various determining factors at the root of any public health problem. The concept of consensus-building should be a priority for any public health manager, and those involved in public health problem-solving must communicate effectively to continuously seek consensus in decision-making. Consensus-building ensures all stakeholders are informed, engaged, and fully understand the issues. The Strategic Mapping Tool strives to assist public health managers achieve consensus-building in program development. Strategic Mapping, in the context of FP/RH, is an opportunity to quickly **visualize** where action is required. It provides a methodology for **participative involvement** and decisions reached by consensus. Its application requires willingness and commitment to involve all stakeholders, to fully communicate with each other, and to gain consensus for the achievement of common goals and for the benefit of people in greatest need for good health.

How to Use this Guide

This guide provides information on how to conduct Strategic Mapping for FP/RH programs. While it is particularly valuable now for FP/RH programs that need strengthening, its flexible approach can be used to design and direct many types of health programs. The text describes the Strategic Mapping concept, process, and tools. The guide includes all necessary materials, both in print and on CD-ROM, for using the Strategic Mapping process to create visual images of information on family planning programs and gaps. Using these "maps," program managers can then develop action plans through a consensus building process.

The guide can be used by:

- Organizational directors who will be overseeing a Strategic Mapping process to rapidly assess and plan for an improved program

- Facilitators who will be conducting the process and helping to build consensus among participants

- Individuals who want to learn about Strategic Mapping to consider a new approach for rapidly diagnosing core program problems and solving them within a short time frame

This Strategic Mapping tool can be used for self-assessment or a technical assistance organization to assist health sector managers and donors refocus efforts. The manual is based on a mapping approach used in selected FP/RH programs Africa, but can readily be adapted for other types of health programs and different regions of the world

The guide is presented as follows:
Introduction. The Introduction explains Strategic Mapping and why it is a valuable approach to improving FP/RH programs in an era of rapidly changing environments and HIV/AIDS. This section introduces several case studies from Advance Africa's work in Senegal, Rwanda, Benin, and Angola. They are illustrative to help you understand how the Strategic Mapping approach and tools can be used.

Methodology. The Strategic Mapping Methodology describes the three phases of the process and the specific activities, tools, and outputs involved at each phase. It shows how the process works in reality, using examples from Angola, Benin, Rwanda, and Senegal.

Facilitators' Plan. The Facilitators' Plan is a guide for implementing the entire Strategic Mapping process. This plan is a synthesis of the experiences of previous facilitators. It is not a rigid set of timetables and instruments, but a flexible structure for selecting a critical FP/RH issue, creating maps, adapting them to the specific situation, and using a participative process to operationalize a plan that is implemented and monitored. The Facilitators' Plan includes illustrative data collection instruments and maps that can be used or adapted as needed.

Follow-Up. Follow-up Activities are to ensure that the Strategic Mapping Phases 1 and 2 evolve into Phase 3 and that the process continues as a cycle.

INTRODUCTION

In an era of rapidly changing environments and HIV/AIDS, the need for coherent, innovative, flexible and participatory management strategies is apparent. Recent trends in program management, however, have generally focused on the development of "fixed" long-term strategic plans. Such plans have not proven effective in the current sub-Saharan African context. To develop a successful approach to FP/RH service delivery in these unstable times, **new emphasis** needs to be placed on **strengthening and monitoring** ongoing programs **in the short term** to maximize results.

To more effectively respond to change, FP/RH program managers must be able to:

- Regularly define their program activities
- Clarify and coordinate stakeholders' roles
- Build the morale and skills of their team
- Improve communications strategies and effectiveness

To offer program managers a flexible way to meet these objectives and strengthen FP/RH program implementation, Advance Africa has developed the Strategic Mapping tool as one of several approaches to increase contraceptive prevalence rates, improve the quality of FP/RH programs, and enhance their sustainability. The Strategic Mapping application permits not only the identification of gaps and weaknesses of ongoing activities, but also opportunities such as best practices, best programs, or promising interventions, brought to scale. It can also simply identify an innovative way to scale up interventions and identify many other opportunities related to reproductive health program implementation. These opportunities facilitate the integration of family planning into other reproductive health services and priority programs to strengthen service performance.

What is Strategic Mapping?

Strategic Mapping is an innovative way to rapidly assess and plan FP/RH activities, based on what is most likely to work. It brings together professionals with different levels of responsibility and from different sectors to analyze all available data relevant to their program. Using this approach, they can then reach consensus about program **gaps**, weaknesses, and **opportunities** that are displayed on **visual maps**. The consensus building fosters coordination and teamwork, and the research analysis allows participants to draw upon available human and financial information and resources in order to discover and apply appropriate corrective measures using existing resources. While the primary objective of Strategic Mapping is to strengthen FP/RH programs, it can also be applied to various other health and non-health programs.

The accelerating pace of change everywhere, including Africa, requires the creation of "fluid maps" and methods to manage performance that continually stress change and shifting directions

The Added Value of this Approach

Strategic Mapping is often incorrectly considered to be a research exercise because one of its initial steps involves data collection. In fact, the purpose of this step is to verify information upon which to base plans that will then lead to concrete actions. Strategic Mapping uses the results from existing quantitative and qualitative studies relevant to the topic. It then compares this information with interviews of the program stakeholders and beneficiaries, as well as with observational data collected on site visits. Together with these same stakeholders, the aim is to build consensus on what the priority gaps, weaknesses, and opportunities are. Then, through group planning, specific corrective activities are determined with measurable outputs that can be monitored.

Strategic Mapping is different from other planning approaches in several ways. First, it is a way to study the whole system from a broad perspective to gain an understanding of program gaps and linkages. It focuses on filling these gaps and/or strengthening FP/RH programs by using maps as a **visual tool** to look at the "whole picture."

Gaps in current programs become evident very quickly. By bringing together various stakeholders from within the health sector, as well as those from other sectors addressing FP/RH issues, the highly **participative** process encourages better program coordination across multiple levels, among parties with diverse interests and program objectives. It promotes local ownership of problems and solutions agreed upon through **consensually** developed action plans. Moreover, Strategic Mapping focuses on strengthening ongoing programs using **existing resources** among multiple partners to achieve maximum effectiveness. The process can be used in an ongoing, **revolving cycle** of rapid assessment, planning, and action.

The Strategic Mapping Framework

Strategic Mapping begins with the introduction of a Strategic Framework (Figure 2). This framework lays out four key factors of quality FP/RH service delivery: **quality, demand, access, and sustainability.** These four factors cut across other dimensions of the system – clients, service providers, organizations, sectors, programs, and policy environment, as well as the broader socioeconomic context – to determine the health outcomes of men, women, and children. Strategic Mapping is a way to analyze problems and opportunities related to quality, demand, access, and sustainability to effectively develop improved interventions.

Visualizing Information with Maps

In order to better visualize information collected, analyzed, planned, and summarized, you can use several types of maps, such as a:

- Data Map: A data map lays out the data. It can be a *textual data map* or an *analytical data map.* A *textual data map* lays out information you have collected in the form of text. An *analytical data map* allows you to visualize gaps and opportunities based on a map using "yes" or "no" (+ or 0) to define whether the program offers or lacks key program components.

- Action Planning Map: An Action Planning Map is a matrix used to identify the activities, responsible parties, timeline, outputs, indicators, and assumptions to address priority gaps and opportunities.

- Strategic Map: A Strategic Map is the final representation of your work, representing the information collected, analyzed, and planned to meet the desired results.

Figure 1. Strategic Framework

STRATEGIC MAPPING METHODOLOGY

Engaging Stakeholders

The Strategic Mapping approach is based on a fundamental principle that all key stakeholders should be committed to the process. These include the host country institution such as the Ministry of Health (MOH), other relevant ministries at the national level, bilateral and multilateral partners, and various international and national participants involved in FP/RH interventions in the country. Organizations and agencies not previously involved in FP/RH activities may be considered as well, especially if the repositioning of family planning is an objective of this exercise. Stakeholders will be specific to each country. It is vital to engage them at the outset of and throughout the mapping exercise.

Defining the Problem

Strategic Mapping begins by defining the main problem to be addressed in the FP/RH program. The lead institution responsible for the initiative usually should define the central problem or the issue to be explored. In sub-Saharan Africa, the high maternal mortality rate can be considered the overarching problem. The lead institution in a certain country, however, may specify a more service-oriented issue. Examples are:

- Integration of STI/HIV/AIDS services with other FP/RH services
- Low contraceptive prevalence rate
- Overemphasis on demographic outcomes or “population control”

Case studies from Senegal, Rwanda, Benin, and Angola show how the central problem was defined for each country.

Senegal: Integration of FP/MCH and STI/HIV AIDS Services

Senegal is fortunate in being the sub-Saharan African country with the lowest incidence of HIV/AIDS (less than 2% according a 2001 UNAIDS report). The spread of the pandemic has been controlled due to a number of factors, including an early response by the government in 1986. However, Senegal is at the same level as most other west African countries with regard to its contraceptive prevalence rate, which stood at 8.1% in 1999 according to the Demographic and Health Survey.

Senegal has decided to integrate the activities of its HIV/AIDS and FP/RH programs at the operational level in order to avoid disadvantages of vertical programs. With a concern that integration could potentially run the risk of eroding results in either of these programs, the Senegalese government, in agreement with the USAID mission in Dakar, asked Advance Africa to initiate a strategic mapping exercise for this integration.

During a preliminary mission conducted by Advance Africa in October 2001, the stakeholders expressed many concerns. The most significant were:

1) *Insufficient integration of STI/HIV/AIDS activities with RH/ FP activities in the field.*
2) *The desire for more synergistic action among the various RH stakeholders.*

In November and December 2001, Advance Africa initiated strategic mapping in Senegal's Kaolack region to identify in a collaborative way, the gaps in integrating HIV/AIDS activities with FP/RH activities and to identify corrective measures.

Rwanda: Utilization of Family Planning Services

Rwanda, a country of approximately 7.6 million people, is the most densely populated country in Africa. Contraceptive prevalence declined from 12% in 1992 to 4% in 2000 according to the Demo-graphic and Health Survey. Rwanda, one of the poorest nations in the world, has also been struggling to recover from internal civil war and genocide. Life expectancy is only 39 years. (1)

Rwanda has reached a broad based consensus for peace, rehabilita-tion, reconciliation, and poverty reduction. To address the country's reproductive health needs, the government and USAID requested a strategic mapping exercise to assess the family planning situation, including barriers to services, degree of unmet need, donor coordination, and to determine where USAID should focus its resources. The MOH requested that the exercise address the following issues:

1) *Why are Rwandan women not using family planning?*
2) *What are the obstacles to providing quality family planning services at service delivery points?*
3) *What are the possibilities and options for community participation in family planning motivation and contraceptive distribution?*

From January to February 2002, a team comprised of representatives of the MOH, USAID/Rwanda, Advance Africa, the DELIVER Project, and PRIME II/Rwanda
used strategic mapping to concentrate on six districts: Gitarama, Kibuye, Byumba, Umutara, Kibungo, and Kigali Ville.

(1) Population Reference Bureau 2001, World Population Data Sheet.

Benin: Low Contraceptive Prevalence Rate

In 1997, the Benin office of the U.S. Agency for International Development (USAID) signed an agreement with the Beninese government to assist the nation increase the use of family health services in an environment of favorable policies. USAID/Benin along with other partners such as the United Nations Fund for Population Activities (UNFPA), the World Bank, the International Planned Parenthood Federation (IPPF), and the German Technical Cooperation Agency (GTZ), supported many interventions.

Quantitative studies, such as the Demographic Health Survey, showed considerable improvement in the contraceptive prevalence rate (CPR) which increased from 3.4% in 1996 to 7.2% in 2001. Although this rate more than doubled in five years, USAID defined the central problem: *The CPR is low*.

To quickly identify concrete measures to reinforce family planning in the short and medium terms, USAID/Benin requested Advance Africa to perform an assessment. Advance Africa, drawing on its previous experiences in Senegal and Rwanda, proposed using strategic mapping to respond. In October to November, 2002, the exercise began with a focus on identifying corrective measures, particularly in the Borgou/Alibori and Oueme/Plateau regions where the Integrated Family Health Program was underway.

Angola: Utilization of Family Planning Services

Angola, a country of approximately 13.5 million people, has one of the highest maternal mortality rates in the world (1850/100,000 live births)(1) The CPR declined from 8.1% in 1996 to 6% in 2001. (2)

To address the country's reproductive health needs, a National Strategic Plan for Reproductive Health 2002-2007 was adopted. Its three major strategies are to: 1) Develop a strong health monitoring system, 2) Implement interventions based on operational research to enhance quality of FP/RH services, and 3) Use social mobilization techniques with a focus on youth.

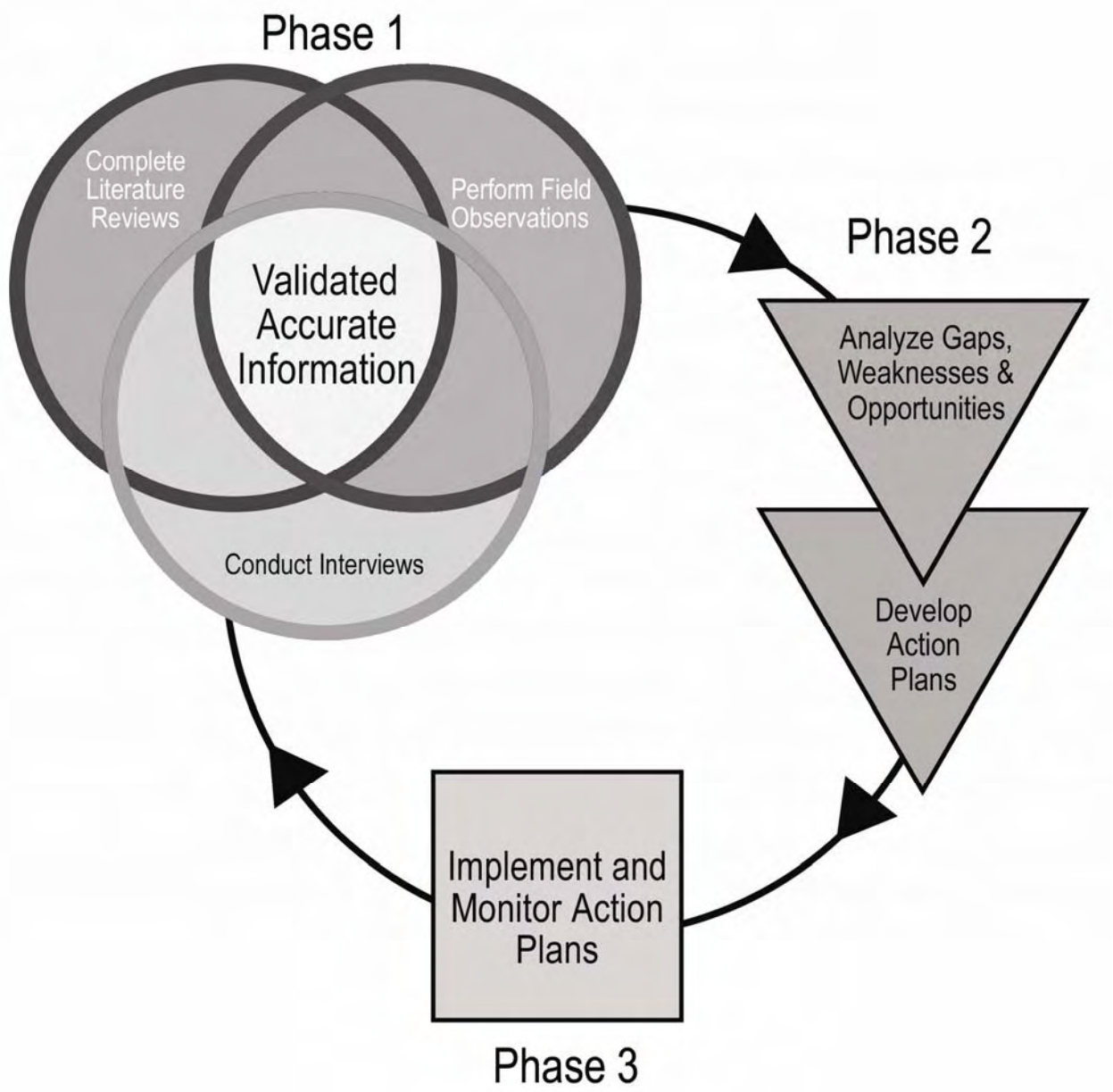
Based on the low utilization of family planning services as indicated by the low CPR, Angola's postconflict context, and the National Strategic Plan for Reproductive Health 2002-2007, the National Directorate of Public Health invited Advance Africa to initiate a strategic mapping exercise to answer the question: *Why is the contraceptive rate decreasing?*

(1) Ministerio da Saude, Direccao Nacional de Saude Publica (DNSP). *Plano Estrategico Nacional de Saude Reprodutiva 2002-2006.* Luanda, Angola: DNSP.
(2) Institutuo nacional de Estatistica (INE) and the United Nations Children's Fund (UNICEF) 2002. *Angola Multiple Indicator Cluster Survey (MICS) 2001.* Luanda, Angola: INE/UNICEF.

A Three-Phase Process

Strategic Mapping is a user-friendly approach that unifies research and participatory planning techniques to rapidly address the issue. As Figure 3 illustrates, it consists of a three-phase process: 1) Participatory Rapid Assessment, 2) Interactive Group Planning, and 3) Program Implementation and Monitoring. Each phase consist of multiple steps—beginning with information collection and ending with the implementation and monitoring of action plans.

Figure 2. The Strategic Mapping Three-Phase Process

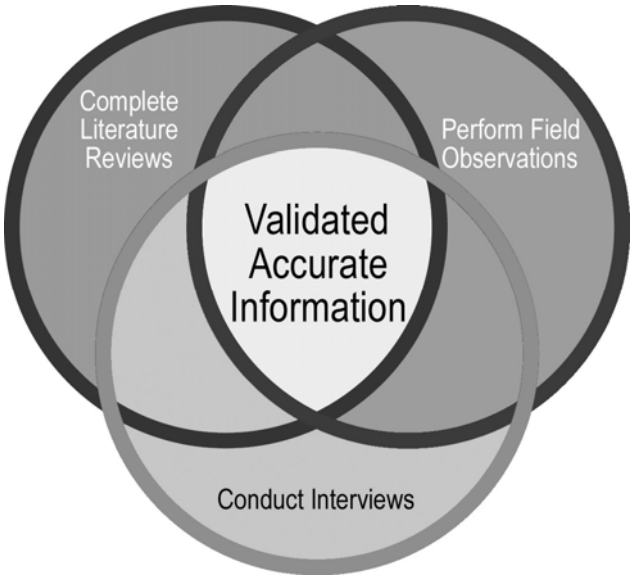


Phase I: Participatory Rapid Assessment

After engaging stakeholders and defining the problem, the participatory rapid assessment phase begins. This phase starts with a literature review, which is a gathering of the results of published and unpublished reports, including quantitative and qualitative studies. A consensus-building meeting with decision makers and stakeholders at the central level is then held to create "buy-in" from all participants. During this meeting, findings from the literature review are presented. Participants discuss them, contributing facts and opinions until they reach a consensus on program gaps, weaknesses, and opportunities that are visualized in an initial "map."

Create a Map by Triangulating Data

Figure 3. Data Triangulation Process



Mapping involves data triangulation—an analysis of various sources of data to identify valid and reliable information about the key FP/RH issue on which the mapping is focused. The process uses a multidimensional approach by adding new data to the initial map of the consensus building meeting. New findings from interviews, focus group discussions (with stakeholders, beneficiaries, and others in the health system), and field observations are compared with the initial map. The results from these three sources are cross-matched through a data triangulation process designed to retain only overlapping information which is now considered validated (Figure 4).

The selection of sites for key informant interviews, focus group discussions, and observations of the program in action considers several factors. The sites should be representative enough to make plans that are realistic and will benefit the program overall. Simultaneously, you should select geographical regions or subpopulations of interest that show enough variation to compare groups (e.g. rural versus urban; migrating versus sedentary; etc.) within the program's coverage area.

Site Selection in Angola

In Angola, the National Directorate of Public health requested that the exercise be undertaken in three provinces: Luanda, Benguela, and Huambo. The three provinces are **representative** of the various economic strata. Luanda's population has a higher standard of living than that of Benguela, whose economic level is low to medium. Huambo, a region profoundly affected by the war, has the lowest economic status. The MOH and Strategic Mapping team leaders agreed that the urban-rural **distinctions** in the provinces might also **highlight variations** in each area. They also considered the fact that a pilot project would be implemented in one of the three provinces, and then scaled up afterwards.

Structure of Maps

A main objective of Strategic Mapping is to look at the "**whole picture**" by creating maps that will assist in visualizing gaps (including weaknesses) and opportunities (see Table 1). Note that the headings are derived from the Strategic Mapping framework shown in Figure 2. A comprehensive view of the program can be constructed by adapting this map to your program elements. The team designated to be responsible for Strategic Mapping should lay out pertinent questions within each box of the table to guide the literature review. Table 2, based on the Strategic Mapping conducted in Angola, contains a completed Literature Review Question Guide as an example for developing a data map.

Table 1. Map of gaps (plus weaknesses) and opportunities

	Access	Demand	Quality	Sustainability
Clients				
Service Providers				
Organizations				
Sectors				
Programs				
Policy Environment				
Socioeconomic Context				

Data maps look like a table of rows and columns. The top row generally presents the four dimensions of effective health service delivery: access, demand, quality, and sustainability. The left-most column lists the determinants that impact health outcomes. The data described inside the table are initially collected during the literature review. The map can then be embellished with data from interviews and site visits to reach a consensus on validated information. This visual representation is used to summarize the information for discussion on where the critical issues are and where the mapping process should initially focus. Table 3 is an example of a map from Senegal using textual data to identify program gaps. It can be modified to include opportunities as well.

Table 2. Literature Review Question Guide

Instructions: Before beginning the literature review, adapt the questions in the following table to reflect the specific focus of the Strategic Mapping. Use the questions to guide the search for data about the program's central problem.

	Access	**Demand**	**Quality**	**Sustainability**
Clients (and community)	What services do clients need? What services are available? What services do clients use? Are service/products within reasonable traveling distances to urban and rural areas? Is transport affordable? Are services/products affordable? Are hours convenient? What community-based services are available/needed/used? Do community based services meet the needs of multiple target audiences?	Why is modern method usage (%) so low relative to the desire to space pregnancies? Why is modern method use so low and declining relative to awareness? Is FP/HIV/AIDS information reaching all population segments, including hard-to-reach, displaced persons, adolescents, etc.? Why is condom use so low among men? How are condoms perceived, as a method for family planning and/or HIV prevention? How does stigma influence condom use? How do RH and HIV knowledge and perceptions influence use of methods? Is client-based research the basis for communication activities? Are appropriate messages directed to appropriate audiences via the best channels? Do communities mobilize to promote FP/HIV/AIDS education, services, and products? How can community mobilization be strengthened?	Is there a choice of methods available? Is VCT and other counseling available to the client? Are clients objectively counseled about their method choices? Is the waiting time reasonable? Do clients feel satisfied with services, including the way they are treated? If not, why are they unsatisfied? Are clients' health problems solved by receiving services? What mechanisms exist to permit individuals or client groups to voice their views on needs, quality, etc.? Why are clients not taking full advantage of available services? What is the quality of available community-based services?	How much can clients afford to pay for services? Are contraceptive users convinced of the long-term need for and benefits of contraceptive use? Why hasn't the fee-for-service approach been successful? Is there a consistent supply of methods available to meet needs?

	Access	Demand	Quality	Sustainability
Service Providers/ Organizations (In this case, questions on organizations have been combined with questions about service providers.)	To what extent are services integrated? e.g. Can clients meet multiple service delivery needs at the same time and location? Are services appropriate for special populations (e.g. older orphans, refugees, adolescents)? Is there a consistent and sufficient supply of methods? Are clients able to pay for the costs? Are services available where they are needed?	Are providers committed to counseling as part of their daily work? Do providers systematically offer counseling based on client needs? Are service providers able to address the needs of underserved populations (including orphans, displaced persons, adolescents)? Are relevant messages directed at service providers? Do local and national medical schools include pre-service training in counseling and interpersonal skills?	What is the quality of services offered? Are providers trained in contraceptive technology? Are providers trained in counseling techniques? Are providers technically competent enough to meet the reproductive needs of underserved groups? Are providers trained to provide integrated FP/HIV/HIV/AIDS needs, including VCT? Are national norms, procedures, and quality standards in place and respected?	Are service providers adequately compensated and motivated to provide quality services? Is the logistics system reliable or does it need improvement? How can management skills be improved? Are providers involved in program decision making? Are there mechanisms in place by which providers can influence program development and/or policies?
Sectors	Are services available at places of work? What other sectors support the RH needs of specific groups?	Do other sectors (education, agriculture, commercial, etc.) promote RH messages? Do primary and secondary schools provide correct information to students? Do appropriate RH messages reach multiple Sectors?	Are educational institutions offering quality training in family planning/ reproductive health, and/or HIV/AIDS?	
Programs	Is the national program adequately addressing health needs equally in both rural and urban populations? Is the national program equitably addressing needs of various population segments (e.g. by gender, age, high-risk groups, etc.)? If not, which are not addressed?	Does the program sufficiently emphasize behavior change strategies? Are program managers and beneficiaries from all levels of the system adequately involved in program development?	Do training programs adequately focus on quality of counseling and provider-client relations? Do programs provide sufficient ongoing continuing education to meet providers' needs?	Are the program strategies compatible with available resources? Do programs collaborate?
Sociopolitical Environment	Is there political will to support the expansion and improvement of the FP/RH and HIV/AIDS programs and services? Are policies in place to improve service delivery?	Do policies actively support FP/RH and HIV/AIDS messages to all client groups? Do policies address reproductive health as a human right? Are appropriate messages directed at policy makers?	Do policies, norms, and procedures exist concerning FP and HIV/AIDS? Are they enforced? When were they updated?	Does the political climate or health sector reform initiative emphasize management improvement?

Table 3. Textual Data Map of Gaps, Senegal 2001

	Access (to information)	Access (to services)	Demand (the community does not support RH)	Quality	Sustain ability
Clients and Community	Insufficient information on HIV/AIDS reaches rural population In rural areas, the existence of AIDS is still denied. Community leaders do not have enough information on RH, which leads to lack of demand	Clients must travel long distances for VCT Services are not always available to clients, depending on the activity schedule Youth, men, and people living with HIV do not have access to services directed to them	Despite good knowledge of methods, the public is not convinced of their use and condom use remains low among risk takers Community leaders lack sufficient RH information The community is not sufficiently involved in managing dispensaries Health committees have little competence in planning and budgeting		
Service Providers	A minimum package of RH/FP and HIV/AIDS information is not regularly given to those seeking health care at the facility Service providers do not have the required competencies to offer HIV/AIDS counseling services	Service providers do not share the same idea of integration as that in policy and procedure documents Referral systems do not always function Service providers are hesitant to discuss HIV/AIDS testing	The number of community health agents is decreasing Community health agents have little motivation due to lack of funds and materials Community health agents are not sufficiently competent in RH		
Organizations	Distribution of funds for reproductive health activities is not always based on the greatest needs among the regions or districts	Partner organizations have programs and projects that are designed vertically based on their mandates or zones	Community organizations are not sufficiently involved in the RH program There is insufficient coordination of NGO activities at the village level		
Sectors	Non-health sectors are not sufficiently involved in FP/RH/HIV/AIDS issues: there are insufficient resources to support FP/RH and HIV/AIDS	The private commercial sector is not sufficiently involved with provision of RH services	The village development committees do not adequately integrate RH into development initiatives		

	Access (to information)	Access (to services)	Demand (the community does not support RH)	Quality	Sustain ability
	education in schools Cooperation between sectors is lagging				
Programs	Behavior change communication is a low priority on financial lists No training programs for HIV/AIDS counseling have yet been implemented in the region Information-education-communication (IEC) programs do not sufficiently target men	The HIV/AIDS training program does not yet cover the entire region The monitoring system is no longer functional No retraining program exists for prenatal exams Health facilities do not meet service standards Lack of coordination among vertical programs slows integration at the operational level	Community-based services are insufficient. RH training for community health agents is insufficient.		
Political and Sociocultural Context	There is low literacy among women, especially in rural areas There is resistance to FP arising from cultural and religious beliefs		Cultural and religious conservatism is present within the community Polygamy makes it difficult to inform partners about STI's such as HIV		

Content of Maps

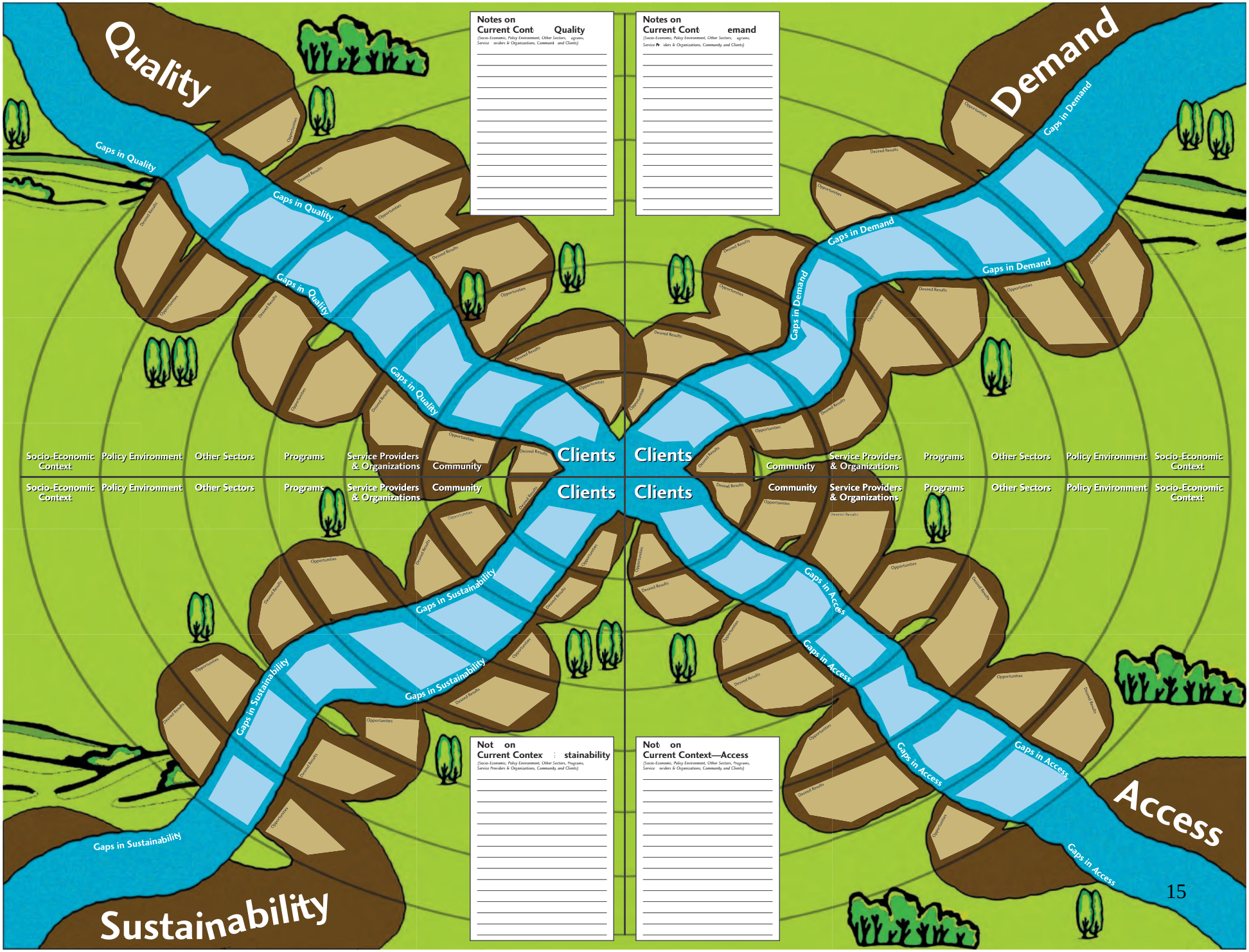
The major program strengths and weaknesses identified can then be summarized by using a grid that asks for detailed text in each area or "yes" and "no" responses. The completed grids will reveal the **gaps** that exist in the program's structure or its implementation and provide a basis for group discussion at various levels. These group discussions will raise awareness and create consensus among stakeholders—including policy makers, managers, and service providers. Table 4 is an Analytical Data Map which was developed to select between a simple dichotomy of "yes" and "no" to represent "exists" or doesn't exist" to analyze family planning/reproductive services.

Table 4. Illustrative Analytical Data Map Summarizing Program Performance

AREAS	STRUCTURES									
	Government-Led Health System				Private Sector		Community-Based Systems		Other Development/Public Sectors	
	Central Hospital	Regional Hospital	District Hospital	Health Center	Private Not for Profit	Private for Profit	Community Health Facilities	Community Organizations	Education System	Other Health-Related Systems
Availability	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Accessibility	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Demand	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Quality	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Sustainability	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Expected Coverage Rate Achieved?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

The ***Strategic Map*** (see Figure 4, also provided as a poster-sized insert at the end of the manual) is a visual representation of the strategic framework (presented on page 2) and the information collected in the data maps. The Strategic Map was designed to look like a road map with the main paths leading to the ultimate goal – high quality, sustainable FP/RH services available to the client. The Map is divided into four quadrants: access, demand, quality, and sustainability. In addition, the Map represents various sectors from the client to the sociocultural environment. Included are land, rivers, paths, and bridges. The land represents the current context in which services are being provided within each sector. The rivers represent gaps in service delivery. The paths represent the road to attaining the ultimate goal. And the bridges represent the actions that should be taken to overcome the gaps in services (the rivers). As the program manager moves down the path to quality for clients (or access, demand, or sustainability), s/he travels through opportunities and hits the river as a barrier. Bridges (actions) are used to cross the river to desired results. As the Strategic Mapping Team and key stakeholders conduct the Strategic Mapping process, the various sections of the Strategic Map can be filled in so that the group has a final visual map and representation of the entire process, including the action plan.

Figure 4. Strategic Map



Flexibility

Strategic Mapping is a flexible process. It can be used at the national level for a thorough assessment of a multisectoral program or for a single program component. Maps can be tailored to the specific situation and priorities of the country. The top row and left-most column can be expanded or collapsed to emphasize various health service dimensions and factors. In Senegal, for example, stakeholders tailored their map (Table 3) to emphasize access and demand as overriding concerns related to the integration of family planning and HIV/AIDS services. They did not significantly address quality and sustainability issues at this stage, but they could be revisited in the future. Moreover, the stakeholders subdivided "access" issues into "access to information" and "access to services". These visual representations promote discussion on where the critical issues are and where the mapping process should focus its analysis to develop action plans.

Analysis of Gaps and Opportunities

In Angola and Senegal, the Strategic Mapping participants decided to focus their analysis of gaps and opportunities of program performance according to type of health system e.g. government-led, private sector, community-based system, or other sectors. The resulting maps, shown in Table 4 and Table 5, were then used to prioritize major gaps, analyze their root causes, and examine the implications of focused action.

The Strategic Mapping team plays a key role in guiding the map analysis. How the information is categorized, whether by specific situation (the structure of the health system) or priority issues (access to FP/RH services and information), can have major implications in terms of analyzing the root causes and developing corrective activities. Facilitators can use specific techniques such as the Delphi method to obtain a consensus among a diverse group of individuals who may not be equally knowledgeable about the problem.

Analysis occurs at several levels. The Strategic Mapping team guides participants from the creation of a preliminary map (see Table 3 as an example) through additional analyses at a more detailed level to develop a final map for each key issue (see Table 5 and Table 6). The process of moving from one level of analysis to another can result in a new view of how to take action. Ultimately, the group needs to reach consensus on how to make the greatest impact within six to 12 months by filling the gaps or expanding opportunities. At first glance, focusing on gaps may lead to one set of responses, but through further analysis, the group may discover that the best impact would be achieved by concentrating on opportunities.

The Strategic Mapping Team Leader and Team

A successful Strategic Mapping process results in change in the short-term which can lead to significant changes in the long-run, but the process needs leadership and a team to implement it. The leader may be selected in one of several ways. In most cases, the lead organization or a technical assistance team identifies the person from their own institution who will direct the process. The composition of the team will vary depending on the nature of the program, but a multidisciplinary group from several stakeholder organizations is recommended. It is imperative

that the director of the lead organization or technical assistance organization wholeheartedly approve the choice and offer full moral and material support. This support may include shifting some of the team's duties to other staff, so that members will have time to carry out their new responsibilities.

Composition of the Strategic Mapping Team in Benin

A team of seven experts was formed to implement the Strategic Mapping. The team comprised two members from Advance Africa, three national consultants, and three representatives of the MOH, representing the following multidisciplinary profile:

Three public health doctors with experience in managing FP/RH programs

One communications specialist with expertise in behavior change

One manager to facilitate the financial, administrative, and logistical assistance of the technical team

One decision maker (director of the Family Planning Department at the Family Health Office)

Two midwives, one responsible for the logistics of contraceptives at the Family Health Office and one family planning specialist

Phase II: Interactive Group Planning

Phase 2, Interactive Group Planning, follows the Participatory Rapid Assessment. This second phase focuses on the identification and implementation of selected corrective actions for each gap, and requires the active participation of all key partners. The partners aim to assess and select the most feasible and potentially effective alternative solutions to fill in the gaps and strengthen the program by targeting opportunities identified in Phase I. The most important goal of this phase is to reach a consensus on corrective actions.

To begin Interactive Group Planning, the Strategic Mapping team facilitates a meeting in which the results of Phase 1 are summarized. The group should then answer the question, "Based on these gaps, weaknesses, and opportunities, what is the most effective action we can take to get the best results?" This question opens up the discussion on how to select priority actions which are feasible given existing resources. Emphasis should be placed on gaining commitment to planned activities to reach the desired results within a six to 12-month timeframe.

Corrective activities should be written on an Action Planning Map (Table 5). This matrix is used to identify the corrective activities, responsible party, timeline, outputs, indicators, and assumptions necessary to address priority gaps and opportunities

Prioritize the corrective activities based on:

1) feasibility given existing resources,
2) contribution to the expected result,
3) whether it is possible to implement and produce results within six to 12 months.

Table 5. Action Planning Map

Gaps (Weak-nesses), and Opportunities	Corrective Activities	Responsible	Dates	Outputs	Indicators	Assumptions
1						
2						
3						
Etc.						

To get the best results, weigh the effect of each potential action. For example, there may be a minor weakness in the drug supply system so that several facilities occasionally experience stock-outs of two to three days. There may also be a gap in the district-level family planning program, such as under-utilization of the community (a hidden resource) for information sharing and contraceptive distribution. In this particular situation, correcting the occasional stock-out is likely to only have a marginal effect on overall program outcomes. Mobilizing communities across the district is likely to have a major impact on improving coverage and outcomes. In this particular case, priority should be given to community mobilization as a corrective activity.

The action planning map should be completed through consensus. It is used as a short-term plan for periods of up to one year. A wise action plan focuses the process on:

- The corrective measures (or what to do) for each of the selected priority gaps and opportunities
- Who the key players should be for each measure
- The dates for completion of each step
- The outputs (or expected performance) for each measure
- Readily measurable indicators to monitor progress
- Assumptions which cover possible constraints

Senegal: Reaching consensus through a debate of perspectives and assessment findings

National representatives of the HIV/AIDS program were convinced that the national program was highly decentralized. Indeed, the donor required decentralization in the primary health care strategy. The national stakeholders thus did not perceive decentralization as a gap during initial mapping. District managers, however, felt that the HIV/AIDS program was not decentralized. They argued that they had no power in program implementation in their own district, not even control over resource allocations in their own area.

During the Interactive Group Planning phase, both sets of stakeholders came to a consensus that the national program was NOT decentralized based on the Initial Mapping findings. Real decentralization and integration of HIV/AIDS programming into primary health care became a priority for the action plan.

Benin: Building consensus through coordination and knowledge sharing

Prior to the Strategic Mapping exercise in Benin, the seven Contracting Agencies and U.N. bodies working in the country had never had such an opportunity to discuss ways to coordinate and share knowledge. During the Interactive Group Planning phase, members were surprised to learn about innovative and promising best practices for community participation which were taking place in the Department of Borgou Proasaf area. Prosaf was a 5-year USAID project which increased CPR at an exceptional rate over a short period.

Benefiting from the interesting exchange of information, the group decided by consensus to include regular quarterly meetings in the action plan. They also agreed to develop a reproductive health proposal, with assistance from Advance Africa, for donor review.

Angola: A new vision of repositioned family planning resulting from consensus

The Strategic Mapping brought together tangible facts about utilization rates to demonstrate that demand and access to contraceptives were low. The group's recognition of the facts from the data illustrated the need to reposition family planning in a country emerging from civil war. With convincing arguments, the group came to a consensus on actions to demonstrate the value of child spacing for saving lives. A novel approach—one based on the family plans of its citizens—and available RH services were essential to convince a population whose numbers had shrunk due to war. A repositioned family planning program could become a central component of the country's education, health, and development strategies, and of the reproductive goals of its citizens.

Phase III: Program Implementation and Monitoring

The implementation of action plans must be monitored regularly by group members, and the plans should also be evaluated periodically—at least twice during the life of the plan—to refine activities. A six month action plan would be monitored every three months; a one-year plan would be monitored around the sixth and 12th month. In this way, strategic mapping becomes an ongoing process of developing, evaluating, and adapting action plans. This process helps to ensure that activities always remain relevant, even in changing environments.

Rapid utilization of data

Strategic Mapping aims to implement changes as quickly as possible. Immediately after the action planning workshop, stakeholders should operationalize and monitor the plan using the existing health information system. During the group planning, indicators will have been identified, selected, and built into the action plan. It is important to select indicators for which data can be collected relatively quickly or those which are regularly scheduled for routine compilation during the 6-12 month cycle of the plan. Data utilization for rapidly defining and redefining the program's direction is a key component of the Strategic Mapping process. For example, if increased contraceptive prevalence rates across selected districts are a priority objective of the plan, data should be collected on a monthly basis to determine if FP utilization rates are increasing at the clinics and through community-based distributors. Where there is lack of positive change, the stakeholders can focus their attention on determining the reasons and adjust interventions accordingly.

Ongoing coordination

When Strategic Mapping is done at the national level, the highest echelons of management in the country's health care system should be involved in the ongoing monitoring of activities. Other sectors, as appropriate, need to coordinate with the lead institution. Stakeholders can hold monthly coordination meetings, as well as maintain regular contact by phone and email correspondence.

The Strategic Mapping Cycle

The frequency of a Strategic Mapping cycle depends on a variety of factors, including the level at which it is being undertaken, the scope and breadth of the plan, the degree of investment by all stakeholders, and the achievements being made. A semi-annual or annual cycle is recommended. A benefit of such a relatively short plan is that the group can come together again to adjust action plans based on new realities and needs.

FACILITATOR'S PLAN

The Facilitators' Plan is a guide to implementing the entire Strategic Mapping process. This plan is a synthesis of the experiences of previous facilitators. As such it is not a standardized rigid set of timetables and instruments, but a flexible structure for selecting a critical FP/RH issue, creating maps, adapting them to the specific situation, and using a participative process to operationalize a plan which is implemented and monitored.

This facilitators' plan builds on the previous sections which provided an overview. In this section, you will find a summary of instructions and step-by step guidelines for engaging stakeholders and conducting each of the three Strategic Mapping phases. The guidelines include the timing and duration of specific components of each phase, including objectives, step-by-step activities, and materials for each phase. Sample instruments, meeting agendas, forms for analysis, maps, and templates follow each key component.

Engaging Stakeholders

The Strategic Mapping approach is based on the consensus and commitment of all key stakeholders. Stakeholders may include Ministries of Health, national and international agencies, and multi-sectoral partners involved in FP/RH interventions in the country. It is vital to engage them at the outset of the mapping exercise as their commitment to the entire process is essential.

Designate a Strategic Mapping Lead Organization and Team Leader. A first task is to ensure that a lead organization will take responsibility for directing the Strategic Mapping process, as mentioned earlier. This can be a host country institution or an external organizer, such as a technical assistance organization. Every stakeholder represented on the Strategic Mapping Team is expected to help implement the changes determined for the action plan.

A Strategic Mapping Team Leader should be designated who has the authority to make decisions regarding the formulation, implementation, and evaluation of the action plan. He or she is then held accountable.

Conduct preliminary contact meetings. The general terms of reference agreed upon by the MOH and the Strategic Mapping Team are not adequate to clarify the expectations of all participants or to obtain commitment to the process. It is important to conduct preliminary face-to-face meetings with key stakeholders, especially if preliminary negotiations are carried out long-distance or if the mapping is being facilitated by an outside technical assistance group. Preliminary contact meetings between the lead institution and the Strategic Mapping Team Leader should take place in-country about two months prior to Phase 1 of the exercise. These meetings generally last from one to two weeks, depending on the site visits undertaken during that time. The terms of reference for the Strategic Mapping should be finalized during these meetings.

Make the arrangements. The Strategic Mapping Team must ensure appropriate support for the process is in place. The lead organization and Team Leader should either designate specific staff or work with a counterpart organization to ensure that all preparations are made in advance for meetings to be held with stakeholders throughout the process. Review administrative and logistical procedures, staffing, and budget to ensure sufficient resources are available to implement the activities.

Engaging Stakeholders

Timing: Preliminary contact meetings should take place approximately two months prior to Strategic Mapping exercise.
Duration: Preliminary contact meetings usually last one to two weeks depending on site visits.

Objectives	Step by step activities	Materials
Define the problem and reach agreement on mapping objectives by engaging key stakeholders in the Strategic Mapping exercise Make initial administrative and logistics arrangements Identify local institution or consultants to organize the Strategic Mapping process	1. Hold meetings with the host organization (usually the MOH) to finalize the terms of reference: - define the key problem - discuss expectations of the process - make a Strategic Mapping presentation (using PowerPoint or brochures) to ensure a clear understanding of how the process can be used to meet expectations - discuss terms of reference, objectives, expected results, length of process, dates, necessary resources - compile a list of contact information including telephone numbers - review and confirm schedule of visits 2. Write a brief report of the discussions as follow-up to each meeting. 3. Meet with stakeholder partners to: - present the basic process - explore partner issues, experience, and expectations - discuss their involvement in the process - identify dates when key decision makers are available to participate in the consensus-building meetings in Phase I 4. Finalize the terms of reference and prepare the agenda for Phase I and II of the Strategic Mapping exercise based on discussions. If an external organization (e.g., technical assistance team) is organizing the exercise, leave the terms of reference and agenda with the requesting contact to review and concur, as appropriate. 5. Make preliminary administrative and logistical arrangements for the Strategic Mapping. Investigate potential sites for holding the stakeholder meetings throughout Phases I to III. 6. Identify and interview additional team members, including administrative support and additional technical consultants who can work with the team to implement the activity.	Brochures PowerPoint presentation about the Strategic Mapping process Outline for the terms of reference Preliminary agenda for Phase I and Phase II with target dates

Phase I: Participatory Rapid Assessment

The participatory rapid assessment consists of a literature review, stakeholder interviews, and field observations, with a consensus-building meeting built into the process.

Conduct a literature review. The first activity of this phase is the literature review. It should be as comprehensive as possible and include published and unpublished information, both quantitative and qualitative data, including government/MOH and local implementing organization documents and official papers if available. The literature review should focus specifically on the issues related to the problem to be addressed. For example, if the goal of the Strategic Mapping is to determine how to strengthen integration of HIV/AIDS with family planning services, the literature review should focus on questions related to this particular topic at the country level. It would include a review of data concerned with the extent of service integration in the country, norms and protocols regarding program integration, quality of integrated services in the country, barriers to improving integration of services, and so on. The literature review is essential for providing a foundation to understand the issues of the specific problem. The information should be summarized in order to identify what should be further investigated through stakeholder interviews and field observations. Drafts of data maps are developed to be shared with key stakeholders.

Conduct an initial consensus-building meeting. A consensus-building meeting should then be arranged to review the results of the literature review with decision-makers, validate initial data and data maps, and to obtain their agreement on the focus, content, and tools for the stakeholder interviews and field observations.

Conduct interviews with stakeholders, program managers, service providers and beneficiaries during site visits. The next step is to conduct stakeholder interviews and field observations. Arrangements should be made to interview stakeholders at various levels—program managers, doctors, nurses, community level providers, and clients. The Strategic Mapping Team then gathers data collected in these meetings and site visits in order to understand previously missing and contradictory information, and to provide greater insight into the program gaps, weaknesses, and opportunities.

When visiting the sites, the Team should look for best or promising practices that are recognized as successful by the local citizens or health providers. These best practices can be considered for extension to other areas if they successfully address the central problem.

Analyze, interpret, and present the data. It is the responsibility of the Strategic Mapping Team to be sure that on-going validation and analysis of the findings is undertaken during the interviewing and site visits. The Team should discuss their interpretation of findings and summarize results along the way, building consensus around the process. In preparation for the next step, they should fill in the findings in the data maps.

The Strategic Mapping Team Leader should use the following guidelines that outline specific activities.

Phase I: Participatory Rapid Assessment

Timing: The Participatory Rapid Assessment begins about two months after the initial meeting with decision makers interested in conducting Strategic Mapping.
Duration: Phase I generally lasts two to three months. It includes a literature review, an initial consensus-building meeting, interviews, field observations, and preparation of data for presentation to decision makers.

Objectives	Step by step activities	Materials
Provide the analytical foundation for understanding the problem, context, program gaps, and opportunities	1. **CONDUCT LITERATURE REVIEW** (2-4 weeks) a. Using the Literature Review Question Guide, adapt questions to the central problem. This tool will help guide the literature review by laying out what questions need to be answered to identify program gaps and opportunities in the country. b. Identify, obtain, and review source materials. c. Summarize all relevant information into a data map such as the one shown in Table 3 or Table 4, depending on the best categorization of issues. Make a list of further documents and information sources needed to complete the initial map. d. Develop a presentation with the data map for use at key stakeholder meetings. The presentation should include: i) a summary of findings ii) tentative conclusions or hypotheses about gaps, weaknesses, and opportunities iii) areas needing further investigation through stakeholder interviews and field observations iv) sources of information	Literature Review Question Guide (see Table 2, page 9) Data Maps (see Table 3, page 11 or Table 4, page 13, as examples) List of additional documents and information sources

Phase I: Participatory Rapid Assessment (continued)

Objectives	Step by step activities	Materials
Develop consensus among key stakeholders on findings to focus the strategic mapping and to build commitment to the process	**2. CONDUCT INITIAL CONSENSUS-BUILDING MEETING WITH KEY STAKEHOLDERS TO PRESENT FINDINGS FROM THE LITERATURE REVIEW (1-2 days)** Prior to the meeting, invite the participants to bring a 15-minute presentation of their FP/RH program. This is an opportunity for participants to express their knowledge and perspectives about their program strengths and weaknesses and discuss issues with other senior level managers from health and non-health organizations. Through a structured debate, build consensus among the group about the program gaps, weaknesses, and opportunities that need further analysis during interviews and site visits. Step-by-step activities for the one-to-two day meeting include: a. Explain meeting objectives and agenda. (Table 8 is a sample agenda.) Clarify why participants are there, what will be their role in the Strategic Mapping process, and what is expected of them. Review administrative and logistical details. A more formal opening ceremony may be preferred, which will require more time. If this is the case, encourage the national-level speaker to link the meeting purpose with the overall goal of the National RH/FP Policy work plan. b. Present the Strategic Mapping exercise and literature review findings. A standardized PowerPoint presentation should be prepared. Allow for questions and discussions to ensure that participants understand and support the mapping process. Explain the Strategic Map, as presented on page 11. An overview of the country situation based on the literature review, including relevant FP/RH and socioeconomic indicators, should accompany this presentation. c. Ask participants to deliver a technical presentation on their own FP/RH program with their own data and to explain how their organization is contributing to the national FP/RH goals. d. Provide the participants with current technical information and international guidelines to help generate support for strengthening the national program and for the Strategic Mapping activity. e. Reach agreement on the program's current situation through small group work.	LCD projector or overhead projector and screen for presentation of results. Computer or transparencies, depending on presentation media. 1-2 flipchart stands, flipchart paper, participant folders, and large detailed geographic map of the country Agenda (see sample which follows on page 30) Strategic Map taped to a wall (inserted at the end of the Manual)

Objectives	Step by step activities	Materials
	i. Divide the group into four groups of five to ten people, according to geographical area of work mixing types of organizations if possible. ii. Have each group review and validate the information collected during the literature review. iii. Instruct them to supplement the information by filling in gaps based on their own knowledge and experience of the situation. Because of time constraints, it can be helpful to have each group analyze a different performance dimension (access, demand, quality, or sustainability). iv. Hand out a copy of the main findings of the literature review to each group. v. Prepare a flip chart with the following two points and ask each small group to discuss: – the validity of findings and conclusions of the literature review – gaps and discrepancies in findings vi. Each small group should designate a reporter who will present the conclusions on these points to the larger group in plenary session. It is important that all participants reach consensus about the current program before they present it to the larger group. Have groups to write their findings on flip charts or transparencies. f. Ask each group to present their group results related to the validity of the literature review and its gaps to the larger group. Organize again in the same small groups to identify the strengths, weaknesses, and opportunities of their respective geographical sites. Each group should identify key factors that led to this situation using a flipchart or the "Strengths and Weaknesses" handout. Using the "Opportunities" handout, each small group should then discuss and reach consensus on opportunities to strengthen intervention the future. g. Have each group report back to the larger group about opportunities to strengthen interventions in the future. At the end of all presentations, lead the large group through questions and a discussion in a plenary session.	"Strengths and Weaknesses" handout or transparency (page 32) "Opportunities" handout or transparency (page 33)

Objectives	Step by step activities	Materials
	h. Focus on achieving consensus among the entire group about the main program gaps, weaknesses, strengths, and opportunities. Questions for discussion should include: – Was there consensus among each of the small groups on program strengths and weaknesses? What were the areas of disagreement? – Did the larger group agree with the conclusions of all the presentations? If not, where is there a divergence of opinion? The Strategic Mapping Team can further investigate these areas of divergence. – What needs to be further assessed in order to come to agreement on the main points regarding program performance? – What are the main areas of agreement in terms of gaps and opportunities? This is an important question because it will help define the remaining work of the Strategic Mapping Team. i. On the Strategic Map (posted on a wall and described in the introductory presentation), fill in current context, opportunities, and gaps based upon the consensus reached above. Current context should be written in the boxes appropriate to the program performance dimensions. Opportunities are written in the path prior to the rivers for each sector. Gaps and weaknesses are written in the river within each sector. Explain that this information will be added to and validated with information from the data collection process. The Map will be presented again at the Action Planning Workshop in Phase II. j. Reach agreement with the larger group on what the highest, realistic standards of performance should be for the key service delivery dimensions, and share knowledge of local promising or best practices. Establishing an "ideal situation" is necessary in order to comprehensively analyze current program performance and see program gaps and weaknesses clearly. By comparing what	

Objectives	Step by step activities	Materials
	realistically exists with what *should* exist, the group can readily identify what program gaps, weaknesses, strengths, and opportunities there are. Ensure that the group does not set standards too high or too low. These standards should also reflect the client's point of view regarding a reasonable and realistic level of service and quality. These standards should be based on the clients' rights and needs, effective policies and protocols, and state-of-the-art international guidelines. The cost of providing these high quality services should not be a factor at this stage. To reach agreement, divide the participants in to small groups again: – Distribute blank copies of the Ideal Program Performance Grid to participants. Also give them a transparency with the same grid and colored markers. Ask each group to fill in the grid with the practices and interventions that they consider successful or promising for expanding and scaling up. – Distribute the Best Practices Questionnaire to each small group. Ask the participants to complete the questionnaire in order to indicate promising practices that may represent opportunities for expanding what already as proven successful in the specific environment. These activities serve two purposes: 1) the participants can learn about various practices from each other 2) the Strategic Mapping team obtains information to guide them in further assessing the success of the interventions during site visits. k. Compare and discuss each group's concept of the "ideal" to reach consensus on the ideal program. Fill in desired results areas on the Strategic Map within each sector. l. Summarize the major conclusions from the meeting, including: – where there was consensus on program gaps and opportunities – where further investigation is needed to assess the current program and achieve consensus – review next steps for the Strategic Mapping activity, and the role these decision makers will have. m. Refine draft data maps to incorporate meeting inputs. Prepare finalized tools for stakeholder interviews and field observations.	Ideal Performance Grid (page 34) Best Practices Questionnaire (page 36)

Sample Agenda

CONSENSUS-BUILDING WITH FP/RH DECISION MAKERS AND STAKEHOLDERS AT THE CENTRAL LEVEL A TWO-DAY MEETING

[Date]	Content	Responsible
9:00 am	Welcome remarks and overall objectives of undertaking this exercise with all interested stakeholders and decision-makers	MOH (host organization)
9:30 am	Ice Breaker Introduction of Participants Review of the objectives of the two-day meeting	Strategic Mapping Team Leader (SMTL)
10:00 am	PowerPoint presentation: Strategic Mapping	SMTL
10:45 am	Coffee Break	
11:15 am	Introduction: Importance of a consensus building process to agree on a FP/RH National Program	USAID
12:30 pm	LUNCH	
1:30 pm	Presentation of local programs addressing FP/RH Discussion: questions/answers	Local organizations
3:30 pm	Coffee Break	
4:00 pm	Presentation of local programs addressing FP/RH (continued) Discussion: questions/answers	Local organizations
5:30 pm	Evaluation of the Day	SMTL

Day Two

[Date]	**Content**	**Responsible**
9:00 am	Review of first day accomplishments	SMTL
9:30 am	Small group work on current program situation and performance in terms of access, demand, quality, and sustainability. *Agreement on the situation; Identification of gaps* (work based on the literature review)	ALL
10:45 am	Coffee Break	
11:15 am	Continuation of group work: *Identification of Gaps*	
12:00 pm	In Plenary: Group presentation	ALL
12:30 pm	LUNCH	
1:30 pm	Continuation Group Work: - *Strengths and weaknesses* - *Divergence in opinion* - *Needs for further assessment* - *Main areas of agreement in terms of gaps and opportunities*	ALL
3:30 pm	Coffee Break	
4:00 pm	Same group work: (1) exchange of knowledge/experience of local *best practices,* and (2) agreement on the "*ideal situation"* with respect to key dimensions of service delivery Group presentation of results Discussion	Exercises facilitated by SMTL
5:30 pm	Closing	

Strengths and Weaknesses

Instructions: Please discuss with the participants of your group the strengths and weaknesses of the program in your geographical area. Discuss the possible factors influencing the situation. Come to a consensus about the final list of strengths and weaknesses at the country level.

Geographical area: Specify which province, regions, and/or districts to which you are referring: _____

Program Performance Dimensions	Strengths	Weaknesses
Access		
Quality		
Demand		
Sustainability		

Opportunities

<u>Instructions:</u> By looking at the completed table "Strengths and Weaknesses," discuss and come to a consensus to identify "Opportunities" that might lend to strengthening your programs. Please be as specific as possible. Write down the intervention and the person(s) responsible.

Program Performance Dimension	Program Sector (e.g., client, facility, policy)	Opportunities
Access		
Quality		
Demand		
Sustainability		

Ideal Performance Grid

SAMPLE
Strategic Mapping of the National Family Planning Program

Instructions:
1. Agree on where each service should be available based on client needs and from the client's point of view.
2. Fill in the boxes using the color codes below:

Blue: Service should be offered; *No color:* Service need not be offered; *Red:* Referral should be offered

	Dispensary	Health Outpost	Health Center	Regional Hospital	Private Clinic	NGO Clinic	Pharmacy	Community	School	Other Sectors	Media
1. MINIMUM PACKAGE OF INFORMATION											
Family Planning											
Postabortion Care											
HIV/AIDS											
PMTCT											
STI											
Child Survival											
2. COUNSELING											
Family Planning											
Postabortion Care											
HIV/AIDS											
PMTCT											
STI											
PLWHA											

	Dispensary	Health Outpost	Health Center	Regional Hospital	Private Clinic	NGO Clinic	Pharmacy	Community	School	Other Sectors	Media
3. SERVICES/PRODUCTS											
Condom, spermicide											
Injectables											
Pill											
IUD											
Norplant											
Postabortion Care											
STI Lab											
STI Treatment											
PMTCT											
VCT											

Acronyms

FP (family planning)	VCT (voluntary counseling and testing)	CS (child survival)
STI (sexually transmitted infection	PMTCT (prevention of mother to child transmission)	PLWHA (persons living with AIDS)

Best Practices Questionnaire

Name/Contact _____ Date _____

_____

Field Program Managers: Please take a moment to complete this form if you have a successful intervention ("Best Practice") worth disseminating to others. Be sure to provide reasons to justify the success of this program.

Name of your successful best practice: _____

Who implemented this practice? (e.g. NGOs, donors, contact)

_____

When was it implemented? (Year)_____

Where was it implemented? (Be specific) _____

What was done? (List the main activities here)

Do you have **results** (data) to demonstrate the this practice achieved its objectives?

What were some of the **environmental factors** that led to the practice's success?

Why do you consider this a best practice?

Why should it be **replicated** in other areas?

Phase I: Participatory Rapid Assessment (continued)

Objectives	Step by step activities	Materials
	3. CONDUCT INTERVIEWS WITH STAKEHOLDERS, PROGRAM MANAGERS, SERVICE PROVIDERS, AND BENEFICIAIRES (minimum of 2 weeks) Although steps 3 and 4 are presented here sequentially, in reality they are carried out **simultaneously**. For purposes of consistency (eg. to match the flow of the Strategic Mapping flowchart) and to differentiate interview tools from observation tools, we present them in distinct steps. A minimum of two full weeks is required for the interviews and site observations, including preparation time, depending on the scope of the activity, and size of the Strategic Mapping team. a. Prepare a list of sites to visit with names, titles, and workplace addresses of key stakeholders, program managers, and service providers to be interviewed at each location. Make room in the schedule for interviews and/or focus group discussions with community members who may be considered potential or actual beneficiaries of the FP/RH program. Lay out a schedule for visiting each site: Who? How? Why? What? Where? When? Be careful in developing criteria for selecting the respondents and health facilities to observe: Is each one of them relevant to answer the specific questions for which you are seeking answers? b. Determine how the Strategic Mapping Team will be divided into sub-groups. c. Obtain approvals for site visits, interviews, and focus group discussions (FGDs) from appropriate departments, such as the MOH, Ministry of Interior, village chiefs, etc. d. Develop or adapt interview guides (e.g., key informant guide, focus group guide) to the central problem and to the number and type of people to be interviewed. Who are the people to interview individually? Usually they are opinion leaders. They are often those who are unique because of their position in or strong commitment to the organization. Prepare each guide for a maximum 30 minute interview.	Key Informant Guide (page 40) Focus Group Guide (page 41)

		Field test the interview guides. Note that the interview guides are semi-structured. The interviewer has a guide with specific questions; s/he needs to let the interviewee(s) respond as they please. Although all of the questions in the guide should be discussed and answers recorded, the instrument is not a formal questionnaire but a structure around which the discussion can evolve. The primary objective is to *understand* the situation and its possible causes. The goal is to elicit information from the respondent about his or her experience, skills, and knowledge of the local situation and culture. Take detailed notes, or it may be desirable to tape record conversations for later reference. Refine the tested interview guides as necessary, for actual implementation. NOTE: If you are using interpreters during any interviews or FGDs, please ensure that all interpreters understand the questions and are appropriately and accurately relaying information.	
	e.	Using a plan for site visits, have the Strategic Mapping Team, or its sub-groups, conduct individual interviews using the appropriate key informant guide at each field site. Practice or train them first if necessary. Interviewers should ask open-ended questions and let the respondent speak openly. Assure and maintain confidentiality with the respondent as appropriate. Focus the discussion on the central research issues. If the speaker deviates from the subject, bring him/her back on track, looking at the interview guide to address the specific research questions.	Site visit plan which includes a list of sites, people, addresses, and research question(s). Notebook for each team member conducting site visits
	f.	Have the Strategic Mapping Team, or its sub-groups, conduct FGDs using an interview guide if there is someone within the team who is familiar with the methodology. A major reason to conduct FGDs is to understand why certain groups behave or perceive reality a certain way. The criteria for selecting respondents (age, sex, ethnic group, education, etc.) are determined by the purpose of the study. Key points to consider before conducting and analyzing focus group discussions are: The Strategic Mapping Team must be organized and systematic in its approach. Focus groups need to be organized in accordance with criteria established to distinguish between groups of interest (e.g., unmarried men of reproductive age, married women with at least one child, female adolescents who attend school). If time is limited, the number of FGDs must be realistically set. Participants must be carefully selected. Keep the following in mind: – It is recommended that no more than eight FGDs be conducted if the team wants to follow the two-week time frame.	Adapted Key Informant Guides and Focus Group Discussion Guides for each respondent profile (e.g. district medical officer, adolescent mothers, village chiefs, health facility providers, etc.) Optional: Tape recorder with extra batteries.

	– Data collection for focus groups is based on an interview guide. This guide has a maximum of four to five major themes related to the research question, gaps, and data inconsistencies that the team has found. – Analysis of focus group information should be done on the same day the discussion is conducted to at least organize the findings. – If the person conducting the focus group discussion has little experience in this methodology, the interviewer should limit the analysis to a description of the data and let those more experienced in the methodology interpret meaning.	

Key Informant Guide

(Opinion Leader Example)

- **Please adapt the guide**
- **Think of the four program performance dimensions you want to get information for: access, demand, quality, and sustainability**
- **Plan for a thirty minute interview**
- **Train all interpreters as needed**

- ✓ Can you please describe your role within the community?
- ✓ In general, how would you describe children's health in your community? And why?
- ✓ Do you or your organization have any interest or responsibility in the community's health activities?
- ✓ In your opinion, can you tell us how you think the community responds to health activities in general, and HIV/AIDS in particular?
- ✓ When we mention "Family Planning" in what do you think?
- ✓ What do you know about Child Spacing?
- ✓ Do you know where young women can find help in FP/RH?
- ✓ Who can help them?
- ✓ What would be factors that prohibit women of reproductive age to seek these services?
- ✓ Do you know the condition of these services, if they exist?
- ✓ Are these services free of charge? If not, do you know the fees?
- ✓ In your opinion, what could be done to improve these FP/RH services?

Focus Group Discussion Guide

(Health Providers Example)

- **Please adapt the guide**
- **Think of the four dimensions for which you want to information: access, demand, quality and sustainability**
- **Plan for a 30 minute interview**
- **Train all interpreters as needed**

I. Introduction

Explain the purpose of the visit.

II. Discussion

General Information

- What is the overall status of health care facilities in the region where you work?
- What services are offered?
- Are there some services that people do not regularly or easily attend? Why?

Family Planning/Reproductive Health Services:

Access to Services:

- What are the major barriers to women seeking FP/RH services?
- What are the major barriers to adolescents seeing FP/RH services?
- What are the major barriers to men seeking FP/RH services?

Demand:

- Do women want to use family planning? Why or why not?

Quality of Services:

- What is the quality of the FP/RH services you are offered at your facility?
- Can you talk about difficulties that you (health providers) encounter in providing FP/RH services?

Sustainability:

- As health providers, tell me how you perceive the supply of the contraceptives?
- What should be the role of the government, the community, and clients in maintenance of FP/RH service provision?

III. Conclusion: Thank the group and summarize what was said.

Phase I: Participatory Rapid Assessment (continued)

Objectives	Step by step activities	Materials
	4. CONDUCT FIELD OBSERVATIONS DURING SITE VISITS a. While some members of the Strategic Mapping Team conduct individual interviews and others conduct focus group discussions, some members of the Strategic Mapping Team should prepare to visit health facilities. Field observations should be conducted while questioning the personnel at the site. There are no right or wrong answers; observations should simply be recorded as observed using the Observation Guide, an adaptation of this tool, or an elaboration from a more sophisticated program such as EpiInfo. The selection of an instrument depends on the time available and type of data already available in the region. b. Field test the tool prior to conducting field observations at selected facilities. c. Conduct field observations. When visiting the sites, look for best or promising practices that are recognized as successful by the local citizens or health providers. Record best or promising practices in the notebooks for analysis, interpretation, and presentation or use the Best Practices Questionnaire.	Observation Guide (page 43) Best Practices Questionnaire (page 36)

Strategic Mapping Observation Guide

(Walk-through tour of health facilities example)

SITE:

DATE:

CONDUCTED BY:

A. Questions:	Comments
What are the hours of the operation during the week?	
What are the hours of the operation during the weekend?	
Does the Center have a maternity ward?	
Does the center have a delivery room?	
How many beds for women in labor?	
Is there a doctor coming to the Center?	
How many nurses are on duty?	
Any for RH/FP?	
What is the cleanliness of the Center? (scale 1 to 5, 1 being very clean) Comment at the end of the visit	

Does the facility have?	Yes	No	Comments: Electricity; running water; room lighting; ventilation; toilet; sink; equipment in maternity room; contraceptive methods (regular supply?); IEC materials;
Waiting area			
FP/RH Room			
Procedure Rooms			
Laboratory area			
Pharmacy			
Maternity area			
Emergency room			

Observation Guide (continued)

Equipment: Is the following equipment available in the facility?	**Yes**	**No**	**Comments**
Examination table			
Instruments table/tray			
Stethoscope			
Stethoscope Pinard			
Blood collection equipment			
Antiseptics			
Sterile gloves			
Autoclave			
Boiler			
Syringes/needles			
Stool			
Desk			
Cabinets			
Bed linen			
Screens			
Curtains			
Separated laundry			

Client's Dimension: Ask the administrator or any health provider the following:

	Yes	**No**	**Comments:**
Is there any cost to be attended (specify)?			
Does the client pay per service received?			
Does the client receive information/educational talks?			
Does the center have any IEC materials (posters, TV, books, pamphlets)			
Does the facility offer any FP/RH counseling?			
Does the client have a certain level of privacy?			

Observation Guide (continued)

Record/Logbook Checklist

Ask the administrator to show you the registry books from the last months and if possible check for the following:

	Yes	No	Comments
PHARMACY			
How are medications recorded?			
Are types of contraceptive methods recorded?			
FAMILY PLANNING FACILITY (if applicable)			
Is there a record system?			
Who conducts FP IEC/Counseling?			
Are there any IEC materials available?			
DELIVERY ROOM			
How many deliveries were conducted at the facility in the last 3 months?			
How many women were treated for complicated delivery (or referred to hospital)?			
VACCINATION			
Are there vaccination record cards available for clients?			
Does the room have a cold chain system?			
LABORATORY			
Does the lab have a record system? If so, for what? (specify)			

Regular Meetings –

Salaries –

Phase I: Participatory Rapid Assessment (continued)

Objectives	Step by step activities	Materials
	5. **ANALYSIS, INTERPRETATION, AND PRESENTATION OF DATA** a. Conduct daily ongoing analysis of the findings and their interpretation to accurately summarize the data in sufficient detail. Build consensus on interpreting the information as it is analyzed. Leave time at the end of each day to discuss and summarize the results. Organize the findings in tables, matrices, and bullets as shown in the "Matrix for Synthesizing Information." It is important that the summary comments to be entered in the matrix are first agreed upon by all members of the Strategic Mapping Team who participated in the interviews. b. Synthesize findings from the sub-teams during the last three-to-four days of the site visits. Identify the links between and among the findings, while drawing conclusions about the major gaps, weaknesses, and opportunities discovered during interviews and observations. Hypotheses about the cause of gaps or weaknesses my also be suggested. The Strategic Mapping Team Leader, or someone experienced in data interpretation, should lead this process. The Strategic Mapping Team needs to reach consensus on the findings that will be reported back to the key stakeholders, interviewees, and observation sites. The synthesis is an opportunity to validate the findings from the literature review. In some cases, simply changing the wording of some of the findings will promote consensus. In other cases, unless persuasive arguments lead to consensus, the results may not be included until additional convincing data is evaluated and agreed upon. c. Develop a presentation of results using the "Analytical Map of Gaps and Opportunities: Summary of Findings" as a foundation. This is an opportunity to synthesize the findings of the three data sources: the literature review, interviews, and field observations. The goal of the presentation is to build consensus with key stakeholders about the findings, hypotheses, and conclusions. The presentation and discussion become the foundation for developing an action plan.	Matrix for Synthesizing Information (page 47) Analytical Map of Gaps and Opportunities: Summary of Findings (page 49)

Matrix for Synthesizing Information

Key informant and focus group interviews: Clients (including population subgroups, e.g. MWRAs, adolescents, PLWHAs), providers, program managers, community leaders, leaders of particular groups and associations, other sectors.

CLIENTS

	Opportunities & Best or Promising Practices	Gaps and Weaknesses	Notes
Access			
Demand			
Quality			
Sustainability			

PROVIDERS

	Opportunities & Best or Promising Practices	Gaps and Weaknesses	Notes
Access			
Demand			
Quality			
Sustainability			

PROGRAM MANAGERS

	Opportunities & Best or Promising Practices	Gaps and Weaknesses	Notes
Access			
Demand			
Quality			
Sustainability			

COMMUNITY LEADERS

	Opportunities & Best or Promising Practices	Gaps and Weaknesses	Notes
Access			
Demand			
Quality			
Sustainability			

LEADERS OF ASSOCIATIONS

	Opportunities & Best or Promising Practices	Gaps and Weaknesses	Notes
Access			
Demand			
Quality			
Sustainability			

OTHER SECTORS

(e.g. education, agriculture, industry, etc.)

	Opportunities & Best or Promising Practices	Gaps and Weaknesses	Notes
Access			
Demand			
Quality			
Sustainability			

Analytical Map of Gaps and Opportunities: Summary of Findings

Focus of Intervention						
Area of Intervention	**Clients***	**Service Providers**	**Community Leaders**	**Program Managers**	**Political Environment**	**Socioeconomic Environment**
Results						
Access						
Demand						
Quality						
Sustainability						

*Can be subdivided into population subgroups such as pregnant women, adolescent girls, adolescent boys, men, PLWHAs, etc.

Phase II: Interactive Group Planning

Interactive Group Planning follows the rapid assessment. This second phase focuses on the identification and implementation of selected actions that may correct for each gap or weakness and take advantage of certain opportunities. The most important goal of this phase is to reach a consensus on realistic actions. Participants will be asked to make commitments to specific actions for implementation. It is important that they take these responsibilities seriously and execute the actions they agree to take on within the timeframe determined.

Interactive Group Planning takes place primarily during an Action Planning Workshop, a participatory group meeting with an action plan as the output. It is a three-to-four day activity that engages the same key stakeholders from initial meetings (Phase I, step 2) and any other central-level decision-makers key to program implementation. They come together to share experiences, knowledge, and ideas for addressing the central problem; to debate and agree on priorities for action; and to develop a complementary, coordinated action plan.

Prepare for Interactive Group Planning. Workshop planners must clearly define the role of each participating organization during the workshop, as well as the potential benefits to each. The host organization (usually the MOH) should also be prepared to play a critical role in implementation. After the Strategic Mapping exercise, the host organization will ultimately be the main channel through which the action plan is monitored. The organization must plan for this role by deciding exactly how, when, and by whom the action plan will be followed. Expert consensus-building facilitation skills are critical to ensure optimal contributions from all participants.

The degree of decision-making authority of participants in the Action Planning Workshop is often directly related to its success. Therefore, the Strategic Mapping Team must inform and motivate the targeted participants before the meeting. The participation of a mix of decision-makers, managers at all relevant levels, major service providers, and beneficiary representatives increases the likelihood of developing a comprehensive and realistic action plan with the highest probability of effective implementation. Much of the preparation for this workshop cannot be done until after Phase I when information is collected.

Conduct the Action Planning Workshop. During the workshop, the facilitators should:

Explain the workshop objectives and review the Strategic Mapping process. Facilitators should explain the workshop objectives: 1) reach a common understanding of the major gaps and opportunities; 2) develop a consensus-based action plan; 3) develop a consensus-based monitoring plan; 4) obtain a commitment from each implementing partner; and 5) build a collaborative coalition to implement and monitor the action plan. Facilitators should review the Strategic Mapping process for any participants who have not been actively engaged previously and the importance of the action planning stage. This task is of critical importance because the quality of the individual participants' contributions will affect the discussions and planning.

Identify the lead organization and implementing partners. The workshop should emphasize the clear assignment of responsibility to the lead organization and the implementing partners. Individuals from these organizations should be enthusiastic about implementing agreed-upon priority actions. They must have the full support of decision-makers, including the time and resources to carry out the activities in the action plan.

Encourage full participation. An important task for the facilitators is to moderate the discussions so that undue weight is not given to participants with more seniority in the health system or in other participating sectors. The facilitators should emphasize at the start of the workshop that everyone's viewpoint is equally valid and that all perspectives must be heard to achieve genuine consensus.

Manage time, balancing flow and flexibility. This is a three-day workshop involving different sub-groups and a variety of issues. The facilitators should be aware of how each group is functioning and lend support to move a group forward when necessary. Using a variety of tools—such as data maps, a service delivery grid, the ideal performance grid, a format for action planning—the facilitators must review the findings to date, reach consensus on results, engage the participants in prioritizing actions, and provide enough structure and flexibility for the participants to complete the development of micro-action plans focused on different components of programming. At several points in the workshop, the facilitators will need to help the participants pull together different threads of discussion into a set of shared perceptions. They must ensure that the micro-action plans are effectively combined into one final action plan.

Resolve conflicts. There may be disagreements and strong emotions that surface during the workshop. This airing of hidden or unknown conflict can be a valuable way to remove obstacles if the facilitators focus on using the workshop as a new starting point for reaching the goal (e.g. increased contraceptive prevalence, integration of family planning with HIV/AIDS, sustainable service provision). Facilitators need to make sure that conflict does not derail the process by maintaining a role as an objective outsider who intervenes when necessary, resolving or postponing the resolution of issues.

Document the decisions made. The facilitators are responsible to ensure that all points agreed upon are documented. This will largely be accomplished through the use of the various tools included in these guidelines or on flipcharts and transparencies. As the action plan is being developed, small groups will be working with previous decisions and refining priorities, so facilitators need to make sure to print and distribute these decisions to the participants. The facilitators should make sure that the decisions are typed up and saved to be fed into the final workshop report.

Phase II: Interactive Group Planning

Timing: Interactive Group Planning begins as soon as the Participatory Rapid Assessment phase is complete.
Duration: This phase lasts approximately two weeks to a month, beginning with preparations for an Action Planning Workshop and ending with the final development of the action plan and its distribution.

Objectives	Step by step activities	Materials
Reach a common understanding of the major gaps and opportunities identified during Phase I, Participatory Rapid Assessment. Develop a consensus-based action plan to resolve the central problem and, perhaps, scale up existing promising or best practices. Develop a consensus-based monitoring plan for implementing the action plan.	1. **WORKSHOP PREPARATION (approximately 3-4 days dispersed over 1-2 weeks)** a. Prepare and send formal invitations that include a brief overview of the workshop's purpose and agenda to targeted participants. Participants should primarily be key stakeholders from the initial consensus-building meeting. Although very busy, decision-makers need to set aside four days for this activity. Follow-up the invitations within one week of receipt to ensure that the time is set aside. If key participants are unable to attend, it may be preferable to change the dates, as participation of key decision-makers is critical. b. Arrange logistics in advance, including travel arrangements, per diem, selection of appropriate location, timing, and so on. The location selected should be able to accommodate all the anticipated participants. It should include two or three breakout rooms for the small group work. Breaks and lunches should be scheduled. c. The Strategic Mapping Team Leader should contact prospective participants before the workshop, either through a direct visit or a telephone, fax, or e-mail message via their organization. An agenda and written draft of the program should be given to the prospective participants during this contact. This offers an opportunity to provide the invitees with new information about the workshop objectives, and to include some of the key findings and overall approach. Facilitators should be prepared to provide additional information on the Strategic Mapping approach if it is requested.	Workshop invitations Workshop agenda List of participants

Objectives	Step by step activities	Materials
Obtain a commitment from each partner organization for implementing the action plan. Build a collaborative coalition among participants to complement and mutually support each other in implementing and following through on commitments to action.	**2. THE ACTION PLANNING WORKSHOP (3 days)** <u>Day 1</u> a. Welcome participants, make introductions, review agenda, and explain administrative logistic matters. (30 minutes) b. Present relevant technical background information. This step may include presentations about state-of-the-art global thinking on the technical issues related to the central problem, best practices, advocacy for policy change, and so on. (1 hour, including discussion) c. Review the Strategic Mapping process to ensure a common understanding of the approach which has led to this point. This can be done with a PowerPoint presentation. In addition, review the Strategic Map that was filled in at the initial consensus-building meeting. (30 minutes, including questions) d. Present the main findings from the Participatory Rapid Assessment. Hand out a completed Analytical Map of Gaps and Opportunities: Summary of Findings Matrix. Present the gaps, weaknesses, and opportunities simply by summarizing each in a few words or sentences. Have participants work in small groups to review the information and reach consensus on each component that has been presented. (1 hour) – Any disagreements or differences in perspectives about results should be discussed and then reported in plenary. – Have each group fill out the Service Delivery Grids with the status of service delivery at each level of the system. This is an important step because it complements the data gathered during Phase I by introducing into the analysis the experience of those working at each level.	Agenda (handout and transparency) Technical presentations, as needed Presentation on the Strategic Mapping process and Strategic Map (taped to wall) Analytical Map of Gaps and Opportunities: Summary of Findings (presented in Phase I on page 49) Service Delivery Grid, handouts and transparency (page 58)

Objectives	Step by step activities	Materials
	e. Return to the plenary and have each small group present their maps/grids showing where they have agreed the gaps exist, where services are available, and where referral is available. (1 hour, including discussion) f. The group should then answer the question: "Based on these gaps, weaknesses, and opportunities, what are the biggest challenges we can act upon to get the best results?" This question opens up the discussion to the group to select priority actions that are feasible given ***existing*** resources. First, however, using the overhead projector, overlay each Service Delivery Grid completed by the small groups on the Ideal Performance Grid developed in Phase I (these grids should have the same format and categories). Overlay them one by one and discuss the differences. Through color coding, the program gaps, weaknesses, and strengths become readily apparent. As the two grids are overlaid, it is important that the facilitators point out where the discrepancies exist between what is "ideal" and what currently exists. These discrepancies represent the ***real program gaps*** and should be easily seen with the use of color coding. This powerful tool can visually communicate where action is needed. It draws attention to patterns and linkages. Review the Strategic Map and add/delete any information for each program performance dimension. When discussing actions for implementation, emphasis should be placed on planning activities that will contribute to the desired or ideal results within a 6- to 12-month timeframe with commitments from all. (1½ to 2 hours)	Ideal Program Performance Grid prepared in Phase I handout and transparency (page 34)

Objectives	Step by step activities	Materials
	DAY 2 a. Discuss promising practices in plenary. Try to fit them into the identified program gaps and opportunities. (45 minutes) b. In small groups, prioritize the gaps and/or opportunities for action based on: i) feasibility given existing resources ii) contribution to the expected results iii) whether it is possible to implement and produce results within 6 to 12 months Each group should summarize the priorities and determining factors. For best results, weigh the effect of each potential action on addressing the gap and achieving the desired results. (1.5 hours) c. Each group should present its work in plenary. The lead facilitator must guide this discussion so that it will lead to a consensus among the larger group on the priorities and rationale. (1.5 hours) d. Develop the Micro-Action Plans. Breaking into four groups, have each group select one program performance dimension (access, quality, demand, and sustainability). Each group should tackle the priority challenges related to that program performance dimension as reached by consensus in the previous discussion. For example, one group will develop an action plan for access, another for quality, another for demand, and another for sustainability. The division of labor needs to be adapted to the situation, depending on the priority gaps and opportunities that have been identified and the number of participants. If there are too few participants or fewer challenges in one dimension, groups can be combined. Include in the plan the specific activities that need to be undertaken, who should undertake them, when, and indicators of success. Use the Format for Micro-Action	Format for Micro-Action Plan handout or transparency (page 63)

Objectives	Step by step activities	Materials
	Plan within each group. (7-8 hours. 4 hours can be done on day 2 of the workshop. The remaining time can be continued on day 3.) <u>DAY 3</u> a. Complete development of the micro plans of action. (3-4 hours) b. Each small group presents its Micro-Action Plan in plenary. A discussion follows amongst the larger group on the assumptions, potential constraints, and challenges involved. Partners identify areas where they can coordinate activities and support one another. Get a verbal commitment from the partners regarding the actions that each organization will undertake to fulfill the action plan. Hand out the "bridges" that come with the Strategic Map. Have participants write agreed-upon corrective actions on each bridge and tape the bridges to the Strategic Map in the appropriate place. The bridges represent action that will bridge the gap (what is written in the river below) between the opportunities and the desired results on road to success. Bridges should be completed for each program performance dimension. For example, one bridge will describe the actions that will be taken to resolve the gaps in access at the community level (and would be taped to the community sector in the access program performance dimension of the Map). (30 minutes per group for presentation. 15 minutes to discuss how the plans will be pulled together into an overall written plan. 15 minutes to obtain commitments. 15 minutes to complete Strategic Map.) c. Discuss follow-up for coordination and supervision of the activities. This final session should be led by the host organization or the organization that has agreed to follow-up on the action plans. Assign specific responsibilities for developing the monitoring and evaluation (M&E)	Either provide copies of each group's handout or show transparency Bridges from Strategic Map cut into single bridge pieces (included at the end of the manual)

Objectives	Step by step activities	Materials
	component of the plan. This can take a great deal of time, so a smaller group of participants—those who will be working on monitoring and evaluation—should ideally form an M&E Committee. They will be responsible for overseeing M&E and developing necessary tools that are not too specific to any one system. Each organization has its own monitoring and evaluation system, so the group will need to decide how they will collaborate. For purposes of presentation, guidelines for the M&E Committee follow in the next section, "Phase III: Program Implementation and Monitoring." (1 hour) d. End the workshop with concluding remarks. Thank the participants and encourage them to fulfill their commitments as documented in the action plan. Tell participants that copies of the Final Action Plan (combination of all Micro-Action Plans) and the report of the workshop will be sent directly to them (preferably within two weeks). (15 minutes)	

Service Delivery Grids

Objective: To identify the gaps for priority action.

Each group should:

1. Identify someone to report out to plenary.

2. Fill in the grids (attached) regarding access, quality, demand, and sustainability of services:

   a. For each grid, fill in each line based on consensus. Use color coding as outlined below.

      X = green
      0 = red
      R = blue
      NA = black

   b. Note X, O, R, or NA as follows :
      - X represents the service activities, information, etc., that exist in a permanent and satisfactory way
      - 0 represents the service activities, information, etc., that do **not** exist in a acceptable way or do not exist at all for the client.
      - R represents that referral is made systematically
      - NA represents that the category is not applicable.

3. Use the hard copies during your discussions

4. Once the group reaches a consensus, write down the results on transparencies using the same color scheme.

SERVICE DELIVERY GRID (continued)

By level of service delivery

	Village Health Center	Maternity Center	Maternal and Child Health Center	Regional Hospital	Private Clinic/NGO	Pharmacy	Community groups, religious institutions	Schools	Other Sectors	Media	
1. Minimum package of information on FP/RH											
Adolescent Girls											
Women of Reproductive Age											
Adolescent Boys											
Men of Reproductive Age											
Parents											
2. Counseling in FP/RH											
Adolescent Girls											
Women of Reproductive Age											
Adolescent Boys											
Men of Reproductive Age											
Parents											

X represents the service activities, information, etc., that exist in a permanent and satisfactory way.
0 represents the service activities, information, etc., that do **not** exist in a acceptable way or do not exist at all for the client.
R represents that referral is made systematically
NA represents that the category is not applicable.

SERVICE DELIVERY GRID (continued)

By level of service delivery

	Village Health Center	Maternity Center	Maternal and Child Health Center	Regional Hospital	Private Clinic/NGO	Pharmacy	Community groups, religious institutions	Schools	Other Sectors	Medi a	
3. Availability of FP/RH Services and Products											
Condoms, spermicides											
Injectable											
Pill											
IUD											
Norplant											
Post-abortion care											
STI testing											
STI treatment											
VCT											

X represents the service activities, information, etc., that exist in a permanent and satisfactory way.
0 represents the service activities, information, etc., that do **not** exist in a acceptable way or do not exist at all for the client.
R represents that referral is made systematically
NA represents that the category is not applicable.

SERVICE DELIVERY GRID (continued)

By service delivery provider

	CBD Worker	Sanitary Agent	Health technician	Nurse	Nurse Midwives	Doctors	Pharmacies	Women's Groups	Religious Leaders	Community Leaders
1. Minimum package of information on FP/RH										
FP										
Post abortion care										
STI										
HIV/AIDS										
PMTCT										
2. Counseling in FP/RH										
FP										
Post abortion care										
STI										
HIV/AIDS										
Persons living with HIV/AIDS										

X represents the service activities, information, etc., that exist in a permanent and satisfactory way.
0 represents the service activities, information, etc., that do **not** exist in a acceptable way or do not exist at all for the client.
R represents that referral is made systematically
NA represents that the category is not applicable.

SERVICE DELIVERY GRID (continued)

By service delivery provider

	CBD Worker	Sanitary Agent	Health technician	Nurse	Nurse Midwives	Doctors	Pharmacies	Women's Groups	Religious Leaders	Community Leaders
3. Availability of RH Services/Products										
Condoms, spermicides										
Injectable										
Pill										
IUD										
Norplant										
Post-abortion care										
STI testing										
STI treatment										
VCT										

X represents the service activities, information, etc., that exist in a permanent and satisfactory way.
0 represents the service activities, information, etc., that do **not** exist in a acceptable way or do not exist at all for the client.
R represents that referral is made systematically
NA represents that the category is not applicable.

Micro-Action Plan

Structure or Geographical Coverage of Intervention (optional)	Priority Gaps, Weaknesses, and/or Opportunities	Corrective Activities	Responsible	Outputs	Dates	Indicators (& Method to Measure)	Assumptions

Phase III: Program Implementation and Monitoring

Based upon the Final Action Plan developed in Phase II, Strategic Mapping partners should aim to implement changes as quickly as possible and monitor them using the existing health information system. During the Action Planning Workshop, or immediately thereafter, an M&E Committee should be established with the following objectives: 1) to assist key stakeholders and implementers to develop an M&E plan, 2) to inform key stakeholders of the implementation status of the Final Action Plan, 3) to strengthen stakeholders' ability to report results and justify resource requests, and 4) to identify lessons learned and best practices and share them with development partners.

Traditional external assessments and evaluations often end with a non-binding report of recommendations. Implementation is then left to the discretion of program managers or donors. By contrast, the Strategic Mapping process results in a Final Action Plan for the resolution of problems, along with a clear commitment to implementation from each participant. The M&E plan is one way to maintain accountability and help solve problems if they arise.

Develop the M&E plan. The Strategic Mapping Team should assist the M&E Committee develop potential indicators, set criteria for selecting indicators, and then select those that realistically can be monitored, preferably with little change to the existing M&E systems. They should assist the M&E Committee in preparing a data collection schedule. These components can then be documented in a formal M&E Plan in collaboration with key stakeholders.

Involve key stakeholders. Because strategic monitoring can help improve the entire primary health care system, the highest echelons of management in the country's health care system should be involved. The support of the MOH and the involvement of the national director of health care services must be obtained. The head of the directorate or division of primary health care must have primary responsibility for introducing strategic monitoring into the system. The M&E Committee should not replace the existing M&E department, nor play the same role, but ensure the specific indicators from the M&E plan are integrated and tracked according to the plan.

Track individual projects. To ensure that the activities in the Final Action Plan are implemented effectively, it is important to track individual projects, to signal when results are less then anticipated, and to identify possible problems. Moreover, it is essential to identify lessons learned and best practices that can be replicated.

Maintain regular contact. Immediately after the Action Planning Workshop, regular contact (by phone or email) and/or periodic meetings should be maintained with the participants responsible for implementing the changes.

Facilitators can use the guide that follows to develop the M&E component of the Final Action Plan. All stakeholders should then begin implementation of activities.

Phase III: Program Implementation and Monitoring

Timing: Development of an M&E plan can occur as part of the Action Planning Workshop or immediately after its formal closure.
Duration: Planning the M&E component requires a half to a full day. Its implementation lasts as long as the implementation cycle, which could be 6-12 months.

Objectives	Step by Step Activities	Materials
Assist country stakeholders to develop a sound M&E plan to follow-up short- and long-term activities outlined in the Final Action Plan Inform stakeholders of the implementation status of the Strategic Mapping by identifying what works, what does not, and why Strengthen stakeholders' ability to report results and justify resource requests to donors, the government, and the community to fill in the identified gaps Identify and share lessons learned and best practices that can be utilized across programs	During the workshop, participants should undertake the following steps. Alternatively, a small group of participants can continue to meet as an M & E Committee immediately after the conclusion of the main workshop to undertake the following steps. 1. Develop a list of potential indicators for monitoring the Final Action Plan as shown in the template "Defining Potential Indicators." These indicators should generally be those that are currently available from various data sources, such as the MOH, the Ministry of Education, the Ministry of Population, the Demographic and Health Survey (DHS), etc. Occasionally a special survey may be required. The initial list will likely have too many indicators to be practical. Moreover, each sector may have its own set of indicators. 2. Set criteria for selecting indicators to actually monitor. Criteria may include how specific and relevant the indicators are, ease of data collection, time required, cost of tracking the indicator, etc. Write these criteria at the top of each column in the form entitled, "Selecting Indicators." 3. Select indicators that will actually be used to monitor the Final Action Plan using criteria filled in on the "Selecting Indicators" form. Too many indicators are cumbersome and require additional resources. A set of five to ten indicators can realistically be selected during the workshop. Reach a consensus on the set of indicators to be tracked to ensure a strong M&E Plan.	"Defining Potential Indicators" (page 67) Selecting Indicators (page 68)

Objectives	Step by Step Activities	Materials
	The M&E Committee should be on-going and meet periodically, depending on the nature of the Final Action Plan, the speed of implementation, and schedules of its members. It may decide to meet monthly or quarterly based upon the timing of the Final Action Plan. As the Final Action Plan is meant to cover 6-12 months, it could be ineffectual to meet less than each quarter. The M&E Committee should: a. Determine a schedule for data collection activities using the "Schedule for Data Collection Activities." b. Develop the M&E Plan in collaboration with the MOH or the host organization, using the "Monitoring and Evaluation Table." c. Meet periodically to ensure track progress of the implementation of the Action Plan. d. Use the "Strategic Mapping Monitoring Report" to track individual projects, signal when results are less then anticipated, identify possible problems, and identify lessons learned and best practices for replication.	Schedule for Data Collection Activities (page 69) Monitoring and Evaluation Table (page 70) Strategic Mapping Monitoring Report (page 71)

Defining Potential Indicators

Identified Gap or Opportunity	Objectives/Desired Results	Activities	Potential Indicators
		Activity 1: **Activity 2:**	**Indicator 1:** **Indicator 2:** **Indicator 1:** **Indicator 2:**
		Activity 1: **Activity 2:**	**Indicator 1:** **Indicator 2:** **Indicator 1:** **Indicator 2:**
		Activity 1: **Activity 2:**	**Indicator 1:** **Indicator 2:** **Indicator 1:** **Indicator 2:**

Selecting Indicators

Criteria for selecting indicators
(include in each column below the selection criteria the group decided to use—columns presented are illustrative and should be adapted to the Final Action Plan and M&E Plan)

Potential Indicators	Indicator exists in current M&E System	Cost of obtaining data	Time required	Other
Indicator 1				
Indicator 2				
Indicator 3				
Indicator 4				
Indicator 5				
Indicator 6				
Indicator 7				
Indicator 8				
Indicator 9				
Indicator 10				

Schedule For Data Collection Activities

Data Collection Activity	Month/Year	Indicators relying on these data	Person/organization responsible (sole or shared)	Estimated cost (total and shared)

Monitoring And Evaluation Summary

Indicator	Definition	Data Source	Collection Method	Responsible	Periodicity

Strategic Mapping Monitoring Report

Objective	Responsible	Others involved	Completed	Continuing	Not addressed	Deferred

FOLLOW-UP ACTIVITIES

A successful Strategic Mapping process will have set the stage for rapid effective implementation of planned activities over a 6 to 12 month period using existing or easily available resources. The main goal of the process is clearly to build consensus and commitment around a rational review of the existing situation. It is designed for key stakeholders involved in the process to be accountable to the group and to achieve results collaboratively and rapidly.

Suggested follow-up activities for the host organization include the following:

- The host organization and the Strategic Mapping Team meet to clarify the responsibilities they and other leaders of the process will take on.
- The host organization and Strategic Mapping Team approve the Final Action Plan and integrate it into their own organizations' operational plan.
- The host organization distributes the workshop report and Final Action Plan and informs the entire staff and board about the process: the rationale for Strategic Mapping, the benefits to the organization and national FP/RH program, the main conclusions of the workshop, and upcoming changes.
- A cyclical approach to follow-up is recommended for the medium and long-term. Ideally, the host organization will ensure that Strategic Mapping will be undertaken at least annually, incorporating the lessons and results of the previous exercise into plans for the next set of priority issues.

Suggested follow-up activities for the Strategic Mapping Team include the following:

- Prepare the workshop report summarizing the key findings, presenting the Final Action Plan, and detailing the M&E plan.
- Review this report with the host organization and the Strategic Mapping Team prior to its circulation.
- Verify that the plan is based on use of existing resources.
- Distribute the report to key stakeholders and data sources, including all who were involved in each phase of the Strategic Mapping process.
- Discuss options for periodic communications, e-mails, teleconferences, or meetings, with the host organization and key stakeholders involved in implementing the Final Action Plan.

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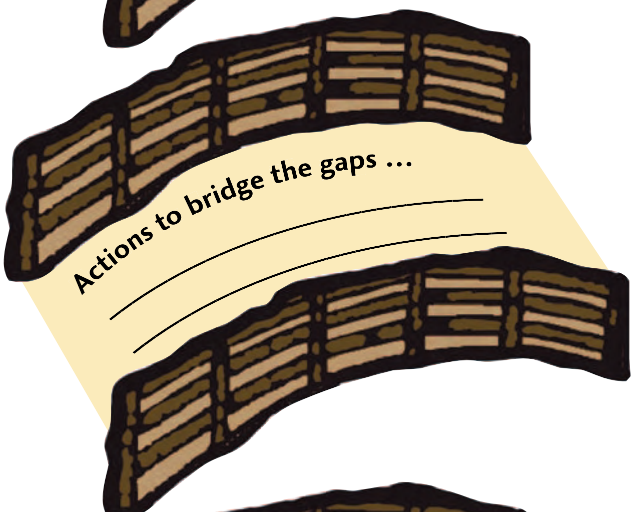
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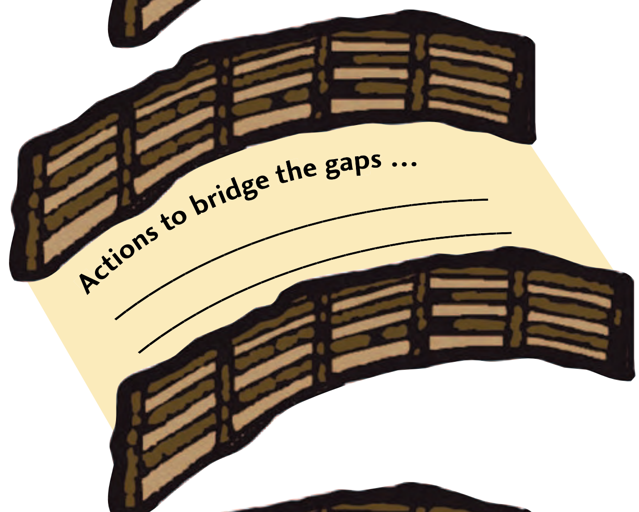
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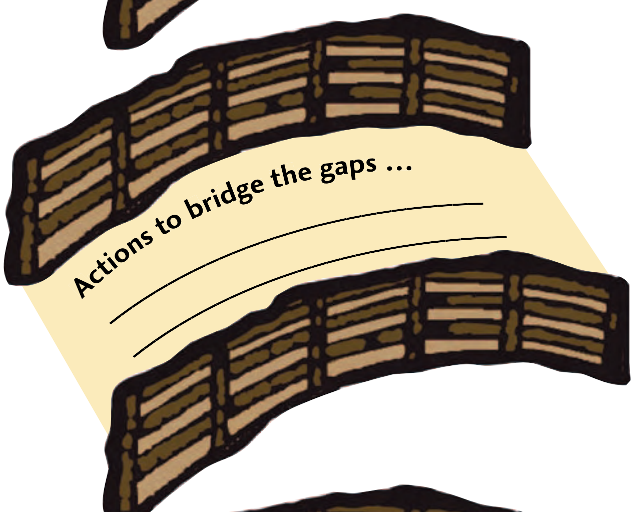
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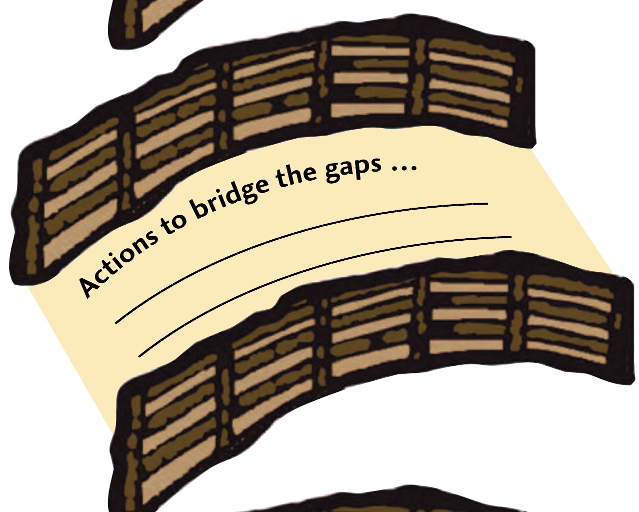
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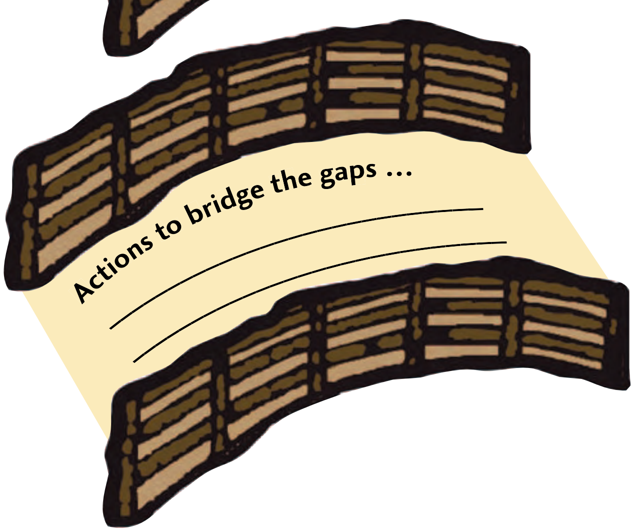
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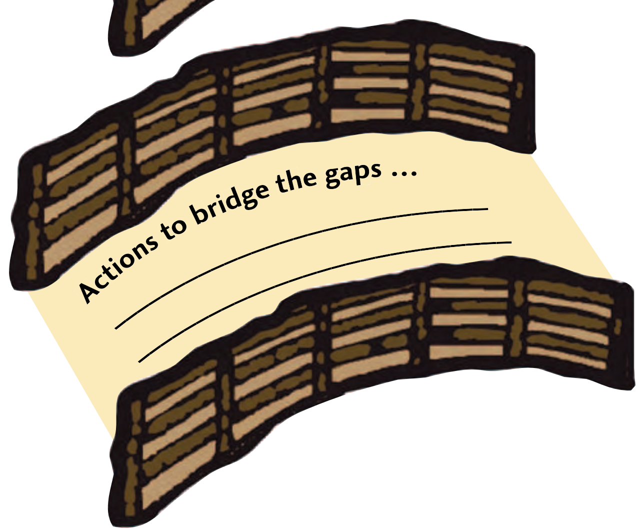
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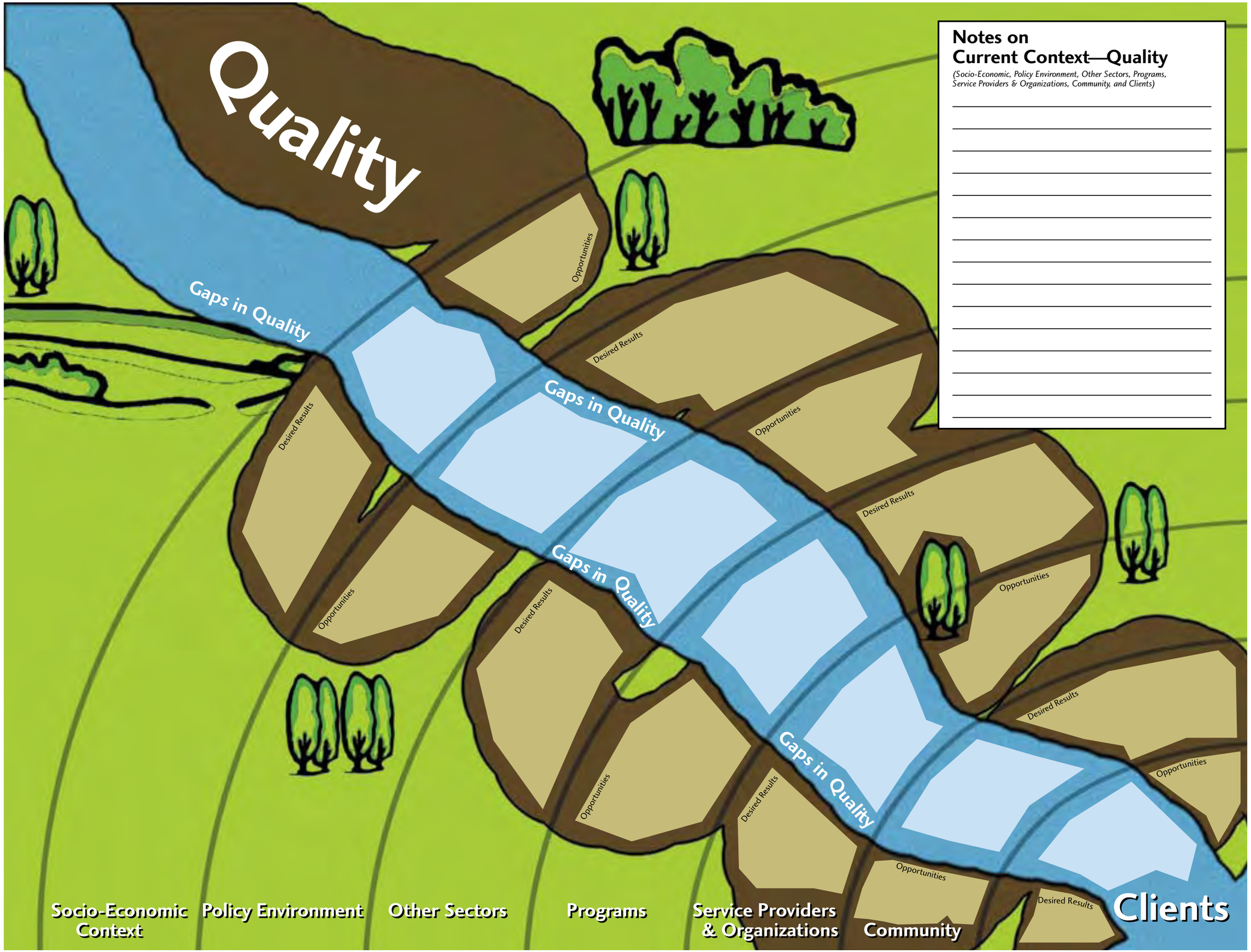

Notes on Current Context—Quality

(Socio-Economic, Policy Environment, Other Sectors, Programs, Service Providers & Organizations, Community, and Clients)

Notes on Current Context—Demand

(Socio-Economic, Policy Environment, Other Sectors, Programs, Service Providers & Organizations, Community, and Clients)

Demand

Gaps in Demand

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Desired Results

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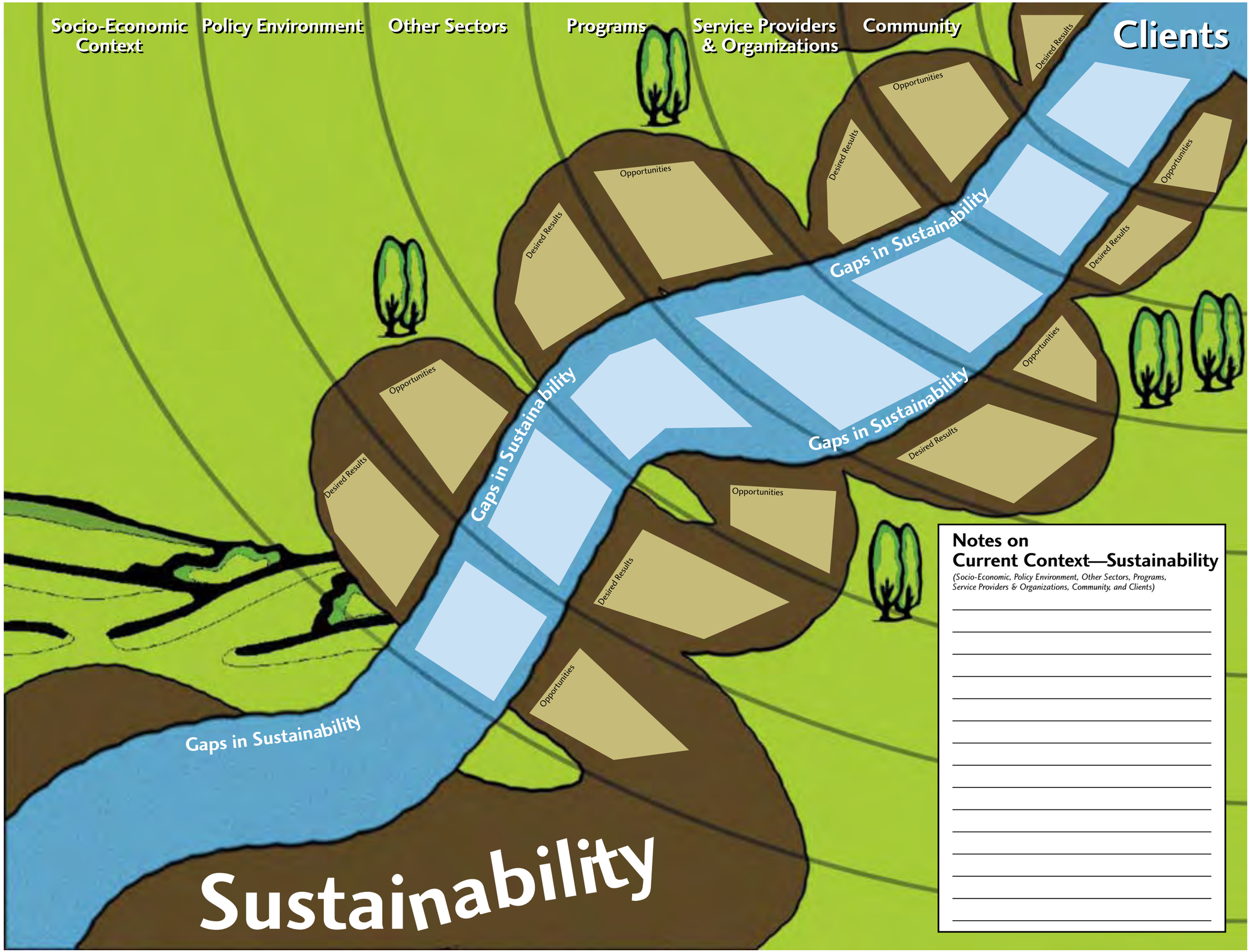
Service Providers & Organizations

Programs

Other Sectors

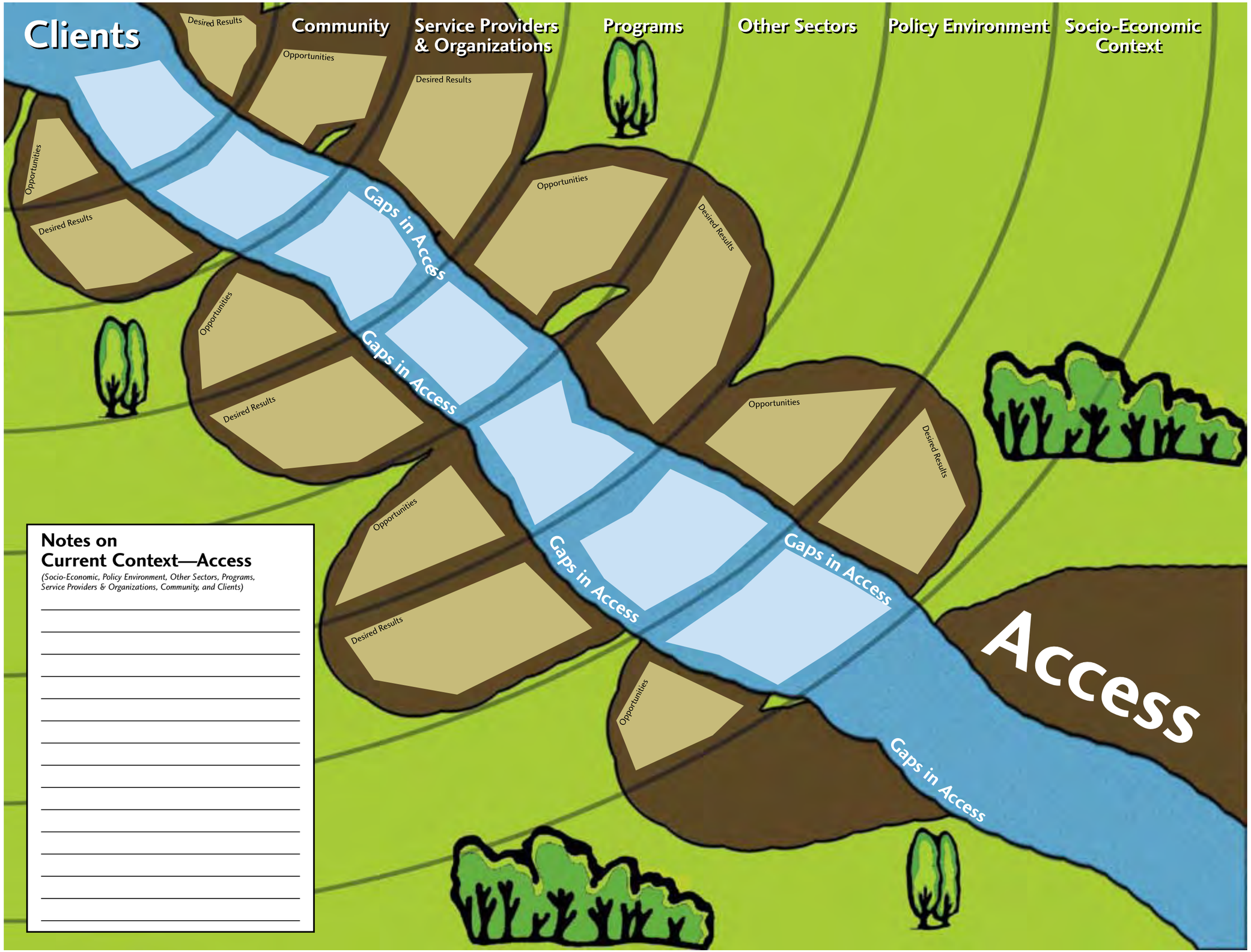
Policy Environment

Socio-Economic Context



Notes on Current Context—Sustainability

(Socio-Economic, Policy Environment, Other Sectors, Programs, Service Providers & Organizations, Community, and Clients)



Notes on Current Context—Access

(Socio-Economic, Policy Environment, Other Sectors, Programs, Service Providers & Organizations, Community, and Clients)

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