Participant's Manual

District Health Planning

Pakistan's Districts That Work Project

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Abbreviations:

AIHS: Assistant Inspectress Health Services
ANC: Antenatal Care
ARI: Acute Respiratory Infections
CD: Communicable Diseases
CPR: Contraceptive Prevalence Rate
CDD: Control of Diarrhea Diseases
DCo: District Coordinator
DDOH: Deputy District Officer Health
DHIS: District Health Information System
DoH: Department of Health
DOH: District Officer Health
DHPT: District Health Planning Team
EPI: Expanded Programme on Immunization
FLCF: First Level Care Facility
FP; Family Planning
GM: Growth Monitoring
HH: Health House
HMIS: Health Management Information System
IMR: Infant Mortality Rate
IMCI: Integrated Management of Childhood Illnesses
IPC: Interpersonal Communication
LBW: Low Birth Weight
LHS: Lady Health Supervisor
LH Lady Health Visitor
LHW: Lady Health Worker
MCH: Mother and Child Health
MIS: Medical Information System
MMR: Maternal Mortality Ratio
MoH: Ministry of Health
NP; National Programme
PHC: Primary Health Care
PHSRP: Punjab Health Sector Reform Programme
RH: Reproductive Health
ToT: Training of Trainers
USAID: United States Agency for International Development

Preface

District Team Problem Solving (DTPS) is one outcome of over twenty years of continual health planning methodology development by the World Health Organization. It is based on the problem-oriented, "rational-analytical" planning concepts and methods in the project management approach developed in the early 1970 entitled "Project System Analysis".

As health systems infrastructure development progressed in most developing countries, decentralization of management authority and control became a common policy and phenomenon, partly because Government-wide reform was going in this direction, particularly in health, because of full implementation of Primary Health Care, community involvement in health demands planning and action-taking below the central level. Pakistan is a developing country and has been lagging behind many low - income countries in terms of health. The Government of Pakistan is committed to supporting the "Health- for All" philosophy as reflected in National Health Policy of 2001.
In this regard, a number of new initiatives have been launched and a greater emphasis has been placed on strengthening of health systems. The devolution initiative opened new avenues for potentially improvement in health service delivery at the district level while a number of new service delivery models held the promise of impacting outcome at the grassroots level. Such policy changes in health sector warrant the need for effective strategy and operational planning. There is growing realization that unless there is capacity building for policy development and planning in the health at the Federal, Provincial and district levels, the level of achievement shall continue to remain low.

New management structure based on devolved administrative and financial authority to the District Government is still in transitional phase and experiencing a number of limitations such as resource scarcity and inappropriate capacity for planning and management of health care facilities. District Health Team may be

taken as nucleus for district health management and service delivery. The existence of strong District Health Team would definitely result in an effective service delivery system at district level.

Capacity building is pre-requisite for a successful performance of Health Team. This training module on health planning has been developed taking the concept of WHO "District Team Problem Solving (DTPS)" health planning approach which has been adopted and modified.

1: District Health Planning:

District health planning is a process, which takes approximately one year, in which teams of health workers are guided, (with rigorously structured sequences of assignments) in:

- ❖ conducting their own analysis of one high priority public health problem, for example in PHC or RH in their district
- ❖ devising and then implementing their own solution to this problem over a one year period
- ❖ conducting and presenting the results of their own evaluation of their implementation (progress, constraints, service improvements, and health impact)
- ❖ developing the ability to gather and use data
- ❖ developing good team work and improved managerial skills

PLANNING: During an initial planning workshop of 03 days, team develops its most feasible solutions and its implementation plan.

IMPLEMENTATION: The team then carries out its implementation plan over a predetermined period (10-12 months).

SELF EVALUATION: Finally, the team presents its self-evaluation at a 01 day follow-up workshop. The team then programmes its future activities, usually for the next year.

Health planning is an on going and continuous process and every year a new or the previous year health problem is identified depending upon the situation analysis of district health profile.

1.1 Planning Strengthens Management of Health services

As part of the planning process, teams will:

- ❖ systematically analyze a problem
- ❖ identify principal causes and locally feasible solutions within the national policy and Programme framework
- ❖ plan and put into operation the team's implementation activities within a realistic time frame
- ❖ decide how they will monitor and evaluate both their efforts to implement and the success of their envisioned solution

- ❖ present all this clearly and briefly within a coherent action plan (or team project proposal)

- ❖ Learn, listen and to use all members during the one year period, thus to function as a real team and to develop team spirit.

In this planning process, district teams find solutions that do not require additional resources. Addressing the question "what can we do to improve this health condition in our population with the resources available within our district"? Team members consult each other. They work on linkages with other sectors and activate the collaboration of those sectors and the participation of their communities.

Health Planning improves communication and teamwork among district health staff through constructive and responsible dialogue within the group and with other staff. The initiatives and actions discussed are those coming from the district staff. They are based on local resources and circumstances. Hence, Planning creates the organizational dynamics required for effective delegation and decentralization of responsibilities.

Through all these effects, planning strengthens management of district health services and produces better health status through improvement in performance of targeted health services, as a result of the initiative, effort and teamwork of district health personnel, usually in combination with the communities they serve.

1.2: Health problems addressed through planning

In planning process, team members must be convinced that the team is addressing a real, very important public health problem in the population for which it is responsible, so that they feel justified in undertaking a sustained effort to solve that problem. Also, the important feeling of "ownership" of the problem would be assured by such self-selection

The problem selected should, therefore, be some specific deficiency in health status of high priority in the district population, e.g. excessive maternal mortality, an unacceptably high prevalence of severe child malnutrition, short birth interval, excessive measles morbidity, etc.

The team also needs to feel that it will be able to achieve significant improvement in this public health problem – or at least to significantly raise the level of the services needed to do so – by making better use of already existing district health resources and/or by mobilizing resources in the community or available through other sectors.

1.3 Nature, objectives and contents of the Planning workshop:

The planning workshop guides groups of district health workers to function as teams while they systematically work their way through the steps needed to develop their own feasible and effective solutions to real health problems. To achieve this, each team completes a series of carefully sequenced and pre-specified tasks, which are introduced and clarified by facilitators. The teams are informed clearly about what they must do and produce in each session, and are shown examples of successful products, It is necessary to clearly state the objectives of the workshop (planning phase). An example of objectives for the planning phase is shown in Figure 2.

Figure 1

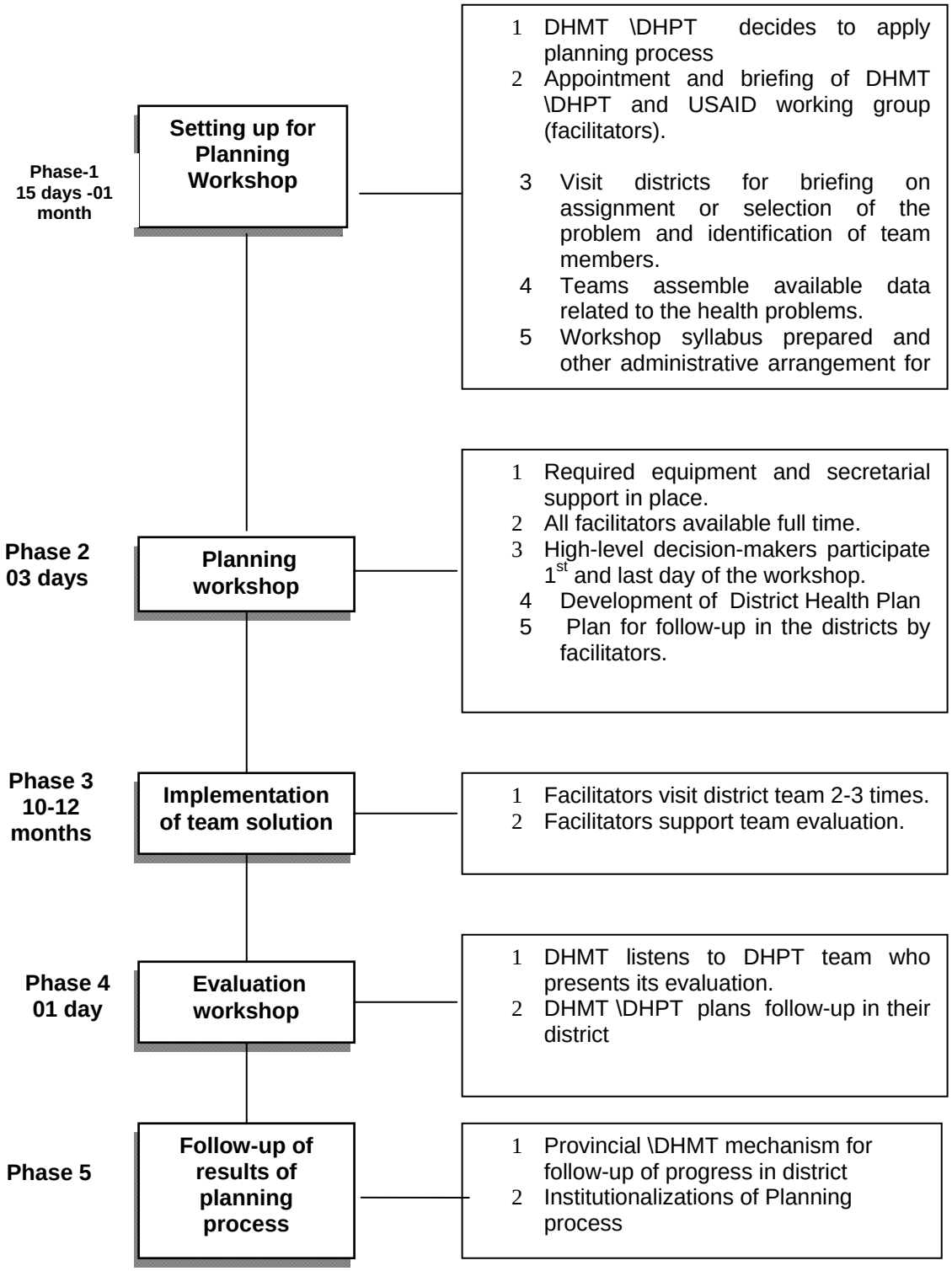

Phase-1
15 days -01 month
Setting up for Planning Workshop
1 DHMT \DHPT decides to apply planning process
2 Appointment and briefing of DHMT \DHPT and USAID working group (facilitators).
3 Visit districts for briefing on assignment or selection of the problem and identification of team members.
4 Teams assemble available data related to the health problems.
5 Workshop syllabus prepared and other administrative arrangement for
Phase 2
03 days
Planning workshop
1 Required equipment and secretarial support in place.
2 All facilitators available full time.
3 High-level decision-makers participate 1st and last day of the workshop.
4 Development of District Health Plan
5 Plan for follow-up in the districts by facilitators.
Phase 3
10-12 months
Implementation of team solution
1 Facilitators visit district team 2-3 times.
2 Facilitators support team evaluation.
Phase 4
01 day
Evaluation workshop
1 DHMT listens to DHPT team who presents its evaluation.
2 DHMT \DHPT plans follow-up in their district
Phase 5
Follow-up of results of planning process
1 Provincial \DHMT mechanism for follow-up of progress in district
2 Institutionalizations of Planning process

Figure 2: Objectives for the Health Planning workshop

At the end of the planning phase, participants should*:*

1. Be able to function in a multi-disciplinary, problem-solving team within their district with the ability to:
   a) apply basic epidemiological analysis in the planning, management and control of PHC/RH, family planning and other public health services;
   b) define and diagnose health, organizational and operational problems at various levels;
   c) formulate practical solutions for such problems, solutions which can be implemented with existing resources and organizational set-ups;
   d) strengthen supervision in their district;
   e) monitor the progress and evaluate the effect of changes resulting from the implementation of their solutions;

2. Have in hand a proposal for solving, within their district, the assigned health problem; such proposal to have been reviewed by decision-makers and their support and guidance received in order that implementation of the proposed solution or its revision is undertaken immediately following the planning phase.

3. Be able to evaluate the effectiveness of their district problem solving effort, according to indicators and methods prescribed in the proposal, and to report the results of their evaluation to decision-makers within a follow-up evaluation process of the same participants to be held at that time.

The sessions, tasks, and major products of the planning workshop are sequenced as shown in Figure 3.

The teams are required to generate assigned diagnostic and planning products, which include lists, tables and diagrams. In these, the teams specify the causes of, and the solution to their health problem. Preparation of results is speeded up and facilitated by completion of four simple, tabular formats. Annex 1 includes the formats used for each session together with completed examples. Including intermediate working lists, the teams produce a total of about 20 paper products during the planning workshop. The final products form the major substantive tables and diagrams of the action plan document, which is completed by the end of workshop.

An agenda of the health planning workshop is shown in Figure 4.

1.4 : The structure of a typical workshop session:

Plenary briefing by a facilitator (lasting no longer than 10-15 minutes) to explain the tasks for the session. The facilitator covers the session objectives, the materials to be used, and the assigned team tasks and products. He or she clarifies what the team is to produce by showing well-chosen examples of the assigned table, or other products, that were produced by earlier teams using the same simplified formats. Copies of these blank formats are contained in the workshop syllabus to guide and assist in the preparation of assigned products. The facilitator does not lecture on the method to be used, but may need to define terms.

Team effort to accomplish the assigned tasks and products. Most of the time of the session (1-2 hours) is devoted to this active team-work: teams review data, organize their work, discuss, reach consensus, and prepare their products, again with very little outside support. Facilitators are present to provide support if required.

Presentations by teams of their products at the end of each session.

1.5 : Workshop syllabus and session guide

The planning workshop syllabus (see Box) is the key to communicating efficiently about the content, working methods, and schedule of the planning workshop. In practice, it is very useful in helping participants and facilitators to keep track of exactly what needs to be done and when during the workshop.

The syllabus should be produced by the coordinator and the core group of facilitators in advance of the workshop. It should clarify, for MoH/DoH decision-makers, support staff and facilitators, exactly what has to be accomplished during the workshop, and how. This should help them to understand why didactic teaching and extraneous or long interventions must be excluded from this workshop.

What needs to be done by the district teams at every point of the planning workshop is clearly presented in the session guides. The prototype session guides (see Annex 1) should be locally adapted as necessary, and then included in the workshop syllabus.

Figure 3: Sessions, tasks and products of the Health Planning Workshop

Sessions	Health Planning Tasks	Main Products
1.	Opening – Identification of health problems	Health problems identification
2.	- Review of available data - Identify problem indicators	❖ Health Problem prioritization ❖ Initial problem table and indicators
3.	Analyze problem variables	❖ Problem diagram
4.	Generate and select ideas for solving the problem	❖ List of selected ideas \ solutions
5.	Formulate and set objectives and targets	❖ Table of objectives and targets
6.	Plan implementation of the solution	❖ Implementation plan (activity schedule and responsibilities)
7.	Develop monitoring and evaluation plan	❖ Table of evaluation indicators ❖ Description of evaluation method
8.	Write proposal document	❖ Proposal document ❖ Prepared presentation
9.	Present proposal	❖ Decision-makers reaction to the proposal
10.	Evaluate and close the planning process.	❖ Summary of participant evaluations ❖ Closing by chief guest

District Health PLANNING

- **Workshop sessions**
- **Formats**

Session 1: OPENING

Objectives

At the end of the session, participants should:

1. Have orientation regarding District health infrastructure and current status of health services.
2. Understand the objectives of the workshop and its methods of work.
3. Be familiar with the workshop syllabus, its session guides and background materials.
4. Understand the rationale of the team approach to problem solving.
5. Understand, in general, the health problems of the district and responsibility for addressing and reducing the problems over the next 10 - 12 months, and evaluating their results.

Materials

1. Workshop syllabus including the objectives and methods of work, the workshop session guides and related formats and background materials.

Programme

1. Administrative matters.
2. Introduction of dignitaries, participants and facilitators.
3. Welcome address by Health Planning workshop coordinator
4. Keynote address: Presentation on District Health Profile
5. The workshop objectives and methods of work
6. The workshop Programme
7. The assignment of team responsibility for reducing their assigned problem.

Session 2: REVIEW OF AVAILABLE DATA Tr -1

Objectives

At the end of the session, teams should have:

1. Assembled the available data needed:
   (a) To identify and prioritize health problem
   (b) To define the problem, the target population, and high risk groups.
   (c) To assess current service coverage
   (d) To describe relevant health resources
   (e) To define the "difficulties" in reducing the problem
2. Initially filled in a PROBLEM TABLE format to present selected indicators
3. Understand some basic epidemiological definitions and differences between indicators.

Materials

1. Results of pertinent surveys research and extracts of data from the health information system (HMIS, LHW-MIS, EPI-MIS, Abstract of Hospital Information System, etc).
2. Data brought by the team from their district describing the general health and service situation and the selected health problem.
3. Population data of district (District Census Report)
4. Maps and distribution of health facilities in the district
5. Problem table format and examples
6. National guidance materials for the health problems chosen.

Tasks

1. Review all available data to assess its usefulness in analyzing and describing the health problem. Assess the apparent reliability and validity of this data.
2. Produce an initial problem table by filling in the format with relevant indicators for health, services and difficulty, after considering the sample problem tables provided.

Products

1. Prioritization matrix
2. Initial problem table.

Tr -2

Fig 1: Health Problems Prioritization

Scoring from + to ++++

Health problem	Magnitude	Severity	Vulnerability	Socio-political affects	Total score	Priority number

Magnitude: The impact on the size of the population
Severity: The affect on morbidity and mortality rates
Vulnerability: The risk groups
Socio-political affects: The social and political impacts of the problem

Tr -3

Fig 2: Health Problems Prioritization

Scoring from + to ++++

Health problem	Magnitude	Severity	Vulnerability	Socio-political affects	Total score	Priority number
High prevalence of diarrhoeal diseases	++++	+++	++++	++++	15	1
High prevalence of nutritional deficiencies among mother and children	++++	++	+++	+++	12	3
Low EPI coverage, especially TT among mothers	+++	++	+++	+++	11	4
Lack of EMoC services	++++	+++	+++	++++	14	2
High prevalence of Skin diseases specifically scabies	+++	+	++	++	8	8
Absence of school health service	+++	+	++	+++	9	7
High prevalence of ARI	+++	+++	+++	++	11	5
Social deprivation, and unhealthy lifestyles / practices	+++	+	+++	+++	10	6

Magnitude: The impact on the size of the population
Severity: The affect on morbidity and mortality rates
Vulnerability: The risk groups
Socio-political affects: The social and political impacts of the problem

Figure 3: Table of problem indicators

Tr - 4

Health Indicators (Output, outcome, Impact indicators)			Services Indicators (Input, Process indicators)		
Indicator	**Baseline**	**Projection**	**Indicator**	**Baseline**	**Projection**

Figure 4: Example Table of problem indicators of a team for problem of "Malnutrition in Children < 3years" District: Jhelum Tr-5

Health Indicators (Output, outcome, Impact indicators)				Services Indicators (Input, Process indicators)				
No	**Indicators**	**Base line**	**Proj**	**No**	**Indicators**	**Base Line**	**Proj**	**Base Line**
1	%age of children < 03 years malnourished	29.1 %	28%	1	% age of children <03 years weighed by health facility personnel	38%	40%	10%
2	% age of children <01 year Malnourished	25%	22%	2	%age of Children 01 years weighed by LHWs	57%	60%	30%
3	% of LBW new born babies	25%	25%	3	%age of population covered by LHWs providing MCH & FP services	65%	75%	60%
4	%age of Pregnant women with Anemia (<10 gm HB %)	11.%	20%	4	%age of health facilities providing MCH & FP services	95%	95%	?
5	Person per family ratio	6.2	6.1	5	%age of Health facilities providing growth monitoring activities.	95%	95%	50%
6	CPR	26%	30%	6	% age of trained health staff providing growth monitoring	95%	95%	30%
7	IMR	77%?	70%	7	Public Water Supply	21%	21%	30%
8	%age of mother start breast feeding	92%	92%	8	Health Education Session per month	?	?	10%
9	Breast-feeding continues at one year.	78%	78%	9	%age of children fully Immunized	53%	55%	50%
10	Weaning at 06 month	20%	20%	10	Antenatal Coverage by FLCFs.	16.4%	18%	
11	Incidence of ARI	29.5 %	29%					
12	Incidence of Diarrhea	20.81 %	20%					
13	Incidence of Malaria	4%	4%					
14	Incidence of Worm Infestation	?	?					
15	Incidence of six communicable diseases.	?	?					

Session 3: PROBLEM ANALYSIS Tr- 6

Objectives

At the end of the session, district team should have:

Designed a problem model to depict the critical variables pertaining to the health problem they are assigned to reduce in their district.

Materials

Example problem diagram \ problem table

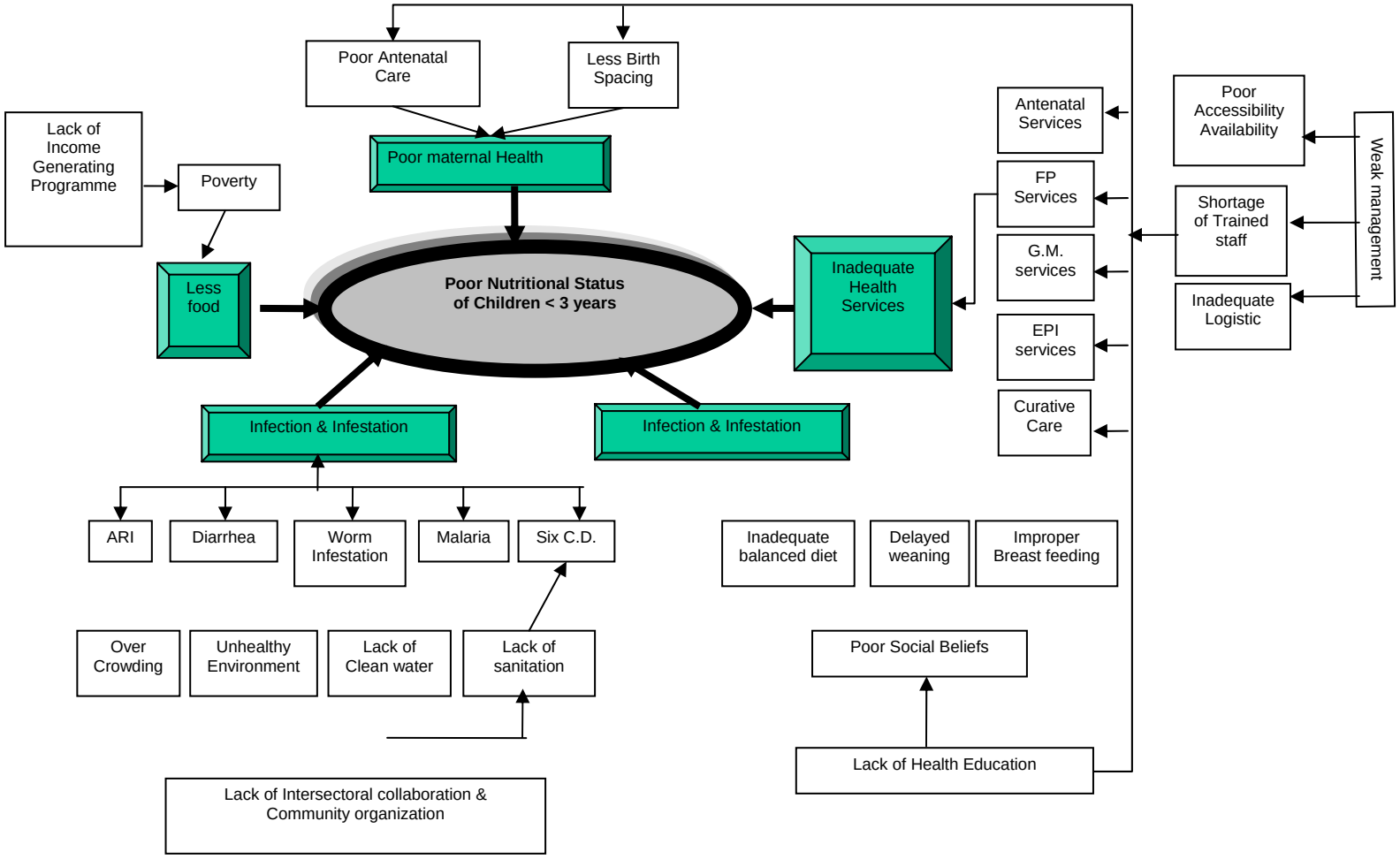
Tasks

1. Discuss the assigned problem in general. Review the sample problem diagram and tentatively list the variables that are needed to describe the problem.
2. Place this list of variables into a problem diagram and show the likely cause and effect relationships.

Products

Problem diagram \ problem table

Figure 5: Example of a problem diagram for malnourishment in Children 3years Tr- 7



Session 4: IDEA GENERATION AND SELECTION Tr- 8

Objectives

At the end of the session, district team should have:

1. Reviewed and understood design criteria, which will help, ensure that proposed solutions are feasible and acceptable to decision-makers.
2. Identified and selected critical points of intervention in the problem diagram.
3. Generated ideas for interventions and selected those felt to be most feasible and effective.

Materials

1. List of design criteria.
2. Expect opinion, guidelines, reference materials and other documents made available.
3. Final problem diagram from session 3.

Tasks

1. Review and discuss the design criteria.
2. Review the problem diagram; identify and indicate by heavier lines which variables are the best entry points for realistic team interventions that can improve the health problem.
3. List ideas for interventions that adhere to the design criteria and are felt to have the potential for reducing the problem.
4. Consider the likely effectiveness of the most promising potential interventions, and then select those interventions that the team feels can be implemented with the greatest success in the next 10-12 months
5. Draw a solution diagram to display the team's strategy for solution.
6. Write a brief description of the solution strategy and interventions selected.

Products

1. List of selected ideas for addressing the problem.
2. Brief description of the team's solution.
3. A solution diagram.

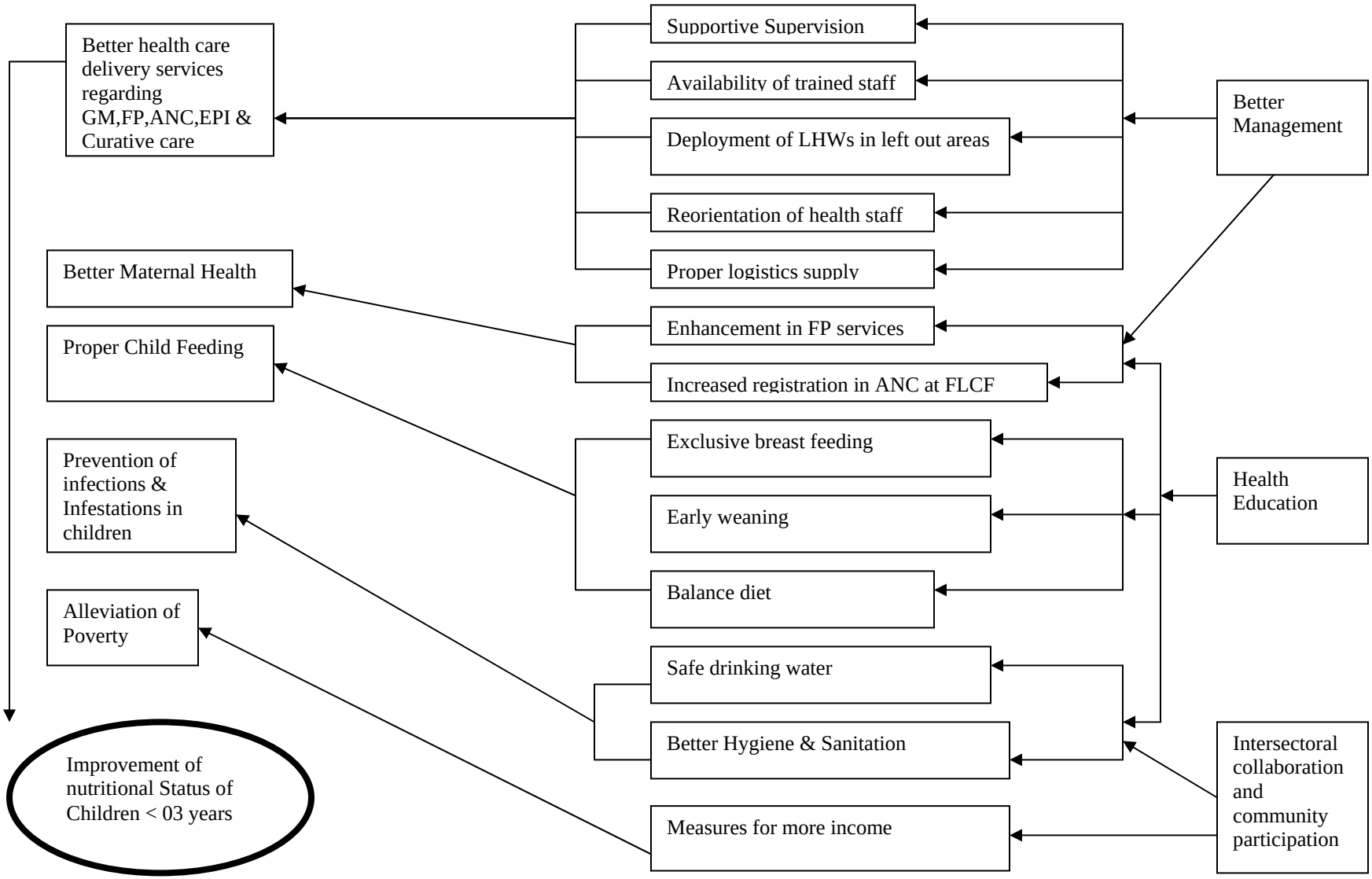
Figure 6: Design Criteria for district team solutions Tr- 9

1. All solutions must support the goals and objectives of the National Health Policy.
2. The strategies and activities of the National Programmes should be taken into account when designing district solutions.
3. The strategies and activities of the National Reproductive Health Service Package should be taken into account when designing district solutions.
4. The district solution should support the Primary Health Care Strategy.
5. Community support and involvement should be utilized to the extent possible in all district solutions.
6. Solution proposals should be designed to be implemented with existing resources such as staff, facilities, transport and recurrent budget.
7. Solutions should focus upon improving staff and service performance, quality of care and efficiency at all levels.
8. Teams are encouraged to introduce or expand the use of the MCH Card, EPI Card, TB Card and Growth Monitoring Card, etc.

Figure 7: Example of intervention ideas \ Solutions Tr- 10

Variables Selected from the Problem Diagram (Entry Points)	Ideas For Interventions
INADEQUATE HEALTH SERVICES.	1. Supportive Supervision 2. Ensure presence of staff to deliver better growth monitoring, antenatal care, CDD, ARI, FP services, Health Education and curative care. 3. Deploy LHWs in left out areas. 4. Reorientation training to health staff regarding MCH care. 5. Ensure better logistic supply. 6. Regular review meetings.
POOR MATERNAL HEALTH • Less birth spacing. • Poor antenatal care.	1. Improvement in FP and ANC Services through better management. 2. Intensive health education to mothers regarding nutrition, ANC and FP.
IMPROPER CHILD FEEDING.	1. Intensive health education campaign through facility staff, LHWs and members of village health committees/women groups via IPC about • Exclusive breast-feeding up to 4 months and continue for 24 months. • Weaning soon after 4 months. • Balanced diet.
INFECTIONS AND INFESTATIONS.	1. Health education about personal hygiene / environmental sanitation, importance of safe water and methods to treat water. 2. Enhance activities through intersectoral collaboration and community participation for provision of safe water better environment, hygiene and sanitation.
LESS FOOD BECAUSE OF POVERTY.	1. Build capacity of community for more income generation through inter-sectoral collaboration and community organization.

Figure 7: Example of a Solution diagram for malnourishment in Children 3years **Tr- 11**



Session 5: FORMULATION OF OBJECTIVES AND TARGETS

Objectives Tr- 12

At the end of the session, district team should have:

1. Produced a statement of objectives and targets, which expresses the amount of problem reduction desired within a specified time-frame, the level of services required and the extent to which current difficulties must be reduced in order to achieve the desired problem reduction.

Material

1. Problem table and diagram from session 3.
2. The list of interventions and solution diagram from session 4.
3. Format for objectives and targets table.
4. Sample objective/ target tables.
5. Existing health policy and plan documents.
6. "Steps for setting objectives and targets".

Tasks

1. Review current health policies to determine whether objectives and targets exist which dictate the amount of problem reduction or service delivery expected.
2. Select the problem indicators felt most appropriate and, with reference to the policies, the problem table and the listed interventions set the desired problem level for an appropriate point of time in the future.
3. Considering the assumed effectiveness of the critical services and interventions set targets for these services and interventions for the implementation period.
4. Prepare a consolidated table of indicators of objectives for the health problem and of targets for the services and difficulties.

Products

1. Table of objectives and targets.

Figure 9: Objectives and targets format Tr- 13

Health Indicators			Service Indicators			
Indicator	Baseline	Objective	Indicator	Baseline	Target	Indicator

Objective: The ultimate achievements one wishes to obtain with a given input and process. Objectives must be **S**pecific, **M**easurable, **A**ttainable, **R**ealistic and **T**ime bound.

Target: In the context of planning target refers to:

- The group, the population, the age bracket (the target group) for which the plan is being prepared.
- The number of activities that have to be carried out to achieve a (target number) given outcome or objective.

Tr- 14

Figure 10: Objectives and targets of a district team to reduce malnutrition in children <3years

Health Indicators				Services Indicators			
No	**Indicators**	**Base Line**	**Objective**	**No**	**Indicators**	**Base Line**	**Targ.**
1	%age of children < 03 years malnourished	29.1%	20%	1	% of children <03 years weighed by health facility personnel	38%	50%
2	CPR	26%	40%	2	%age of Children < 01 years weighed by LHWs	57%	80%
3	IMR	77/1000	70/1000	3	No of Supervisory Visits of FLCF per month by District Team	1	2
4	%age of mother start breast feeding	92%	94%	4	No of Supervisory visits to H.H. per month by LHW's Supervisor	1	2
5	Weaning starts at 06 month	20%	50%	5	%age of children fully Immunized	48%	65%
6	Incidence of ARI in children under 05 years	29.5%	25%	6	% of ANC registration at FLCF	16.4 %	25%
7	Incidence of Diarrhea in children under 05 years	20.81%	17%	7	% of ANC registration by LHWS in their catchment areas.	?	95%
8	% of mothers start breast feeding	92%	92%				

Figure 11: Steps for setting objectives and targets Tr- 15

1. Identify the indicators of the health problem to be reduced.
2. Identify the critical services felt effective for problem reduction
3. Note the projected size of the target population group
4. Note the current output and coverage with the critical services
5. Consider the ideas for expanding the coverage of critical services (as listed in the last session) and the presumed effectiveness of the critical services.

SET:

A. A desired level of the problem at a future point of time, say two to four years (stating the amount and rate of the problem).

B. The amount of service coverage (number of patients and percent of target group) felt needed at future points of time to achieve the desired problem reduction.

C. The amount of reduction in selected indicators of difficulty felt needed by future points of time in order to achieve the desired service coverage.

GENERAL ALTERNATIVE APPROACHES TO TARGET SETTING

1. Raise the coverage with critical services evenly throughout the district
2. Set coverage targets in selected, currently under-served areas of the district.
3. Set targets in terms of the number of villages to be progressively brought into the scheme with intent that there would be full coverage with critical services in each village.

Tr- 16

Session 6: IMPLEMENTATION PLANNING

Objectives:

At the end of the session, district team will have:

1. Produced a list of the activities and their products needed to carry out the proposed solution.
2. Placed the activities in a time frame indicating who is responsible for each.

Materials:

1. Ideas and solution description from session 4.
2. Format for project implementation schedule.
3. Example of a project implementation schedule.

Tasks:

1. Review the list of selected interventions and the solution description in order to identify the specific activities required for each element of the solution devised.
2. List the specific activities that will have to be carried out in order to implement each change or development.
3. Determine human, logistics and financial resource requirement (plan) to achieve objectives
4. Determine what staff within the district must provide support to the project (members of the team and others who are not present), and who should be responsible for each activity (by name).
5. Schedule the full set of activities over the next 10-12 months

Product:

1. Implementation plan (activity schedule)
2. (Optional) A Gantt chart or activity network

.

Figure 12: Implementation schedule Tr- 17

ACTIVITY			SCHEDULE		RESPONSIBLE OFFICER	SUPPORT STAFF
No	Title or Description	Expected Product	Start	Compl.		

Figure 13: Example of implementation schedule (partial) Tr- 18

ACTIVITY			SCHEDULE		Responsible officer	Support staff
No	**Title or Description**	**Expected Product**	**Start**	**Compl.**		
1	Briefing sessions to staff (MO, LHVs, MHT, Supervisors) about the plan.	Introduction of Plan to facilities staff.	Jan,10,13,16, 2002	01 day each		
2	Better Health Care Delivery Services regarding GM, FP, ANC, EPI, % Curative Care Services.					
2.1	*Capacity Building of staff to provide better MCH Services.*					
2.a	**Re-Orientation of available staff about MCH.**					
2.a.1	Identify health staff (i.e. LHVs, Supervisors, MHT,etc) requiring training regarding MCH .	List of trainees	19.01.2002	20.01.2002.	DDOH	AIHS
2.a.2	Preparation of Training material.	Training Plan/material	26.01.2002.	28.01.2002	District Team Members	
2.a.3	Implement Re-orientation workshops on MCH care for health facilities staff.	Trained health staff for provision of better MCH services	02.02.2002	12.02.2002	DHDC Incharge	District Trainers
2.a.4	Re-orientation training of old LHWs,	Better knowledge of LHWs.	02.02.2002.	07.02.2002	DCo	ADC
2.a.5	Provision of increased and effective GM, ANC, FP, curative services.	Improvement of health and services indicators	15.02.2002	Continue	DDDOH	Storekeeper
2.b	**Training of Newly Selected LHWs,**					
2.b.1	Selection of LHWs, from left out areas.	List of new LHW	On going	31.12.2002	DCo	FLCF Incharge
2.b.2	Training of newly recruited LHWs,	Trained LHWs	05.01.2002.	28.03.2002	FLCF Incharge	Trainers
2.b.3	Increased coverage by LHWs.	Better health services	10.02.2002.	Continue	LHWs	
2.2	**Logistics Support**					
2.2.1	Identify shortage of Logistics	List of supply /equip.	19.01.2002	20.01.2002	DDOH	Storekeeper
2.2.2	Ensure logistics supply		26.01.2002	Continue	DDOH	Storekeeper
2.2.3	Provision of better health care delivery services.	Increase of Health services	02.02.2002	Continue	FLCF Incharge	FLCF Staff

Fig 14 : Budgeting and Finance Tr- 19

Problem	High infant mortality													
Solutions	Activities	Sub-activities	Description	Resources status			Unit price	Total Cost	Gap - Budgeted by Government		Gap - Not budgeted		Potential source of funding	Remarks
				Qty required	Qty Available	Gap			Qty	Allocation	Qty	Budget Required		
Health education and awareness building of families on child health	Health education through LHWs to the families, in particular mother, on all significant aspects of child health	Provide health education materials and supplies to LHWS through Health facilities	LHWs to be provided health education materials (package)	1000	0	1000	300	300000	0	0	1000	300000	Partners	
		Conduct monthly health education sessions by LHWs with the families	Conduct health education sessions during home visits	20000	0	20000	0	0		0	20000	0		
Re-training of health staff on neonatal and infant diseases through refresher courses	Organize refresher training courses for the PHC staff on neonatal and child health	Development / adaptation and printing of related materials	Printing of materials for health staff (package)	300	0	300	500	150000	0	0	300	150000	seek partners	
		Training of TOTs	One training session for 12 for 4 days	1	0	1	100000	100000		0	1	100000	seek partners	
		Training of related health staff of FLCFs (6 courses)	6 courses (each for 35 participants) x 2 days	6	0	6	110000	660000		0	6	660000	seek partners	
Improve the coverage and	Implement IMCI in all	Adaptation, procurement	200 sets	200	0	200	1000	200000	0	0	200	200000	seek partners	

quality of IMCI services	FLCFs and ensure logistic / material support	and supply of materials to all health facilities												
		Monthly monitoring by DHMT	300 visits in a year	300	0	300	2500	750000	100	250000	200	500000	Government	
Mop up and strengthening of routine EPI coverage	Improve the EPI coverage through involving LHWs, streamlining logistic support and strengthening the supervision	Training of all LHWs in EPI vaccination and related aspects	30 training courses (35 in each) for 3 days	30	0	30	50000	1500000	0	0	30	1500000	Government and partners	
		Provide supplies and materials	1000 kits	1000	0	1000	3000	3000000		0	1000	3000000	seek partners	
		Start EPI vaccination through LHWs	200 follow up visit by LHS	200	0	200	1000	200000	200	200000	0	0	government	
		Plan and conduct mop up activities on quarterly basis in identified weak areas / pockets	4 activities	4	0	4	50000	200000	0	0	4	200000	seek partners	
Total				**23041**	**0**	**23041**		**7060000**	**300**	**450000**	**22741**	**6610000**		

Tr- 20

Session 7: MONITORING/ EVALUATION PLAN AND INDICATORS

Objectives:

At the end of the session, district team will have:

1. Specified the indicators for monitoring progress and evaluating the effect of the solution
2. Described how they will monitor and evaluate their solution.

Materials

1. The problem table from session 3.
2. The objectives and targets from session 5
3. The implementation plan from session 6.
4. Format for table of monitoring and evaluation indicators.
5. An outline of the evaluation report.

Tasks:

1. Review the problem table and the objectives and targets table. Choose the only a few of the indicators (1-3) which are felt to be required, measurable, and specific.

Product:

Plan of monitoring and evaluation indicators.

Figure 15: Table of indicators for monitoring and evaluation Tr 21

Indicator	Definition	Source	Baseline	Target	When to Monitor/Evaluate

Figure 16: Monitoring/ Evaluation Plan for a birth spacing solution Tr- 22

No	Indicator	Definition	Source	Baseline	Target	When to Monitor/uate
1.	% age of Malnourished children under 03 years	(No. of children less than 03 years malnourished * 100) / (Total No. of children under 03 years weighed)	HMIS Reports	29.1%	20%	March, June, September, December 1998
2	CPR	(No. of women using contraceptives methods * 100) / (Total No. of eligible couples)	LHW - HMIS	26%	40%	March, June, September, December 1998
3	Breast Feeding continued upto 01 year	(No. of children on breast fed upto 01 year * 100) / (Total No. of children under 01 year)	Community based sample survey (after 01 year)	78%	80%	December 1998
4	Weaning started at 04 months	(Total No. of children weaning after 04 months * 100) / (Total No. of children of 04 months of age)	Community based survey		80%	December 1998
5	Average No. of days ORS stock out / month	No. of days ORS stock out per month / No. of facilities out of stock	HMIS	08 days / month	02 days / month	Monthly
6	Incidence of Diarrhea in children under 05 years of age	(Children under 05 years of age having diarrhea * 100) / (Total No. of children under 05 years)	HMIS	20%	18%	Monthly
7	Incidence of ARI in children under 05 years of age	(Children under 05 years of age having ARI* 100) / (Total No. of children under 05 years)	HMIS	29%	28%	Quarterly
8	%age of children less than 03 years weighed by facility personnel	(No. of children less than 03 years weighed * 100) / (Total No. of children under 03 years)	HMIS	38%	50%	Monthly
9	%age of children less than 03 years weighed by LHWs	(No. of children less than 03 years weighed * 100) / (Total No. of children under 03 years)	HMIS	57%	80%	Monthly
10	%age of children fully immunized under 01 years of age	(No. of children less then 01 years of age fully immunized * 100)/ (Total No. of children under 01 years)	HMIS	53%	60%	Monthly
11	%age of mothers having knowledge, attitude & practice regarding GM, ANC, FP and personal hygiene	(No. of mothers knowing about GM, ANC, FP, Hygiene * 100) / (Total No. of married CBAs)	Community based survey		75%	December 1998
12	%age of women registered for ante-natal care at FLCFs.	(No. of pregnant women reg. For Ante-natal care * 100) / (Total pregnant women)	HMIS	16.4%	30%	Monthly

Session 8: PROPOSAL PREPARATION Tr- 23

Objectives:

At the end of the session, district team will have:

1. Created an outline for their proposal document
2. Written their solution proposal.

Materials:

1. Outline of a proposal
2. Planning workshop evaluation form

Tasks:

1. Discuss the major issues, which the decision-maker must consider, and may raise for discussion, in order to approve the proposal.
2. Refer to the outline for the proposal document. Discuss how best to describe briefly the problem as your analytical and planning products produced thus far. Write brief texts which describe and connect these products. These connecting texts should make it clear why the team's proposed interventions are both feasible and potentially effective.
3. Draft a proposal document according to the agreed outline. Make sure that the proposal addresses the issues felt most likely to concern decision-makers.
4. Prepare a brief (15 minute) verbal and graphic (transparencies or flipchart) presentation of the proposal, which highlights its features, to be delivered to decision-makers. The presentation should show the main features of the problem, the solution developed its implementation and evaluation.
5. District team presents its proposal to facilitators, and uses their feedback to improve the presentation to decision-makers in the next session.
6. Each participant takes and completes an evaluation questionnaire about the planning workshop, and hands it in at the time indicated by the facilitator. Alternatively, this questionnaire might be distributed and filled out at the end of session.

Products:

1. Solution proposal document.
2. A prepared presentation

Figure 18: Outline of a proposal Tr- 24

Section	Text	Tables/Figures
Cover	Short summary of the proposal	
I. Problem statement	Problem definition and description	Table Map Problem diagram Data summary tables
II Objectives/targets	Statement on objectives and targets	Table.
III Solution Description	Description of the chosen interventions	Tables Diagrams Illustrations Solution diagram (optional)
IV. Implementation Plan	Description of the chosen interventions	Table/schedule of activities List of participating staff, facilities, and villages Budget (if appropriate) Illustrations Gantt chart (optional)
V. Evaluation Plan	Description of evaluation plan	Table of evaluation indicators Monitoring Instruments
References		

Session 9: PRESENTATION OF PROPOSAL Tr- 25

Objectives:

At the end of the session

1. District team will have made a verbal and graphic presentation of its proposal to the workshop participants, facilitators and attending decision-makers.
2. Participants will have heard the reaction to their proposal from decision-makers.

Materials:

1. The solution proposal prepared in session 8.
2. The presentation prepared in session 8.

Programme:

1. Each team delivers a verbal and graphic presentation of its problem analysis and solution proposal within a 20 minutes period.
2. Following the presentation, 20 minutes are allowed for question from other participants, facilitators, and decision-makers.
3. Decision-makers give their immediate reactions to each proposal including guidance.
4. At the end of the session, each participant (team members, regional supervisor and facilitator) completes the evaluation questionnaire about the planning workshop and turns it into the facilitators.

Results:

1. General understanding and reaction by the entire workshop group to each team's proposal.
2. Completed evaluation questionnaire.

Tr- 26

Session 10: WORKSHOP EVALUATION AND CLOSURE

Objectives:

At the end of the session participants will have:

1. Heard and discussed the analysis of their evaluation of the planning process and given suggestions for its improvement in the future.
2. Been charged with the responsibility to proceed with the implementation of their solution and its evaluation, and to report the results to this same group in one year.

Materials:

1. Analysis of completed workshop evaluation forms.

Programme:

1. The Chief Guest charges the teams with the responsibility to implement their solution and evaluate it after 10-12 months.
2. Presentation by facilitators of the results of the workshop evaluation.
3. Discussion by participants, facilitators and decision-makers about the DTPS planning process and how it can be improved.
4. Closing comments by facilitators, participants and decision-makers.

Annexure

Annex 1:

Fig 4: Agenda ---- District Health Planning Workshop

Time	Day -1	Day -2	Day -3	Day- 4
8.30 am	Registration / Welcome/ Introduction Workshop Objectives	**Session 3 Health Planning** Analysis of problem Session Briefing Group Work Presentation by Team Discussion	**Session 5 Health Planning** Formulation of objectives and targets Session Briefing Group Work Presentation by Team Discussion	**Session 8 Health Planning** Proposal Preparation and Presentation
10.0 am	**Session 1 Health Planning** Presentation on District Health Profile By the District	Contd	**Session 6 Health Planning** Implementation Plan Session Briefing Group Work Presentation by Team Discussion	Contd
11 .0 am	Tea Break	Tea Break	Tea Break	Tea Break
11: 30	**Session 2 Health Planning** Review of Available Data Session Briefing Group Work Presentation by Team Discussion	**Session 4 Health Planning** Idea generation and selection\ Solution Session Briefing Group Work Presentation by Team Discussion	**Session 7 Health Planning** Monitoring & Evaluation plan and indicators Session Briefing Group Work Presentation by Team Discussion	Contd
1.30 – 2.30	Lunch & Prayer	Lunch & Prayer	Lunch & Prayer	Lunch & Prayer
2.30 pm	Contd	Contd	Contd	Workshop evaluation & Closing
5: 00 pm	Closed	Closed	Closed	

Annex II:

Figure 19: Participants Feedback on Planning workshop

Rec. No_____

The purpose of this questionnaire is to obtain your proposal assessment of how well you were able to perform and participate in the various tasks of each session and the extent to which you feel the objectives of each session were achieved. You are also asked some general questions about the effectiveness of the planning process and your ability to proceed, and are encouraged to make additional comments and suggestions.

	Degree Of Achievement			
	Full	Partial	Minimal	Nil
Achievement of Objectives and Tasks (Numbers Refer To Sessions)				
1. Understood The Health Planning Process				
2 Became Familiar With Available Data				
3 Completed The Problem Diagram \ Problem table				
4 Generated Ideas For The Problem Solution				
5. Formulated Objectives And Targets				
6. Described The Proposal Solution				
7. Prepared The Implementation Plan (Scheduled And Responsibilities)				
8. Specified Indicators And Methods For Monitoring And Evaluating The Solution				
9. Completed The Outline And Proposal Of The Solution (Health Plan)				
10. Presented The Solution Proposal (Health Plan)				
11. Received A Reaction To The Presentation From Decision-Makers				

	Degree of Achievement			
	Full	Partial	Minimal	Nil
II. Effectiveness Of The Preparation And Conduct Of The Planning Process				
1. Explanation of session tasks				
2. Background materials/information				
3. Participation of team members				
4. Support by facilitators				
5. Workshop accommodations				
6. Living accommodations				
III. GENERAL ASSESSMENT				
1. The subject matter is relevant to my work				
2. The methods applied will be useful in my work				
3. I feel able to participate in my district problem-solving work				
4. I feel able to lead or teach such work at my level of the service				
5. I feel the solution my team proposed will be:				
- successfully implemented				
- effective in improving maternal health				

Other comments:

Annex III

GLOSSARY

Aim: Aim refers to the final overall "goal" of a project or program. An aim is usually not reached by any single program but requires the collaboration of many "Programs". Aims are in general stated quite vaguely, such as "Health for All", "Improvement of Maternal health services".

Assumption: "Assumptions" are statement specifying the condition not under ones control, under which the program or program activities are expected to proceed. These may concern the environment, the formal health aspects of or impinging upon health care delivery

Assumptions do not need to be always specified. However, they depend on it. Example:

The MOH will provide extra human resources
(A "killer assumption" is one, which cannot be fulfilled, and it effectively ensures that the program or program activity will not succeed; Health care budget will be tripled next year)

Budget: A comprehensive plan of how much money is needed for any one-year and how that will be raised and expended.

Capital Cost: One time investment of any sort, basically used to indicate developmental part of finances e.g. cost of building, equipment, land, etc.

Cost: It is the price, cost, rate or charge for anything in financial terms,

Demand: (Health) demands are (health) needs expressed by individuals or communities.

Effectiveness: Effectiveness is defined as the extent to which a specific intervention procedure, regimen or service, when deployed under field conditions, does what it is intended to do.

Efficacy: Efficacy is defined as the extent to which a specific intervention procedure, regimen or service, produces the intended result under ideal condition, such as in a laboratory.

Efficiency: It is best described as obtaining the maximum output from a given input.

Equity: Equity is the principal of being fair to all, with references to a defined and recognized set of values; it is implies social justice in the sense that those with most health need should be provided with most care.

Equity - is related to concern for fairness and justice.

Health Problem: A health problem is a state of an individual or a community hindering normal activities, social, physical, economic development, or enjoyment. It may or may not be perceived as such by the community.

Health Promotion: Efforts to maintain and improve the health of the individual or the community. Health promotion aims to prevent disease through improving awareness and promoting healthy lifestyles by providing an enabling environment.

Health Services Utilization rate:
It is the number of visits paid to the health services per individual per year. For health services to be effective, this rate is minimally accepted to be 2 visits per person per year.

Impact: It is the achievement of the ultimate objective e.g. reduction in maternal mortality, reduction in infant mortality.

Input: A term commonly used in health planning. Inputs are the program that are being offered as well as the material prerequisites, usually referred to as the three M's (Material, Manpower, and Money) necessary to run these programs.

Interventions: Specific activities meant to reduce disease risks, treat illness, or palliate the consequences of disease and disability.

Management: Day to day organization and implementation of (health) policy and plan within well defined resource boundaries for the purpose of optimizing the health service systems efficiency. "Getting things done".

Mean: Mean is the sum of the data divided by the number of values in the data.

Median: Median is positional mid point of the data; half the values are less than median and half are greater.

Objective: Objectives define the ultimate achievement one wishes to obtain with a given input and process. Objectives must be **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**ime bound. For example: "To reduce preschool child mortality from diarrheal disease by 50% within a two year period".

Outcome: Outcomes are the intermediate results short of reaching the main or principal objective. These may be coverage outcomes e.g. proportion of high-risk children identified and provided service.

Output Output refers to both the quantity and quality of health service activities that are being carried out, such as within a given program the number of workers trained, the number of children immunized, the number of condoms distributed.

Process: Process denotes all activities and components that enter into health care delivery)' to achieve a desired result. As such, it includes inputs, input distribution, M&O, and outputs.

Programme: Health care activities that are an integral part of routine health services, such as MCH, FP, TB control, EPI, etc.

Project: Health care activities that are being carried out on a pilot or demonstration basis.

Recurrent Cost: Repeatable costs that occur each year for continuing any activity like Salaries, Drugs and Supplies, POL and Repair Maintenance

Situation Analysis: In health planning refers to the process of analyzing and interpreting all information available on the current situation of the health system as it prevails within the specific geographic area under consideration. It makes use of the full or partial results of the Health Systems Review

Strategy: In planning terminology strategy refers to the combination of Interventions employed in order to achieve a given objective. If reduced IMR is the objective, implementing Diarrheal Disease and ARI control programs might be the strategy

Target: In the context of planning target refers to:

- ❖ The group, the population the age (the target group) for which the plan is being prepared.
- ❖ The number of activities that have to be carried out to achieve a (target number) given outcome or objective.

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