Improving Reproductive Health Care Within the Context of District Health Services:

A Hands-on Manual for Planners and Managers

Improving Reproductive Health Care Within the Context of District Health Services:

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Royal Tropical Institute (KIT), Amsterdam
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For ease of use, this manual is accompanied by a CD, which contains the entire document in a PDF format, as well as each of the exercises and supervisory checklist in blank formats under their respective exercise titles. Please feel free to replicate and utilize any or all sections of this manual, as long as you reference its use in any further publications.
The authors welcome comments or suggestions on the content or usefulness of this manual, in order to begin preparation for a second edition. In this regard, please contact Bruce Campbell, UNFPA, Zimbabwe campbell@unfpa.org or contact Ietje Reerink, ietje@psimyanmar.org.mm.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BCC	Behaviour Change Communication
CBO	Community-Based Organization
CBD	Community-Based Distribution
CHV	Community Health Volunteer
CHW	Community Health Worker
CYP	Couple-Years of Protection
DHMT	District Health Management Team
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
FGC	Female Genital Cutting
FP	Family Planning
GBV	Gender-based Violence
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive Device
KIT	Koninklijk Instituut voor de Tropen (Royal Tropical Institute)
MVA	Manual Vacuum Aspiration
NGO	Non-governmental Organization
PLA	Participatory Learning Approaches
PM&E	Planning, Monitoring and Evaluation
PNC	Postnatal Care
RTI	Reproductive Tract Infection
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TTBA	Trained Traditional Birth Attendant
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
WHO	World Health Organization
YF	Youth-friendly

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Preface

Sexual and reproductive health (SRH) care is a major component of primary health care services in a district. Women, men and adolescents need quality information and services to allow them to have a safe and fulfilling sexual and reproductive life. In most societies, the major burden of disease for women aged 15-49 is related to their reproductive life and role in society. Men and young people too have special needs when it comes to education, information and services for SRH. For this reason, SRH care needs particular attention while planning and managing primary health care activities.

Additionally, SRH issues pose a series of specific challenges to health planners and managers. Attitudes and practices related to sexuality and reproduction are deeply embedded in societal norms and beliefs, making SRH a complex and sometimes difficult topic to discuss. Beliefs about the role and position of women also affect SRH. In this manual, we make occasional references to HIV/AIDS as an SRH issue. With growing attention and resources for local HIV/AIDS responses, a unique opportunity exists to integrate related activities at the district level and below.

This hands-on manual should help district health staff in systematically planning, implementing, monitoring and reviewing SRH activities, as part of the overall district health plan. While the manual is written with district managers and planners in mind, its use should not be limited to just this group. Any planner, decision maker or service provider who is involved at the district level in primary health care activities can find important information, tools or ideas in the manual. All organizations who are part of the district health system - non-governmental organizations, community-based organizations and the private sector - are encouraged to use this manual for their own programmes and activities.

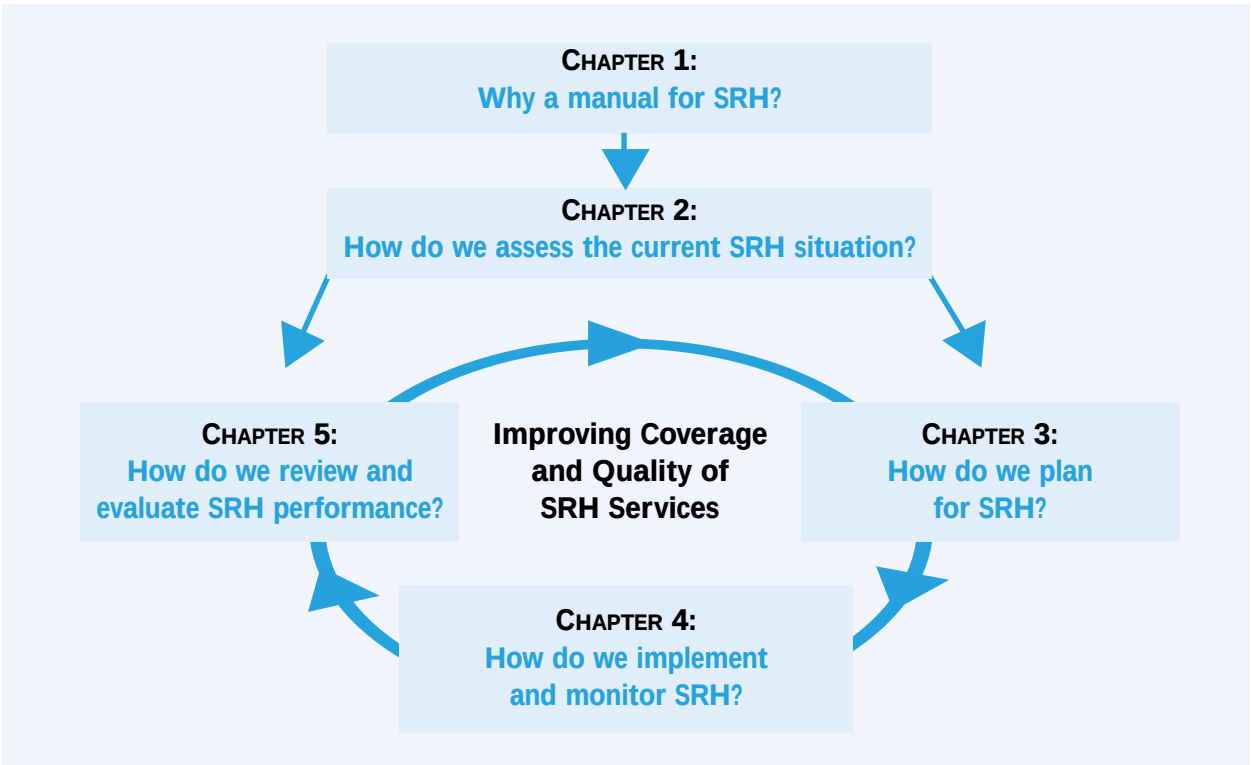
The manual was developed by a group of individuals from the North and the South. Some of them participated in a week-long workshop organized at KIT/Amsterdam to define the content of the manual. The authors are planners, managers, and technical experts with broad experience in SRH: they have worked at national, subnational and community level; developed and reviewed SRH policies and programmes; supported implementation at all levels; and visited many districts along the way. District and national level Ministry of Health staff in Eritrea, Malawi and Nepal reviewed the draft manual and provided important suggestions for improvement. The authors welcome feedback from users to further improve the content and format of the manual.

Introduction to the manual

This manual is an action-oriented document which will facilitate improved coverage and quality of SRH services. Its main target audience are those individuals, alone or as part of the district health management team (DHMT), who have responsibility for the planning and management of sexual and reproductive health/ primary health care services in the district.
They include:

- District managers and planners
- District medical officers, nurses and midwives
- Directors or chief medical officers of district hospitals
- Representatives of non-governmental organizations (NGOs) and community-based organizations (CBOs)
- District coordinating and/or development committees
- Other partners working in SRH such as mission hospital staff, women's organizations, youth groups, etc.

The manual facilitates strategic planning and management, for a period of one to three years. Its aim is to improve coverage and quality of SRH services. The content is based on a management cycle that involves the review of existing services, strategic planning for additional or new activities, implementation, monitoring, performance review and evaluation. The manual guides the user through the different stages of this planning, monitoring and evaluation (PM&E) cycle. Since the PM&E process is continuous, it is possible to begin using the manual with any chapter or related exercise. Some activities, however, are best initiated at the start of the district planning cycle each year. An overview of all exercises, and a suggested time of the year when these can be done, is included on the back cover of the manual. The following figure indicates the relationship between the PM&E cycle and the key operational questions in the manual.



There are several exercises at the end of each chapter. Each exercise starts with stating the expected outcome. An outcome can be anything from a community map, service targets or an advocacy poster to an annual work plan or a health facility schedule. Next is a series of steps, to guide the user in answering the operational question(s) for their own district. To help doing this, each exercise comes with a blank sheet that can be found at the very end of the manual. This blank sheet can be easily adapted, reproduced and photocopied for repeated use over time. *The manual is designed so that no outside facilitator is needed to assist with the exercises.*

Last, each exercise provides an example of the outcome, partly using data available from a sample district in Nepal. There are blank spots in some examples simply because it would make the manual too long to complete each exercise from beginning to end. Most of the exercises and examples build on each other as part of an ongoing management cycle.

The contents of each chapter are as follows:

Chapter 1: Why a manual for SRH?
Chapter 1 provides an overview of the full scope of SRH services. It shows an example of a national SRH package and introduces guiding principles and challenges in planning and managing SRH.
We review the national SRH policy and define the existing SRH package for the district. We also discuss the content of the SRH package with the different community groups we want to reach with information and services.

Chapter 2: How do we assess the current SRH situation?
Chapter 2 addresses the question "Where are we now?" It presents a series of activities for examining coverage of SRH services in the district. To do this, we look at existing SRH service delivery sites and staff, identify partners and map available services. We also use a series of health management information system (HMIS) indicators and look at SRH service data for the past three years. We analyse trends with partners.

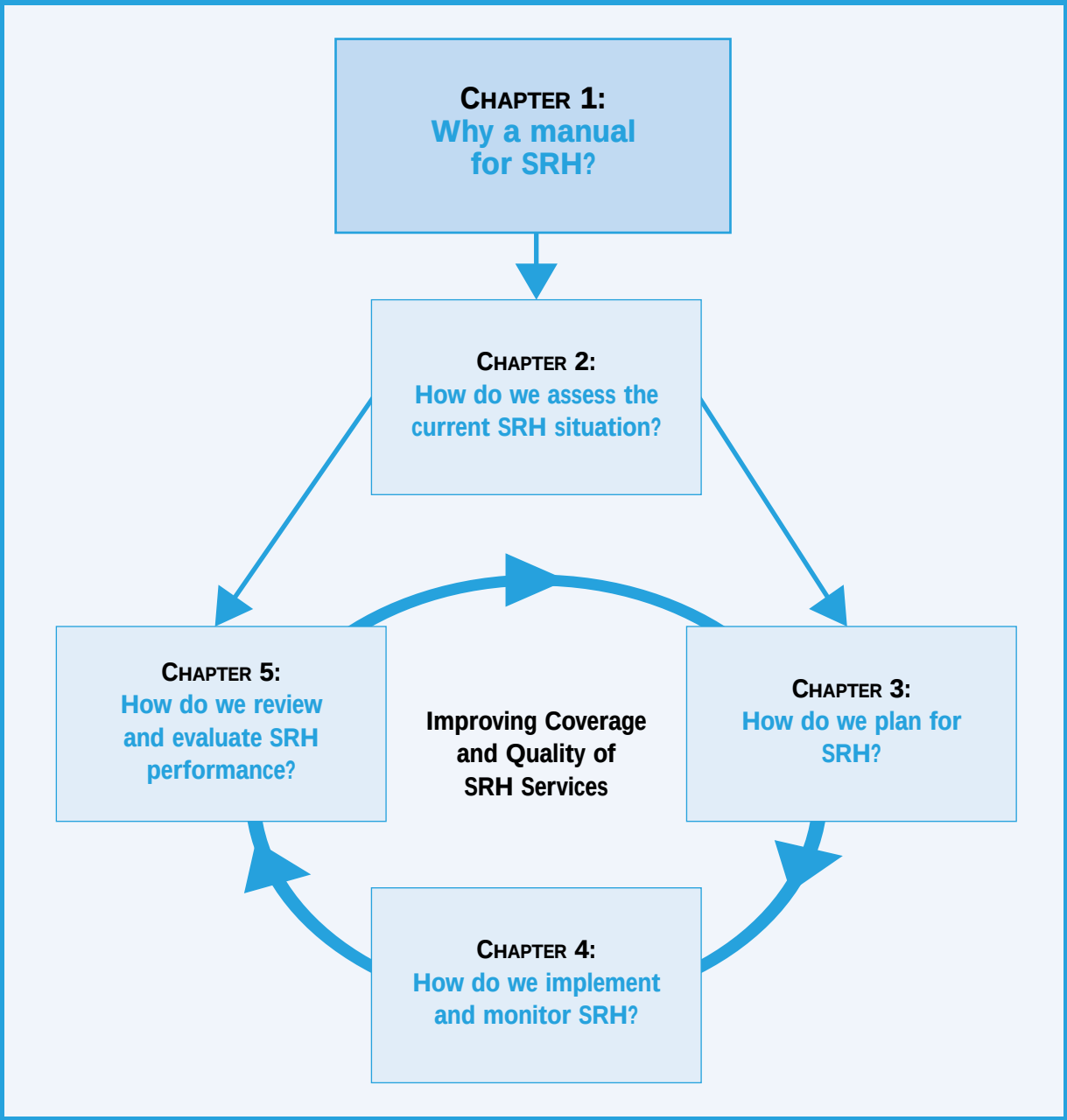
Chapter 3: How do we plan for SRH?
Chapter 3 addresses the question "Where do we want to go?" First we formulate objectives for SRH in the district. These objectives reflect the district's commitment to SRH. Next, we define targets for SRH services for the next three years. We then analyse strengths and weaknesses of current SRH strategies. On the basis of this analysis, we define and prioritize new or improved strategies for the next three years. We also look at learning and training needs and we assess supply and equipment requirements. To get started in Year 1, we develop a work plan for the district and a routine monthly activity schedule for health facilities. Last, we make a financial plan that matches the objectives and targets for SRH.

Chapter 4: How do we implement and monitor SRH?
Chapter 4 addresses the question "How will we get there?" It presents a series of activities for implementing and monitoring the elements of the SRH package. We explore opportunities to expand collaboration with partners in the district. We monitor progress of the district work plan and related expenditures. At health facility level, we look at opportunities to improve quality and efficiency of service delivery. We also develop a comprehensive supervisory schedule for the district.

Chapter 5: How do we review and evaluate SRH performance?
Chapter 5 addresses the question "How do we know when we have arrived?" It focuses partly on coordination and partnership. Additionally, it discusses the planning and organizing of an annual performance review together with partners in the district. This review initiates the planning cycle for next year's activities. In addition to annual reviews, every two to three years it is important to evaluate the process toward meeting targets and objectives. Steps to prepare for such a process evaluation are described. Last, some thought is given to an SRH advocacy strategy, to maintain the commitment and momentum that has been created.

CHAPTER 1:

Why a manual for sexual and reproductive health?



By the end of this chapter we will have:

- reviewed the national SRH policy and defined the district SRH package (Exercise 1a); and
- discussed the SRH package with different community groups (Exercise 1b).

CHAPTER 1:

Why a manual for sexual and reproductive health?

1.1 Introduction

This chapter sets the stage for planning, monitoring and evaluating SRH services within the district health system. The chapter defines SRH and describes its full scope. It also highlights guiding principles and challenges for planning and managing a SRH programme. The chapter is organized as follows:

- Using the country SRH policy or strategy, we review the contents of the national SRH package and define the *district SRH package* (Exercise 1a).
- Health providers from health facilities are encouraged to discuss the SRH package with different community groups in the district, and to *map* where difficult to reach or marginalized groups live that need to be reached with information and services (Exercise 1b).

1.2 What is SRH?

SRH is a state of complete physical, mental and social well-being in all matters relating to the reproductive system, its functions and processes. This includes the right of all individuals to a safe and satisfying sex life, the capacity to reproduce and the freedom to decide if, when and how often to do so.

SRH is an important part of the human life cycle. Culture and society frame people's ideas about sexual health and reproduction. Many health planners see SRH as women's health, mostly related to pregnancy and childbirth. This is a rather narrow view. We now recognize that SRH is a concern to everyone, and that both men's health and women's health are important for healthy reproduction, healthy children and a healthy society.

Both men *and* women need access to information and appropriate health services throughout their lives. Such information and services should be gender sensitive and allow:

- all individuals to make informed choices about sexuality and reproduction, and to have a safe and satisfying sexual life, free of STIs/HIV/AIDS, violence and coercion;
- women to go safely through pregnancy and childbirth;
- couples to have the best chance of having a healthy infant;
- women to avoid unwanted pregnancy, and to address the consequences of unsafe abortion, which include the management of complications of abortion and post-abortion care.

1.3 The full scope of SRH

In many countries, SRH services make up a large part of the health services in the district. To a large extent, we are already planning and managing these services as part of the district health plan. In doing so, we are setting priorities in what can be done by carefully considering available financial and human resources. As part of integrated planning for health, we may find that we can do more to improve coverage and quality of SRH services, especially with decentralized planning and budgeting responsibilities.

The following box presents a full SRH package. While it may not be possible to offer all these services all at once, knowing the contents of the full package is helpful in gradually increasing the scope of SRH activities in the district.

A full SRH package includes:

- Family planning (FP)/birth spacing services
- Antenatal care (ANC), skilled attendance at delivery, and postnatal care (PNC)
- Management of obstetric and neonatal complications and emergencies
- Management of abortion complications and provision of post-abortion care
- Prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs) including HIV/AIDS
- Early diagnosis and treatment for breast cancer and reproductive tract cancers (men and women)
- Promotion, education and support for exclusive breast feeding[1]
- Prevention and appropriate treatment of sub-fertility and infertility
- Active discouragement of harmful practices such as female genital cutting (FGC)
- Adolescent SRH
- Prevention and management of gender-based violence (GBV)

From: Programme of Action, International Conference on Population and Development 1994

In Exercise 1a we review the package of SRH services currently provided in the district. To ensure these services are provided according to a minimal standard of quality, existing technical standards and service delivery protocols should be referred to.

1.4 Guiding principles

In planning and providing SRH services, it is important to consider the following guiding principles:

- SRH is a societal issue and not only the responsibility of the health sector. It is important to build *partnerships* with other public and private sectors, as well as with civil society: NGOs, religious groups, CBOs, and others. The involvement of SRH partners in the PM&E cycle is a prerequisite for broad ownership and participation.
- All individuals have SRH needs and these needs will differ between sexes, and between phases of the *life cycle*[2].
- The different needs of *men and women* must be considered in the way services are provided, resources are allocated, and the needs addressed of marginalized groups, such as (unmarried) adolescents, women who live far away from health services, etc. In general, women are particularly vulnerable to SRH problems due to the risks of childbearing, their lack of decision-making power, and inadequate services.
- SRH services are part of a broader service package. One way to make such services optimally accessible and available for men, women and adolescents is to *integrate* SRH services at the point of service delivery. Integration makes the organization of services easier to manage and oversee, and is user-friendly for those who attend the services.

Effective health service delivery including of SRH services can be achieved by:

- partnerships with civil society
- community involvement
- integration of services
- inclusion of health promotion activities
- advocacy for sexual and reproductive health and rights
- coordination across services, sectors, ministries, etc.

1.5 Challenges in planning and managing SRH services

Two factors make SRH a health issue more difficult to discuss than other health issues, namely gender and culture.

[1] Following the International Conference on Population and Development, a number of countries have adopted strategies for "Prevention of Mother to Child Transmission of HIV/AIDS". These strategies may outline varying approaches to "exclusive" breastfeeding.

[2] The life cycle approach acknowledges that an individual's SRH concerns change in the course of their life. For example, during infancy and childhood, SRH concerns include harmful practices such as FGC and poor nutrition. During adolescence, early marriage and childbearing, unprotected sexual intercourse, STIs and unwanted pregnancy become risk factors for SRH. For young adults, SRH evolves around a satisfying, safe sexual life and healthy reproduction. For middle-aged adults and elderly people, reproductive cancers are an important health risk. Risk of STIs and GBV exists during most stages of the life cycle.

In most societies, relations between women and men are not equal. These inequalities are reflected in laws, policies and social practices, and in the way boys and girls are socialized. Imbalances in power also have an impact on attitudes and behaviour of people. This is particularly so for women's SRH: often women are unable to decide and take action to protect their health. They face the risk of STIs, HIV/AIDS, unwanted pregnancy and sexual coercion and exploitation. Men may not want to discuss matters related to sexuality, or to admit to a lack of knowledge, sometimes as a result of strong beliefs about masculinity, and what is considered appropriate male behaviour.

Many attitudes and practices around SRH are embedded in or influenced by cultural norms and religious beliefs. Indeed, even to talk about SRH is difficult in some settings. Society and culture play perhaps the most important role in determining what is acceptable behaviour, and what is not. Health planners, managers and providers face specific challenges in providing SRH information and services such as: gender imbalances; negative attitudes (of providers and communities); taboos; and cultural definitions of appropriate male and female sexual behaviour.

Examples of gender and culture related barriers to good SRH include:

- illiteracy leading to inadequate knowledge about human sexuality and fertility
- suboptimal quality of SRH services especially for adolescents
- sexual practices such as "dry sex" and widow inheritance
- discriminatory social and legal policies leading to social exclusion
- negative/protective attitudes toward women and girls
- lack of equity and equality in social status of men and women, especially in terms of the right to control fertility and sexual activity

1.6 Community involvement

Communities are made up of many groups with varying interests and problems. There are differences between the sexes, the age groups, the rich and the poor, and between people of different ethnic or religious backgrounds. Community participation in health means that all these different groups are *involved* at all the stages of the PM&E cycle.

The first level where SRH information and services are provided is the family/community level. Nearly all activities at this level are related to health promotion, including IEC (information, education and communication). Health workers usually define the issues for discussion and hold the health education talks. However, knowledge gained through education does not automatically lead to behaviour change. For behaviour change to occur people must feel ownership over decisions and activities, and believe that the change will have a positive impact on their lives.

Exercise 1b is about discussing the current SRH package with different groups in the community. The maps made with community groups are a good starting point for planning improved SRH coverage.

CHAPTER 1: Summary/Key Lessons

In this chapter we have looked at the district SRH package. This shows the scope of SRH services that are provided right now. By comparing this to the full SRH package, it is easy to identify gaps or areas that need strengthening as part of the overall district health plan.

We need to plan and manage SRH/primary health care activities together with other partners in SRH. Involving community groups in the PM&E cycle is an essential condition for promoting ownership and commitment on the part of communities. During community discussions, it is important that the community defines the issues for discussion. Maps and other visual tools are useful for discussing existing services and identifying gaps.

Exercises Chapter 1:

Why a manual for sexual and reproductive health?

Exercise 1a: How do we define the current SRH package?

Expected outcome

At the end of this exercise, we will have identified the current package of SRH services in the district according to institutional level (and/or provider, in the case of an NGO or private practitioner).

Participation

This exercise is best done by members of the DHMT together with partners that are providing services.

Duration/Venue

This is an exercise that can take place at the DHMT office and should not take more than one hour.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils/tape
- Copies of national SRH policy or strategy, if available

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

On a large piece of paper, list in the left-hand column the SRH services that are currently being provided in the district. Refer to the national SRH policy or strategy, if available.

Step two

Across the top of the paper, identify the different types of institutions that are providing SRH services in the district. Include NGOs or private practitioners if they are active in service provision.

Step three

For each element of the SRH package, identify the type of services provided at each level. Complete the rows of the matrix. It is not necessary to give details about each service.

The SRH package for the district is the basis for other exercises in this manual. The package should give a realistic overview of what SRH services are currently provided. In Chapter 3 we will work on expanding or improving the contents of the package.

Example of SRH service package by level

SRH element/ Level	Family/ Community	Health post	Health centre	Hospital	NGO
Maternal health: antenatal and postnatal care	IEC, ANC/PNC at outreach sites, referral	IEC, ANC/PNC, referral	IEC, ANC/PNC including laboratory services (albumin, glucose, Hb testing)	IEC, ANC/PNC, referral	IEC and counselling, ANC/PNC, referral
Maternal health: assisted delivery	Delivery with CHW and TTBA, safe delivery kits, IEC, referral	Delivery services with trained health personnel including obstetric first aid, referral of complications	Delivery with trained health personnel including basic EOC[2]	Delivery with trained health personnel including comprehensive EOC[3]	No delivery services, promotion and distribution of safe delivery kits, IEC and referral
Neonatal care	Basic care, referral	Basic care, IEC, referral	Basic care/limited treatment, IEC, referral	Comprehensive treatment, IEC	No direct services, promotion of breastfeeding
Complications of abortion	Referral	IEC, treatment of infection, referral	IEC, counselling diagnosis and treatment of infection, referral	IEC, counselling, diagnosis and treatment, referral	IEC, counselling, referral
RTI/STI/ HIV/AIDS	BCC, referral	BCC, counselling, syndromic management, referral	BCC, counselling, diagnosis and treatment, referral	BCC, counselling, diagnosis & treatment	BCC, counselling, referral
Adolescent SRH	IEC, referral	IEC, referral	IEC, counselling, treatment, referral	IEC, counselling, treatment, some contraceptive services	IEC, counselling, referral, special opening hours for adolescents
Family planning	IEC, condoms, pills through VHWs, injectables through outreach	IEC, counselling, condoms, pills, injectables, IUCD,* implant*	IEC, counselling, condoms, pills, injectables, IUCD, implant, management of complications and referral	IEC, counselling, condoms, pills, injectables, IUCD, implant, surgical contraception,* management of complications	IEC, counselling condoms, pill, injectables, IUCD, management of complications
Sub-/Infertility	IEC, referral	IEC, referral	IEC, counselling, referral	IEC, counselling, limited diagnosis	IEC, counselling, referral
Life cycle SRH issues (cancers, fistulas)	IEC, referral	IEC, referral	IEC, counselling, referral	IEC, counselling, referral	IEC, counselling, referral
Complications of FGC	IEC, referral	IEC, counselling, referral	IEC, counselling, management of complications, referral	IEC, counselling, management of complications, referral	IEC, counselling, referral, special services for adolescents
Gender-based violence	No activities yet	Some IEC, minor treatment, referral	IEC, counselling, treatment, referral	IEC, counselling, treatment, referral	IEC, counselling, referral

* In selected sites only

[3] Basic emergency obstetric care (EOC) provided in health centres and small maternity homes includes administration of antibiotics, oxytocics, anticonvulsants, manual removal of the placenta and retained products, and assisted vaginal delivery with forceps or vacuum extractor. Comprehensive EOC is available in (district) hospitals and includes all basic EOC functions plus caesarean section and blood transfusion.

Exercise 1b: How do we discuss the SRH package with the community?

Expected outcome

At the end of this exercise, health workers from each institutional level will have discussed the current SRH package with women, men and adolescents in the district. Gaps in service coverage and quality are identified.

Participation

This mapping exercise should involve members of the DHMT who have good interpersonal skills. Collaboration with NGOs who have experience in participatory learning approaches (PLAs) will promote the exchanging of views and learning from each other. In addition, enlisting the help of NGOs may yield a more reliable response from the community. It is helpful to do this exercise in pairs (two facilitators for each group). Include as many partners as possible, keeping in mind logistics and transportation. Participants can include representatives of women's groups, NGOs, the private sector, community health volunteers (CHVs), etc. Four groups can be made, as follows:

- Married men (ages 19-49)
- Young unmarried men (ages 12-18)
- Married women of reproductive age (ages 19-49)
- Young unmarried women (ages 12-18)

Ideally, the groups consist of no more than six to eight participants. If possible, select people from different community groups. It is important to consult with local leaders beforehand about the purpose of the exercise. For the actual mapping it is better not to involve formal leaders or very vocal informal leaders: in many communities it is culturally unacceptable to disagree with leaders. Informal leaders can be helpful but only if they are clear that it is important that information is obtained from all participants in the group. It is crucial that the ground rules for conducting focus group discussions and PLA exercises are agreed on at the beginning of the exercise: no one should dominate the discussion, everyone's contribution is important and should be respected, and differences of opinion are allowed.

Duration/Venue

This exercise involves visits to different community groups: ideally four groups from two to three communities. Approximately two hours per group are needed to do the exercise well. The total time required depends on how many groups we include and on how many facilitators there are. Presentation of the maps should take 10-15 minutes per group, including time for questions.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils/chalk/sticks
- Map of the various communities and groups living in the community (if available)

Step one

Start by looking at the distribution of health services and decide which communities in the district have easy, moderate or difficult geographical access to health services. This information may already be available at the DHMT office. If not, draw a quick map.

For large districts, it is best to assign this task to health facility staff who can make a map of the facility's coverage area. They can organize discussions with communities in their coverage area. We will use this map again in Exercise 2c.

Step two

Select two to three communities with different degrees of access. If possible, include different communities in terms of language, culture, religion, etc. Organize separate meetings with small groups of men, women, and male and female adolescents.

Step three

Identify the facilitators, and organize the field visit including the most appropriate procedure of protocol for introducing the exercise in the community. Ensure that all facilitators are well trained in conducting group discussions and that they have practised the mapping exercise. Make sure that the mapping by the various groups can be conducted simultaneously.

Step four

Explain the objectives and the methodology, and agree on the ground rules. Explain that participants can refuse to answer a question or withdraw altogether without any consequences for their access to services. Explain to the participants that they do not need to give personal answers to questions and instead can talk about the practices of various groups.

Step five

Ask the participants what the important health issues are. If not spontaneously mentioned, probe for pregnancy, delivery, contraceptives, problems of the sexual organs etc. until all the elements of a SRH package are covered. Using symbols, visualize each major problem.

Step six

Ask the participants to draw an outline of their village, and to mark with symbols the different types of neighbourhoods or villages, as well as the kinds of houses and families – for example in terms of language, religion, size and income. Then ask that any special families – such as orphans or widows, people with a chronic illness and families with malnourished children – are indicated.

Step seven

Go back to the symbols for the major health issues, and ask where people go for help for each of them. Ask the participants to mark on the map where the various providers are. Then discuss which of the various groups marked on the map will go where, and why.

Step eight

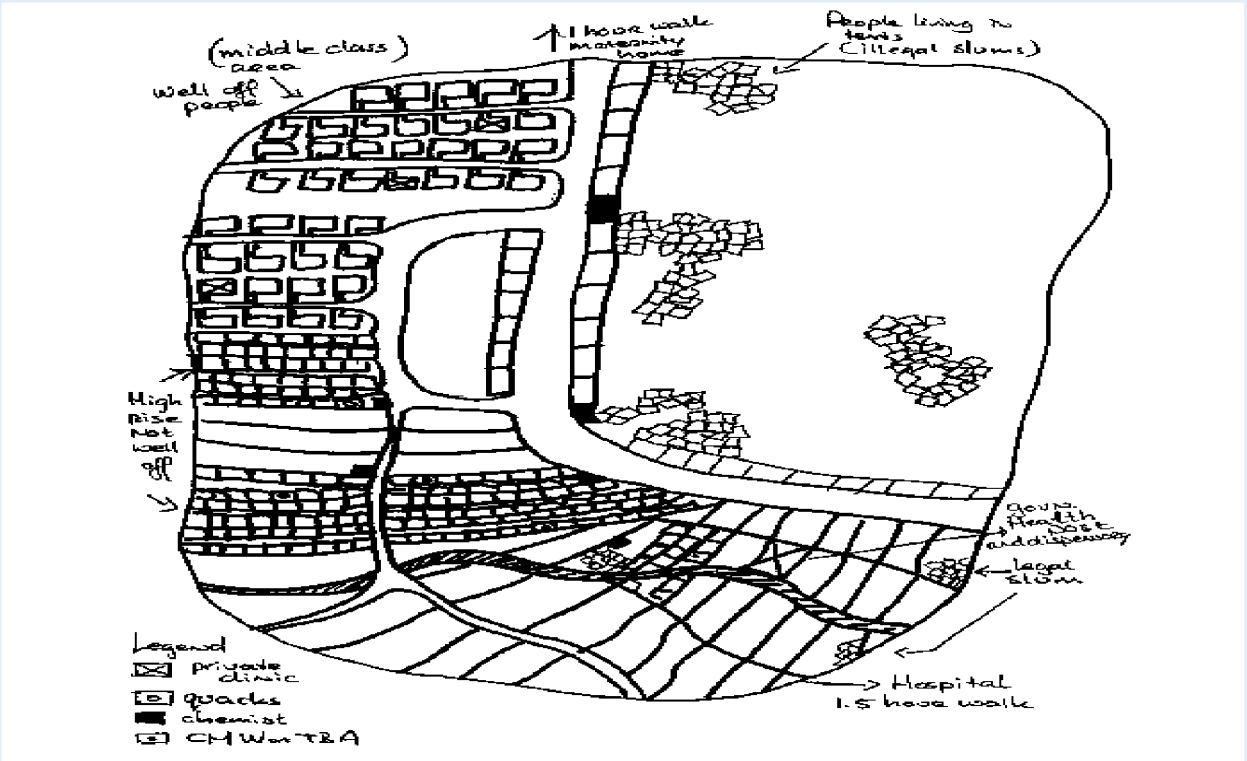
Discuss any gaps that are mentioned, and find out what people think can be done to fill these gaps. Write down suggestions and ideas.

Step nine

When each group has finished, the various groups can present the results of their discussions to each other. Enough time should be given to allow each group to present their map and to discuss their observations. Facilitators should take care that participants do the talking, and that everyone has a chance to speak.

The perceptions and priorities of the communities involved in this exercise may not be representative of the entire district. However, the discussions do give insights into concerns, gaps and areas that can be improved. Copy the maps onto paper for further discussion with the DHMT. The maps show where services are provided and where vulnerable groups live. These groups may need information, services and/or outreach activities.

Example of a community map made by women in an urban area in India

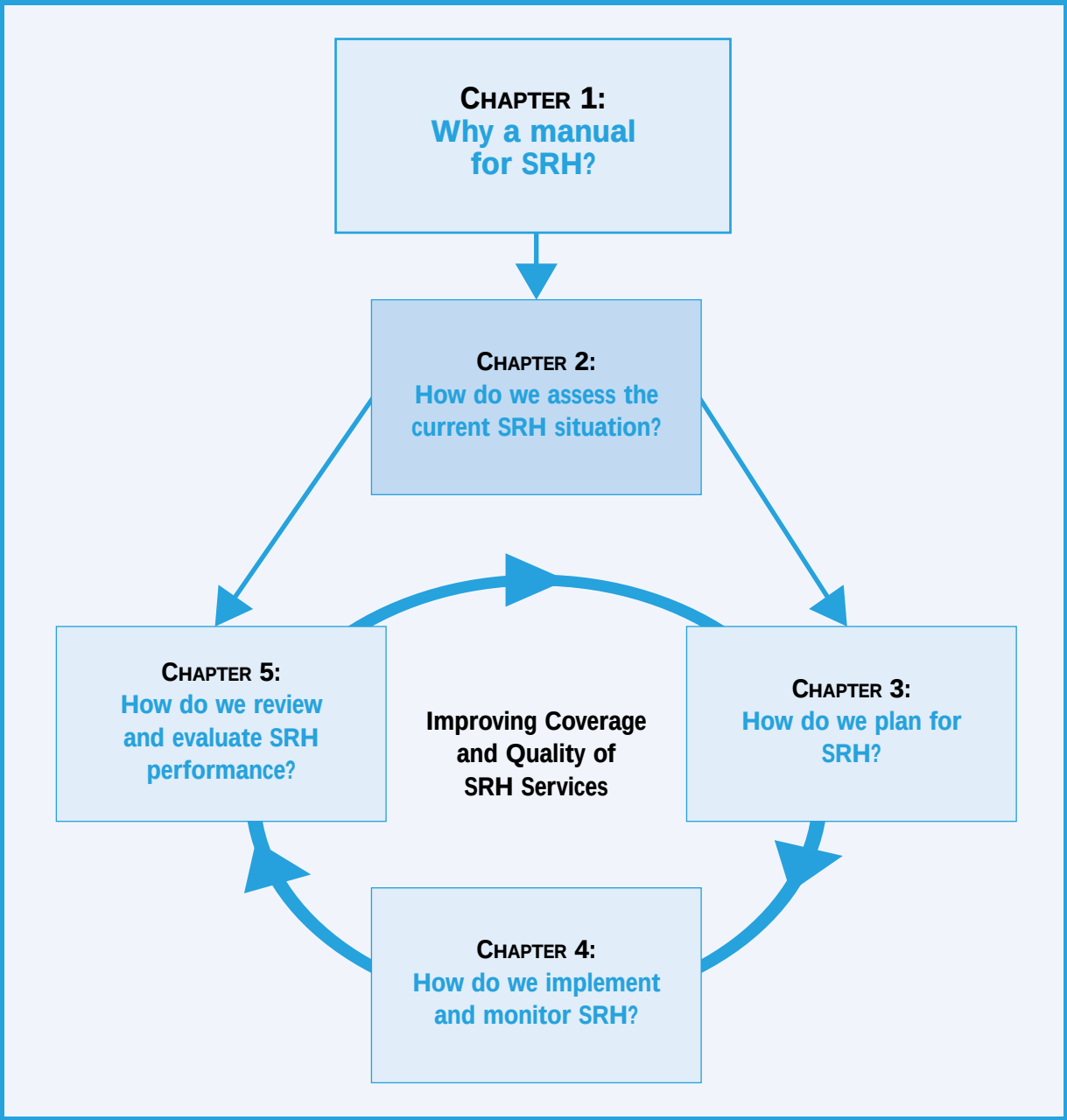


SRH problems identified by women, and ideas to address gaps in services

Problems identified	Ideas to address gaps
For ANC and delivery the CHWs pay home visits and refer women to the maternity home or hospital for check-ups and delivery. Some women do not go because the staff is rude and they prefer to deliver at home with a TTBA.	Organize a meeting between health staff and community representatives to address community attitudes
For immunization and FP women go to the mother and child health clinic. CHWs tell them they need to go there and most women do. During the last five months no baby clinic was held because there is no staff.	A women's group will request that an outreach clinic is organized to visit their neighbourhood from the nearest health facility that has staff.
For vaginal discharge, prolapse and other problems of the sexual and reproductive organs women use traditional healers and/or herbal remedies. They feel ashamed to talk about these things and they only go to the hospital when the complaints have become severe and nothing else helps.	Organize a meeting between traditional healers and health facility staff to design a more appropriate health promotion and referral system.
There are no services for adolescents. Adolescents are informed about HIV/AIDS at school, but they have no one they can go to when they have questions.	Using an existing youth group, identify peer leaders and organize HIV/AIDS, peer education training for in-school as well as out-of-school youth.
Women and girls who are sexually abused keep quiet because they are ashamed. There is no place they can go to.	Meet with local NGO and women's group to organize support.

CHAPTER 2:

How do we assess the current SRH situation?



By the end of this chapter we will have:

- made the district SRH profile - including services, staff and partners (Exercise 2a);
- calculated SRH target populations (Exercise 2b);
- mapped existing SRH services in the district (Exercise 2c);
- used data to assess current SRH services (Exercise 2d); and
- analysed SRH service data with partners (Exercise 2e).

CHAPTER 2:

How do we assess the current SRH situation?

2.1 Introduction

This chapter helps to assess trends in coverage and performance of the SRH services in the package identified in Chapter 1. The chapter is organized as follows:

- We review the district, looking at facilities, staff and partners working in SRH (district profile, Exercise 2a).
- We calculate target populations for different SRH services (Exercise 2b).
- We map specific existing SRH services (Exercise 2c). The map will tell us, for example, where obstetric care is available, where contraceptives are available, and other details we find important.
- We assess current SRH services using routine HMIS data (Exercise 2d).
- Using results from earlier exercises, we discuss and analyse SRH service data with partners (Exercise 2e).

2.2 Making the district profile

We begin the assessment by making a district profile. First, we review the existence of national policies for the different elements of the SRH package. This shows if there is nationwide support for a particular SRH issue. In the district profile, we also include information on the number of health facilities and the number of staff working in SRH. This tells us at one glance who is working where in SRH in the district from the government sector. This information comes in handy for developing a training plan. In the profile, we also list other partners active in SRH in the district. Exercise 2a shows how to make a district SRH profile.

2.3 Calculating SRH target populations

Planning can be further improved if we know how many people we want to reach with specific SRH services. Knowing the size of different target populations helps in planning and allocating resources, supplies and equipment for SRH activities. This information also serves to analyse performance, and to set targets for the coming years. Exercise 2b shows how to calculate target populations.

2.4 Taking a closer look at coverage of SRH services

A map can be a good visual tool to show coverage of specific (and not just facility-based) SRH services in the district, and to highlight gaps. The district map should be as comprehensive as possible, and show the location of SRH related services such as Voluntary Counselling and Testing (VCT) for HIV, basic EOC, condom availability, etc. It is up to the district health team to decide what should be on the map. Exercise 2c provides details on how to make the district map.

2.5 Using data to assess current SRH services

The next step is to assess current services. For this, we use data for a series of indicators; typically such data are available from HMIS and summarize information for the entire district. Sometimes, however, additional information is collected through rapid surveys, baseline studies or other methods. Keep in mind that it is generally not a good idea to work with indicators for which data are not easily accessible from routine sources. Also, data quality may not be optimal and we need to pay attention to this when we gather and use existing data.

Exercise 2d uses service data to assess current performance. Of course, routine information from health facilities does not capture information about those who are not using these facilities. This problem is not easy to overcome, but other partners may be able to help. They can possibly contribute information from their own data sources. Information from community-based sources, for example, is useful to cross-check whether knowledge, awareness, and utilization of services has improved.

Selecting indicators is a complex process. In this manual, the authors have chosen not to include an exercise on how to do this, as most countries

already have good district indicators in their HMIS. The example in Exercise 2d includes SRH indicators that are applicable to the district level.

2.6 Analysing SRH service data with partners

It is not enough to look at trends in service data; We should to understand why certain trends occur. For this reason, it is important to discuss observations related to coverage and quality of SRH services with partners in the district. We review achievements for the most recent year and compare them with expected achievements for each element of the package. This tells us where the gaps are. Exercise 2e shows how to do this analysis.

CHAPTER 2: Summary/Key Lessons

The district profile should regularly be updated (Exercise 2a). A component of this is to keep partners in the district informed of ongoing and planned activities.

EXERCISES CHAPTER 2:

How do we assess the current SRH situation?

Exercise 2a: How do we make the district SRH profile?

Expected outcome

At the end of this exercise, we will have an overview of SRH services available in the district. This includes both services with and without national policies to guide their implementation. We will have indicated the number of SRH service delivery sites and the number of health workers providing SRH care in the district. We will also have identified partners involved in SRH planning and provision.

Participation

This exercise is best done by one or more members of the DHMT. To strengthen ownership, it can be done jointly with other partners.

Duration/Venue

This exercise can be done at the DHMT office and will take a morning or an afternoon (two to three hours).

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Data from annual reports and other official sources

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

On a large sheet of paper, create a table with columns as shown in the sample district profile. List each of the SRH services that are currently being provided in the district in the left-hand column. This can be taken from Exercise 1a. Across the top list the types of health institutions and staff categories that exist in the district.

Step two

For each SRH service, put an X in the "national policy" column if official policy guidelines or protocols are available to support this activity. Country-level norms are available in the annual report and strategy documents on SRH from the Ministry of Health, in the National HIV/AIDS Control Programme, and in other sources.

Step three

For each SRH service, put the number of service delivery sites in the next column to show where information and services are currently being provided.

Step four

For each SRH service, identify the number of staff working in this area. Complete the respective column for each staff category.

Step five

Identify partners working on the different SRH elements. Consider those who are involved in planning, provision and/or financing of SRH services.

Optional step

As a brainstorming activity, discuss which facilities human resources and materials (drugs, supplies, etc.) are in shortage, and similarly, which items are easily available and why. Keep this information, as it will come back in Exercises 3e and 3f.

The profile shows areas where coverage of SRH services and staff capacity in SRH need strengthening. We will use information from this exercise to develop the district work plan and training plan.

Example of a district SRH profile for district of 206,397 population (census data)

Existing SRH services	National policy support	Number of sites where SRH services are currently being provided						Number of staff working on specific SRH issues in the district						Partners working in SRH in the district (planning, provision and/or financing)
		Village	Health post	Health centre	Private clinic	Hospital	Total sites	VHW/CHV	Auxiliary health worker	Nurse midwife	Health assistant	Doctor	Total staff	
Total facilities and staff		**22**	**9**	**1**	**1**	**1**	**34**	**22**	**11**	**2**	**1**	**1**	**37**	Not applicable
Maternal health: antenatal and postnatal care TTBA	X	22	9	1	1	1	**34**	22	11	2	1	1	**37**	Private practitioner; women's NGO; mission hospital
Maternal health: skilled attendance at delivery (including first aid and basic EOC)	X	0	8	1	1	1	**11**	0	8	2	1	1	**12**	Mission hospital; private clinic
Comprehensive EOC	X	0	0	0	1	1	**2**	0	0	1	0	1	**2**	Mission hospital; private clinic
Neonatal care	X	0	9	1	1	1	**12**	0	11	2	1	1	**15**	Mission hospital; private clinic
Complications of abortion	__	0	0	0	1	1	**2**	0	0	1	0	1	**2**	Mission hospital
RTI/STI/HIV/AIDS Marie	X	0	0	1	1	1	**3**	0	1	1	1	1	**4**	Save the Children Stopes International
Adolescent SRH	__	0	0	0	1	1	**2**	0	0	1	0	0	**1**	Private clinic
Family planning	X	18	9	1	1	1	**30**	18	11	2	1	1	**33**	Save the Children; mission hospital; women's NGO
Sub-/Infertility	__	0	0	0	0	1	**1**	0	0	0	0	1	**1**	No services
Life cycle SRH issues including breast/ reproductive tract cancers, fistulas, etc.	__	0	0	0	0	0	**0**	0	0	0	0	0	**0**	Mission hospital
Complications of FGC	__	0	0	0	1	1	**2**	0	0	1	0	1	**2**	Women's NGO (counselling and support)
Gender-based violence	__	0	0	0	0	0	**0**	0	0	1	0	0	**1**	Women's NGO (counselling and support)
_____														

Exercise 2b: How do we calculate SRH target populations?

Expected outcome

By the end of this exercise, we will have calculated the approximate target populations for the district SRH package. This target population information needs to be updated yearly to reflect changes in population.

Participation

This exercise can be done by one or more members of the DHMT.

Duration/Venue

This is an exercise that can take place at the DHMT office in a morning or an afternoon, if all information is available.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Calculator and ruler/computer with spreadsheet programme
- The latest "official" demographic data for the district

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Discuss what is the most appropriate source of demographic data. This will be the basis for calculations.

Step two

List selected SRH target populations across a piece of paper, as shown in the example.

Step three

List the names of each health facility down the left-hand column. If NGOs are responsible for providing services to certain catchment populations, include them as well.

Step four

Identify the latest district population figure. Calculate the various district SRH target populations, using percentages from census data or from other official sources; if these are unavailable, use best estimates. Specify these target populations in the column headings.

Step five

Determine the total catchment population for each health facility using official data, or make best estimates. The total of these catchment area populations should be the same as the district total. List these population figures in the second column.

Step six

Calculate the SRH target populations for each health facility, using the formulas shown in the example.

The calculations assist in defining coverage. They help set realistic targets and estimate supply and equipment needs. Every health facility should have a copy of these target populations. Remember that besides the target populations included in the exercise, we need to provide SRH services for vulnerable groups such as those with limited access, women with previous obstetric complications, married and unmarried adolescents, etc.

Example of SRH target populations for a district with 206,397 population (census data)

Target population (calculation)	Total population (data from latest census or other reliable source)	Family planning (women in their reproductive ages,[4] approx. 20% of the total population)	Antenatal, delivery and postnatal care (expected number of births = approx. 5% of the total population)	Maternal complications (an average of 15% of expected births experience a direct obstetric complication)	Caesarian sections (approx. 5% of expected births require a C-section)	Tetanus toxoid (approx. 20% of the total population are women eligible for TT)
	A	**B**	**C**	**D**	**E**	**F**
Formula		**A x 0.20**	**A x 0.05**	**C x 0.15**	**C x 0.05**	**A x 0.20**
District total	**206,397**	**41,279**	**10,320**	**1,548**	**516**	**41,279**
Name of health institution						
Health posts						
Changunarayan	17,445	3,489	872	131	Not applicable	3,489
Nagarkot	36,840	7,368	1,842	276	Not applicable	7,368
Bageswori	10,005	2,001	500	75	Not applicable	2,001
Tathali	10,430	2,086	522	78	Not applicable	2,086
Nankhel	11,065	2,213	553	83	Not applicable	2,213
Gundu	10,490	2,098	525	79	Not applicable	2,098
Bode	17,380	3,476	869	130	Not applicable	3,476
Nagadesh	27,820	5,564	1,391	209	Not applicable	5,564
Dadhikot	7,580	1,516	379	57	Not applicable	1,516
Health centres						
NP	57,342	11,468	2,867	430		11,468
Hospitals[5]						
Bhaktapur					**516**	

Please note, certain percentages are rough indications; where possible, use census or other official data to estimate target populations.

[4] We have calculated the number of couples in their reproductive years as the number of women who are 15-49 years of age. This avoids the problem of estimating how many men and women are sexually active.

[5] As the hospital covers the entire district, it does not have its own distinct catchment population. However, it is the only facility providing caesarean sections.

Exercise 2c: How do we map existing SRH services in the district?

Expected outcome

At the end of this exercise, we will have a large, hand-drawn map, showing the location of selected SRH services in the district. Additionally, each health facility will have a map of their coverage area for basic and comprehensive EOC.

Participation

This map can be developed by one or more members of the DHMT together with selected partners.

Duration/Venue

This exercise can be done at the DHMT office or another suitable location and will take two to three hours.

Materials required

- Flipchart/newsprint paper
- Coloured markers/pens/pencils
- Annual report/records of service statistics/other data sources
- Detailed district map and/or the map from Exercise 1b

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

On a large piece of paper, mark the location of health facilities and communities in the district - if not too many. Use the map from Exercise 1b as a starting point.

Step two

Draw (as accurately as possible) the district boundaries, approximate health facility catchment area boundaries, and any paved roads or major dirt tracks.

Step three

Discuss what services/elements of the district package should be displayed on the map. Think of a symbol or letter for each service. For example, the location of obstetric first aid can be marked with EOFA, basic EOC can be marked with the letters BEOC and comprehensive EOC with CEOC.

Step four

Locate and mark the SRH services on the map using the symbols or letters.

Step five

Produce sufficient copies of the map so that selected partners can have their own map (each health facility, NGO, etc.).

Step six

Repeat this process with staff from each health facility so that they have a map for their own catchment area.

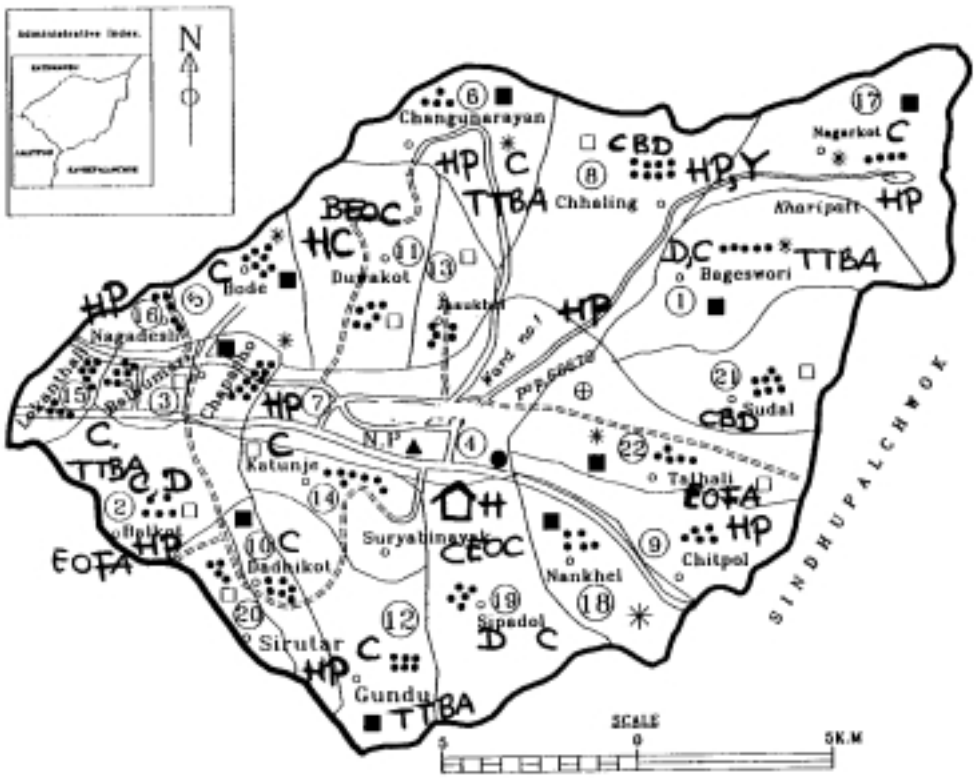
One very important way to use the health facility map is to discuss the average time a woman from each community in the catchment area would need to travel to reach a facility that can provide either basic or comprehensive EOC. An example of a health facility catchment area map from Malawi is included.

Step seven

Organize a meeting with partners to discuss the findings and their implications. Brainstorm on possibilities to improve EOC coverage, and to strengthen referral from the peripheral level.

Together with the community maps (Exercise 1b), the district and health facility maps indicate current SRH coverage. They provide a visual tool to guide decisions on expanding or improving the content of the district SRH package, particularly life-saving skills and basic and comprehensive EOC. They also guide decisions on training, supplies and equipment needs.

Example of district SRH map (206,397 population, 9 health posts, 1 health centre, 1 hospital and 1 private practitioner/clinic)



H	Hospital			-------	District boundary
HC	Health centre	CBD	Community-based distribution of FP supplies	----------	Health facility catchment area boundary (approximate)
HP	Health post	C	Condoms available	==	Paved road
CEOC	Comprehensive EOC	P	Pills available	- - -	Dirt track passable by motorized vehicle
BEOC	Basic EOC	D	Injectables available	+ + + +	Foot path
EOFA	Emergency obstetric first aid[6]	I	IUCDs available	·····	Communities
TTBA	Trained traditional birth attendant	*	VCT for HIV/STI	■	Community leader's house
Y	Youth-friendly services	①	Village Development Committee	□	Safe delivery kit distribution point

[6] Emergency obstetric first aid is defined as the ability of a health worker (at home or in the health facility) to stabilise and refer patients with haemorrhage, sepsis, or eclampsia.

Example of a catchment area map for basic and comprehensive EOC, Zomba district, Malawi.

Selected communities (list is incomplete)	Average time needed to reach Mayaka Health Centre for basic EOC*	Average time needed to reach Zomba Central Hospital for comprehensive EOC*
Chimowa	45 minutes	2 hours
Chisawa	30 minutes	2 hours 15 hours
Daundi	1 hour	2 hours 30 minutes
Hapala	1 hour	3 hours
Jalifu	1 hour	1 hour 30 minutes
Jimu	30 minutes	1 hour 45 minutes
Kamowa	15 minutes	2 hours
Kavithiwa	45 minutes	2 hours
Kholomana	30 minutes	1 hour 30 minutes
Komwa	45 minutes	2 hours
Lichapa	1 hour	2 hours 15 minutes
Etc...		

* Using the most likely mode of transport

Exercise 2d: How do we use data to assess current SRH services?

Expected outcome

At the end of this exercise, we will have used health facility data for a minimum series of SRH indicators, to assess three-year trends for each element of the SRH package.

Participation

This exercise can be done by one or more DHMT members, including the person in charge of HMIS. Ideally, health workers from one or more of the health facilities in the district participate. Additional participants can be representatives from NGOs, women's groups, CBOs, etc.

Duration/Venue

This exercise can take place at the DHMT office and will take a morning or an afternoon, provided the information for calculating each indicator is easily accessible. Ideally, a planning workshop with the entire DHMT and selected health staff is organized, where this is one of the activities (in combination with exercises in Chapter 3).

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- HMIS and other district-specific data
- Service records/annual reports/partner reports

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Check with HMIS to see what SRH data or indicators are being used for each of the elements of SRH. Use data and information from the district records, with totals for all health facilities in the district.

Step two

Review the list of SRH data and/or indicators. From this list, select indicators to measure coverage and quality of the SRH package. Please remember, FP coverage is hard to measure. Couple-years of protection (CYP[7]) is one indicator which is recommended.

Step three

For each element of SRH, decide which indicator(s) or data elements best capture changes in coverage or quality of SRH services.

Step four

If the HMIS (or other routine data sources) do not include the SRH indicator, we need to calculate it ourselves. This is fairly straightforward. For many SRH services, numbers (or percentages) are sufficient. For some, we will need information on subpopulations, such as the expected number of births, the expected number of direct obstetric complications, etc. Refer to Exercise 2b for target populations. Target population information needs yearly updating to reflect changes in the population.

Step five

On a big piece of white paper, draw a matrix as shown in the example. The elements of the SRH package are listed in the left-hand column. Using district and HMIS records, simply copy the indicator or service element selected, and complete the first column of the matrix, as shown in the example.

Step six

For each service element/indicator, complete the columns for the past three years.

[7] In this district (without permanent methods) 1 CYP=13 cycles of oral contraceptives, four doses of injectables , 100 condoms, 0.2 IUCDs, and 0.2 implants.

It is important to realize that increases for selected indicators, such as number of new STI cases, are not necessarily good or bad. Performance data and indicators are essential to monitor progress toward targets. Make sure that the number of indicators chosen remains manageable: the more there are, the more unwieldy it becomes to assess services.

Example of SRH service data for district with 206,397 population (census data)

SRH indicator for the elements of the SRH package	Service data for 2000, 2001 and 2002		
	2000	2001	2002
Maternal health (antenatal, postnatal, delivery and EOC)			
Number of deliveries attended in a health facility	1,222	1,367	1,275
Percentage of pregnant women receiving ANC at least once from skilled personnel	45%	47%	51%
Number of maternal complications treated	403	490	419
Percentage of caesarian sections performed out of total number of expected births in the district	5%	1%	2%
Number of pregnant women treated for severe anaemia (haemoglobin levels below 10g)	867	1,033	1,180
Neonatal care			
Number of neonates born in health facility with low birthweight (<2.5kg)	51	57	64
Complications of abortion			
Number of new cases admitted	1,135	1,246	1,197
RTI/STI/HIV/AIDS			
Number of HIV+ new cases	0	0	89
Number of new STI cases	1,883	1,967	2,151
Adolescent SRH			
Number of 15-19 year old girls attending ANC (first visit)	924	976	1,011
Family planning			
CYP* administered	10,446	11,982	12,347
Number of postpartum women accepting FP	407	435	446
(up to 6 weeks post delivery)			
Sub-/Infertility			
Number of new sub-fertility cases	0	0	0
Fistulas			
Number of new fistula cases	0	0	0
Complications from FGC			
Number of FGC new cases	225	258	290
Gender-based violence			
Number of clients coming to health facilities with problems/injuries related to violence	0	136	180

* In this district (without permanent methods) 1 CYP=13 cycles of oral contraceptives, four doses of injectables , 100 condoms, 0.2 IUCDs, and 0.2 implants.

Exercise 2e: How do we analyse SRH service data with partners?

Expected outcome

At the end of this exercise, we will have analysed a series of SRH indicators, and identified as many factors as possible that may contribute to trends in these indicators. We will focus on the current year, comparing the expected with actual achievements. We will do this together with other partners, including community representatives, and look into WHY these trends are occurring.

Participation

This exercise is best done jointly with district SRH partners, including some community representatives. It is important that health facility staff also participates.

Duration/Venue

This exercise can be done at the DHMT office, and will easily take an entire morning or afternoon. It is a good idea to do it in combination with Exercise 2d.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Data from HMIS, annual reports, and other sources
- Results from Exercises 1b (community discussions), 2b (target population) and 2d (using service data)

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Copy the table/matrix developed in Exercise 2d. Include one additional column, marked "Expected", followed by two additional columns on the right side. Mark the last two columns in big letters with "BUT WHY?" One such column will include "institutional factors" and the other "community factors".

Step two

In the column for the most recent year, indicate actual numbers and percentages, followed by expected numbers and percentages. To do this, use information from Exercise 2b (expected births, expected direct obstetric/maternal complications, etc.).

Step three

Make a list of what is known about coverage for the district. For example, after reviewing actual versus expected performance (see example on following page), for the sample district, we see that in 2002:

- coverage of institutional births was about 12% (of expected births in the district);
- 51% of pregnant women in the district received ANC at least once;
- 11% of pregnant women suffered from severe anaemia;
- 446 postpartum women in the district accepted a FP method (of women attending PNC in the district);
- there was a reported increase in the number of HIV/AIDS cases.

We also note that for 2002 we had expected to:

- achieve institutional births for 14% of expected births;
- provide ANC at least once to 60% of expected births;
- find low birthweight for 5% of new-born babies in health facilities;
- etc.

These were the old targets that the sample district did not reach completely.

Step four

As a group, discuss and brainstorm why the data in the expected versus actual columns may be different. Use data from previous years to assess if trends are decreasing/increasing/the same. Keep asking "BUT WHY?" until the group has an explanation that we can do something about!

Step five

List all the reasons that were mentioned in the two columns on the right. Divide possible causes into institutional and community factors. Brainstorm as a group on what can be done to improve the situation, and make a list of ideas for follow-up. We will use this list to set realistic targets (Exercise 3b), and to develop the district SRH work plan.

This exercise analyses service data for a three-year period, with emphasis on expected versus actual performance in the most recent year. We will use this analysis to set targets and come up with improved strategies (Exercises 3b, 3c, 3d).

Example of service data analysis for selected SRH indicators

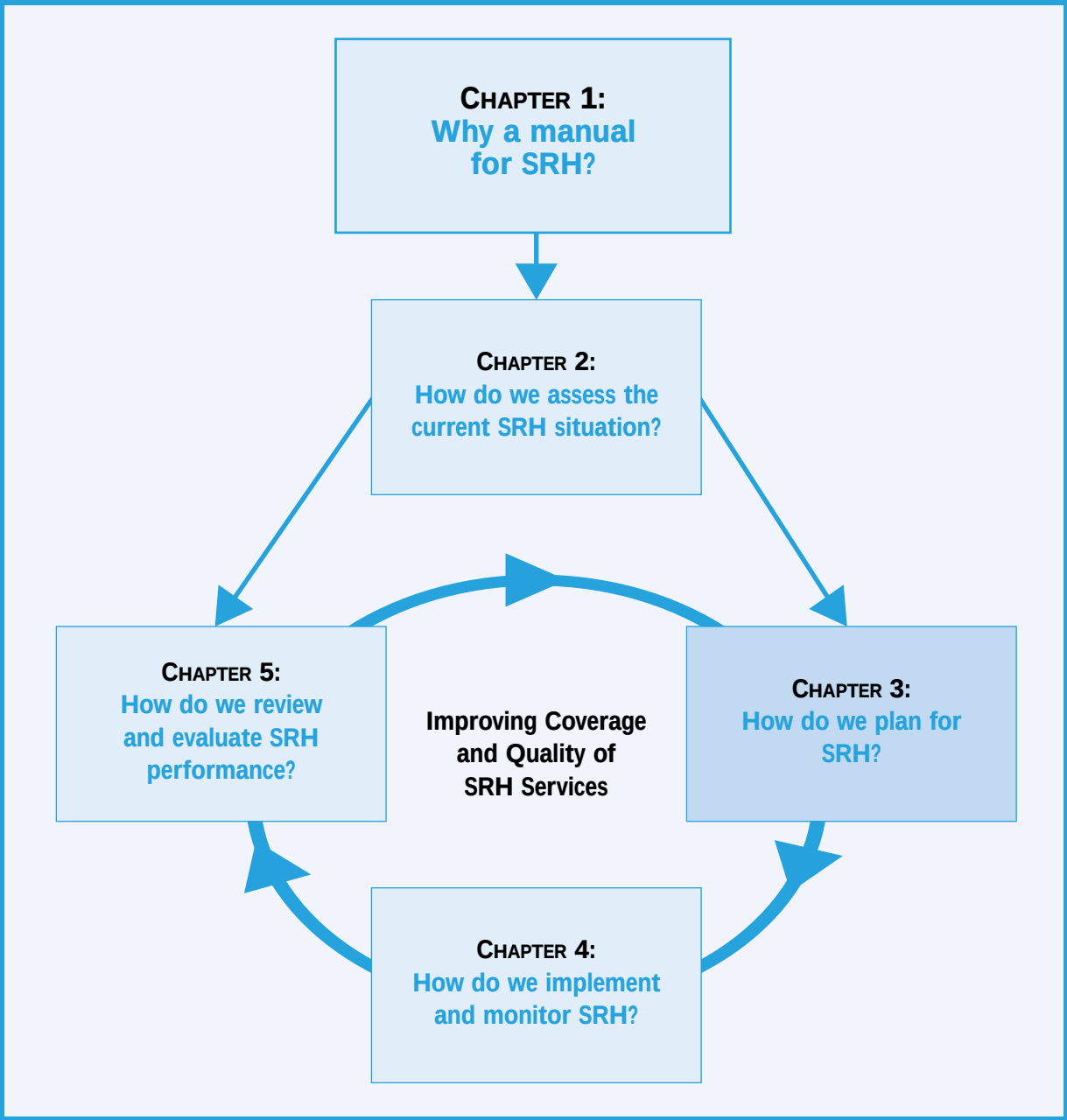
Indicator for each element of the SRH package	Service data for 2000, 2001 and 2002				BUT WHY ? Institutional factors (staffing, supplies, training) *	BUT WHY? Community factors (summary of Exercise 1b)
	2000	2001	2002 Expect.	2002 Actual		
Maternal health (antenatal, postnatal, delivery and EOC)					**Decreasing trend in safe motherhood indicators is of great concern**	**Community perceives quality of care as poor**
Number of deliveries attended in a health facility	1,222	1,367	**1,486** (**14%** of expect. births)	**1,275** (**12%** of expect. births)	- Mission hospital services were reduced as a result of severe budgetary constraints - Mostly male health providers - Few staff are trained in EOC	- Women deliver at home with family members, and prefer female staff in health facilities. - Communities are interested in having safe delivery kit available through TTBA
Percentage of pregnant women receiving ANC at least once from skilled personnel	45%	47%	**60%**	**51%**	- Same as above	- Women have limited time for health care; access is difficult
Number of maternal complications treated	403	490	**1,548** (**15%** of expect. births)	**419** of **1,548** expect. direct obstetric compli-cations	- Same as above	- TTBAs are often consulted first. Link with health facilities not strong enough
% of C-sections performed out of total number of expected pregnant women in the district	5%	1%	**5%**	**2%**	- Hospital gynaecologist responsible for C-sections was on leave for much of 2001 and 2002	- Not enough awareness on danger signs and symptoms
Number of pregnant women with severe anaemia (haemoglobin levels below 10g)	867	1,033	**1,032** (**10%** of expected births)	**1,180** (**11%** of expected births)	- Iron & folic acid not always available during ANC visits	- Difficulty for women and children to have good diet - Strong pregnancy-related beliefs about food intake
Neonatal health						
Number of neonates born in health facility with low birthweight (<2.5kg)	51	57	**64** (**5%** of births in health facility)	**89** (**7%** of births in health facility)	- Little attention to new-born health at health facility level	- Breastfeeding practices not optimal for quick weight gain - Growth monitoring is not done regularly
Complications of abortion						
Number of new cases admitted	196	238	**215**	**Increase expected**	- Several staff members re-trained on techniques for the management of incomplete abortion	- Unwanted pregnancy is still a taboo issue
RTI/STI/HIV/AIDS						
Number of HIV+ new cases	0	0	**150**	**89**	- VCT introduced in 2002 on a pilot basis in a small number of health facilities	- Stigma related to STIs and HIV is increasing
Number of new STI cases	1,883	1,967	**Increase expected**	**2,151**	- STI drugs occasionally stocked out	- Men feel ashamed to go to health facilities - Seasonal migration influences incidence of STIs - Difficult for women and adolescents to access services

Indicator for each element of the SRH package	Service data for 2000, 2001 and 2002				BUT WHY ? Institutional factors (staffing, supplies, training) *	BUT WHY? Community factors (summary of Exercise 1b)
	2000	2001	2002 Expect.	2002 Actual		
Adolescent SRH						
Number of 15-19 year old girls attending ANC (first visit)	924	976	**Increase expected**	**1,011**	- Few staff aware/trained on adolescent SRH issues	- Girls are marrying younger and get pregnant sooner
Family planning						
CYP	10,446	11,982	**13,000**	**12,347**	- No stock-outs reported	- Use of modern methods slowly increasing. Most women use pill or IUCD
Number of postpartum women accepting FP (up to 6 weeks post delivery)	407	435	**450**	**446**	- No PNC or follow-up once women go home	- Women breastfeed a long time and don't want to accept a FP method yet
Sub-/Infertility						
Number of new sub-fertility cases	0	0	**--**	**0**	- No services in the district	- Infertility is a big taboo issue
Fistulas						
Number of new fistula cases	0	0	**--**	**0**	- No services in the district	- This issue has not been discussed
Complications from FGC						
Number of FGC new cases	225	258	**Increase expected**	**290**	- More IEC in 2001 and 2002. Referral mechanism was reinforced for surgery	- FGC was discussed by teachers but not by health workers
Gender-based violence						
Number of clients coming to health facilities with problems/ injuries related to violence	0	136	**Unknown**	**180**	- No specific routine information available yet - No screening tools	- Identified as a serious issue by communities

* The DHMT identified a common institutional factor that influenced performance on most of the SRH elements of the package, namely "low staff morale", or "lack of incentive" for what was perceived as extra work.

CHAPTER 3:

How do we plan for SRH?



By the end of this chapter we will have:

- formulated objectives for SRH (Exercise 3a);
- defined targets for SRH performance in the next three years (Exercise 3b);
- analysed strengths and weaknesses of current SRH strategies and developed improved strategies (Exercise 3c);
- prioritized and selected new SRH strategies for the next three years (Exercise 3d);
- developed a learning and training plan for SRH (Exercise 3e);
- made an annual work plan (Exercise 3f);
- planned and managed SRH supply and equipment needs (Exercise 3g);
- prepared a routine monthly health facility schedule (Exercise 3h); and
- developed a financial plan (Exercise 3i).

CHAPTER 3:

How do we plan for SRH?

3.1 Introduction

This chapter is about planning for SRH as part of the overall district health strategies. In essence, SRH objectives, targets and strategies are combined with a financial plan and a budget. Chapter 3 is organized as follows:

- We start with formulating objectives for SRH and design an advocacy poster (Exercise 3a).
- Next, we define targets for SRH performance (Exercise 3b).
- We analyse existing strategies and activities for SRH, and select improved strategies to reach the targets for the next three years (Exercises 3c and 3d).
- We develop a learning and training plan for SRH (Exercise 3e).
- We develop a work plan for the first year, within the context of the district health plan (Exercise 3f).
- We plan and manage SRH supply and equipment needs for next year (Exercise 3g).
- We develop a routine monthly health facility schedule (Exercise 3h).
- We develop a financial plan (Exercise 3i).

3.2 Formulating objectives for SRH

With the analysis of trends in services for recent years (see Exercise 2e), we have a basis for the formulation of objectives for SRH activities in the district. In general, objectives describe where we want to be at the end of the implementation period. For example, in safe motherhood, a general objective can be "to improve access to skilled attendance at birth in the district."

Using this general objective, specific objectives and targets can be developed (see also Exercise 3b).

Specific objectives should be **SMART**:[8]

- Specific – to avoid differing interpretations. For example, a specific objective can be "to improve the percentage of deliveries with skilled attendance in the district by 10% by the end of next year."

- Measurable – to allow for monitoring and evaluation. Ideally, we attach numbers or percentages to the objectives, both baseline (where we are at the start of activities) and target (where we want to be at the end of the implementation period). For example, "to improve skilled attendance at birth in the district from 35% of all deliveries in Year X to 45% by Year Y."

- Agreed/appropriate – to the issue. If maternal mortality/morbidity is a national priority, maternal death rates are high in the district and many women deliver at home without skilled care, it is very appropriate to make skilled attendance at birth a priority.

- Realistic – to be achievable and meaningful. Objectives must reflect available financial and human resources (see Exercise 3c).

- Time-bound – to indicate a specific time period for achieving the objectives (see example under Measurable).

Exercise 3a helps to define broad objectives for each element of the SRH package, looking at a three-to-five year time period. It suggests that an advocacy poster be developed that lists these objectives, for everyone to see and remember.

3.3 Defining targets to achieve objectives

With the broad objective(s) for SRH well defined, next is to define service targets. We aim for SRH services to reach a certain level by the end of each year. Exercise 3b helps to determine future targets for

[8] Another set of criteria increasingly used to define objectives (and/or indicators) are the "DOPA" criteria: Direct, Observable, Practical and Adequate.

the SRH elements in the district package. In Chapter 4, we will monitor progress toward these targets.

With our targets, we now need to consider an overall approach or strategy to achieve them. The first step is to look at what the district is already doing. We analyse strengths and weaknesses of existing SRH strategies, and identify what can be done better. Exercise 3c helps to do this, using the results from Exercise 2e.

3.4 Prioritizing and choosing strategies

It will not be possible to try to do everything we want to do (or do better) in the next three years. Therefore, we need to make some choices. Exercise 3d helps to prioritize the district's future efforts in SRH.

It is likely that many objectives may be achieved in more than one way. We need a systematic approach to deciding between alternatives. One strategy may require different resources than another strategy. Generally, we should only consider strategies for which resources are either routinely available, or not too difficult to mobilize. These resources include human resources, equipment, consumables and financial resources. Among the questions to consider are:

- Which strategies can be implemented with existing resources?
- Which strategies require extra input that is likely to be available?
- Which strategies require extra input from partners?
- Which strategies require extra input that is likely to be unavailable?

We then allocate time, prepare a budget, call a meeting with partners and/or prepare a proposal for financing by an external partner. We can also decide to drop those activities for which we think no resources can be mobilized.

Note that criteria other than financial ones should also be considered. Often there is a conflict between achieving high efficiency (value for money) and achieving high levels of equity (reaching all that need services with those services, including groups that are hard to reach).

3.5 Identifying learning and training needs

We now know what we want to do (objectives and targets), and how we are going to do it (strategies), but we need capable people to do it. In Exercise 2a (district profile), we identified the number of trained health workers who provide SRH services, and the sites where services are offered.

To upgrade skills in the district, we will review learning and training needs (Exercise 3e). In the long run, it may be necessary to relocate staff with certain skills, so that we achieve the greatest possible coverage and availability of services. Of course, training needs in SRH must be considered within the overall district health training plan, and decisions must be made on the priority assigned to proposed training.

3.6 Making an annual SRH work plan

Exercise 3f describes the steps involved in preparing a work plan. For most district level planners and managers, making a work plan is a routine component of their work. In the work plan, we outline who will do what and by when this should be done. This way everybody knows the expectations for the coming period.

It is important to look at each of the activities we will introduce this year and to calculate as precisely as possible what inputs they require, and what this will cost. For instance, if a training programme is part of the work plan, we have to mention in the financial plan the teachers' fee, the course materials, travel and accommodation expenses, etc. It is of course easiest to develop the financial plan and the work plan at the same time, to make sure they match (see section 3.9).

3.7 Planning and managing SRH supply and equipment needs

Maintaining an appropriate level of supplies and equipment is essential for avoiding stock-outs, which can easily disrupt service utilization and wastage due to expiry. Thus, we must plan needs for SRH drugs and supplies in advance. One way to do this is by looking at figures from last year's consumption. This is more reliable than trying to estimate needs by simply looking at target populations, as those data may be both hard to get and less accurate. It is best to combine the two methods, but that is not always feasible.

Exercise 3g assists in planning supplies for next year. We can repeat this exercise for the year after that, and begin planning requests for regional/national level. In this way, we can work to establish a more secure logistics system for all commodities including those for SRH. Many of these commodities may already be part of a standard commodity management programme for all supplies and drugs. It is a good idea to plan additional commodity needs according to similar steps.

3.8 Making a routine monthly health facility schedule

On the basis of the SRH annual work plan, Exercise 3h assists in developing a routine monthly activity schedule for the health facility. This schedule is important for monitoring and supervision, as will be discussed in Chapter 4.

In addition to the routine schedule, we also have the option of developing a Gantt chart that shows when activities take place during each month and week. Activities are divided into several categories, and include non-routine work and special events (such as national immunization days, World AIDS Day, etc.).

3.9 Developing a financial plan

Exercise 3i helps with making a financial plan. A well-designed financial plan shows both expected expenditures and projected income for a specific activity. The financial plan covers three years, and should reflect when certain expenditures are likely to occur. It is not a good idea to simply divide the financial plan in three equal parts, as activities may occur at different levels over the years.

A financial plan provides the information required to answer the following questions:

- How much will it cost to realize the annual plans?
- Are the annual plans efficient, equitable and financially sustainable?
- What possibilities are there to adjust plans during the three-year time period?

The financial plan for SRH should be part of the overall district financial plan. To make sure that this happens, we can divide the finalized SRH financial plan into several parts, and allocate these to different budgets. For example, one part can go into the district budget from central level, and another into a budget for donor financing. If there is only one coordinated channel of financing to the district level, the whole financial plan can be incorporated into this budget.

The financial plan will have identified sources of financial support for each of the different strategies, and the corresponding activities in the annual work plan. Next, this needs to be translated into a budget for each source of financing. This should be relatively straightforward, and can be done by an administrative or finance clerk. For each source of financing, the budget should be prepared according to the financial rules and requirements of each of the different donors. From a management perspective, the most important thing is to ensure that expenditure and activities can be clearly linked to each other. This will be essential when it comes to monitoring and evaluating SRH strategies and expenditures (see Exercises 4c and 4d).

All SRH activities should be incorporated in the district budget, although certain resources (capital items) may require separate proposals for financing.

CHAPTER 3:
Summary/Key Lessons

This chapter has introduced objectives and targets for SRH; these are not fixed for the duration of the implementation or intervention period; we adjust them as information from routine monitoring becomes available. Such information should show progress toward meeting targets.

We also developed a series of plans for SRH in the next three years. This includes an annual work plan, along with monthly schedules for health facilities, all of which will need reviewing at the end of Year 1, in line with a review of the overall district health plan. The financial plan will also need regular updating.

As with all PM&E activities, the most effective and participatory way to prepare and plan is through a workshop involving all stakeholders. This will help ensure that there is broad consensus and ownership regarding plans and any follow-up that is necessary. Such follow-up action can be integrated within existing yearly planning activities for the health sector.

Exercises Chapter 3:

How do we plan for SRH?

Exercise 3a: How do we formulate SRH objectives?

Expected outcome

At the end of this exercise, we will have an advocacy poster that clearly states the objectives for SRH in the district. Each element of the package will have one or more objectives attached to it.

Participation

It is essential that all DHMT members take part in this exercise, together with health facility staff, and any other partners who can make the time to participate (women's groups, community representatives, youth participants, etc.).

Duration/Venue

This exercise can be done at the DHMT office. Formulating the broad objectives will take about one to two hours. This activity is best done in a two or three-day planning workshop at district level, together with the earlier exercises on performance (Exercises 2d, 2e) and those presented later in Chapter 3.

Materials required

- Flipchart/newsprintpaper/cardboard/ regular size paper
- Coloured markers/pens/pencils
- Tape/string/pins
- Baseline HMIS data (optional)

Step one

Brainstorm as a group what the "mission" of the DHMT and its partners is in relation to SRH, and in relation to the elements of the district SRH package.

Step two

Define a broad objective for each of the elements of the SRH package. Make the text short and to the point. Also, make sure the objective can be translated into actions, and does not remain rhetoric!

Step three (optional)

Include information from Exercise 2e on coverage to make the objectives specific. This means that we attach a measurable change in a specific indicator to the objective, as well as a time period. The change in the indicator is the target (see Exercise 3b).

For example, using the sample district again:

Safe motherhood - improving maternal health by increasing the number of direct maternal complications treated at health facilities from 419 in 2002 to 600 in 2004.

Family planning - improving utilisation of FP methods by increasing the number of postpartum women who accept a modern FP method from 446 in 2002 to 600 in 2004.

Step four

Choose durable material, and copy the text onto a large advocacy poster. Distribute the poster, and display it in the DHMT office and elsewhere in the district. Make sure each partner and each health facility has a copy. Remind staff to refer to the poster when they talk with clients, visitors, etc.

It might be a good idea to produce several copies of this poster and to make it widely available in the district. Also, the poster could be taken along on visits to other districts, to encourage colleagues to formulate their own objectives for SRH.

Example of objectives for selected SRH elements (advocacy poster)

In this district, we are committed to:

Maternal health – improving maternal health by timely management of obstetric complications and implementing community-based interventions.

Family planning – increasing access to FP methods, reducing unwanted pregnancy and better meeting client needs.

Adolescent SRH – meeting the needs of young people, by providing youth-friendly services and improving access to information and services.

HIV/AIDS – increasing HIV prevention by making Voluntary Counselling and Testing accessible at selected sites in the district.

Exercise 3b: How do we define targets for SRH performance?

Expected outcome

At the end of this exercise, we will have specific targets for each element of the SRH package for the next three years. We will have developed graphs that show past performance, and that will allow us to plot progress toward the targets.

Participation

This exercise is best done by the DHMT and selected partners involved in service provision (refer to the district profile, Exercise 2a).

Duration/Venue

This exercise can take place at the DHMT office and will take one to two days, depending on how many partners participate. As with Exercises 2d and 2e, and the other exercises in Chapter 3, this is best done in a two to three day planning workshop each year.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Calculator
- HMIS data/facility records

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of this manual once the exercise is completed.

Step one

Review performance/service data for the SRH package from Exercise 2e. Use the numbers or percentages that we calculated for the different elements of the SRH package (see step three, Exercise 2e).

Step two

On a large piece of paper, list the indicators down the left-hand column. Copy numbers/percentages on performance from the last two years (Exercise 2e) in the second and third column. Create a blank column for "Change per year". Last, create three blank columns for the coming three years. Label these "Targets" for each year.

Step three

Using data on actual performance from the last two years, calculate the average change per service element/indicator. With this information, and with what we know about the district (district profile, Exercise 2a) discuss appropriate targets for each of the elements of the SRH package for the next three years. List these in the appropriate columns.

To make target setting as realistic as possible, assess changes in the past two years, check national priorities and use the analysis from Exercise 2e. Also assess available human and financial resources.

Step four

Once the columns for each year have been completed, make a graph for each element of SRH. Start with the last two years of the performance data, and plot targets for each consecutive year.

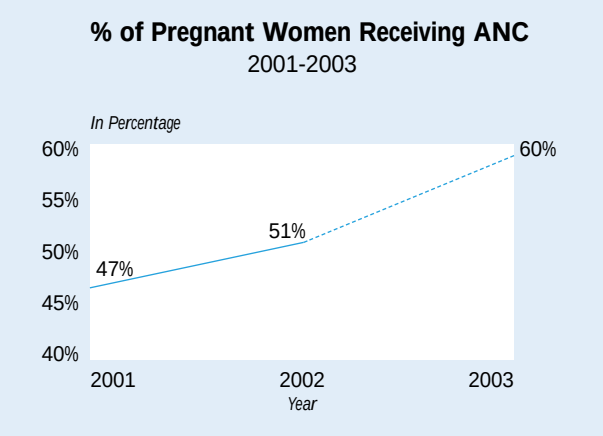
To prepare the graphs, write numbers or percentages on the vertical Y-axis and years on the horizontal X-axis. Draw a line from the earliest year to the current year, to show performance trends. Draw another line, using ----- (dots or interrupted line) to show the target for next year.

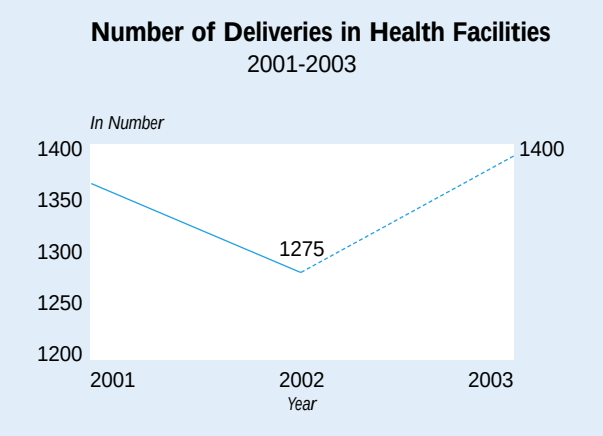
We use this information to monitor coverage and to estimate supply and equipment needs. Building consensus on targets is the basis for action for the coming three years. Consider displaying the graphs in the DHMT office so that the trends in coverage are highly visible.

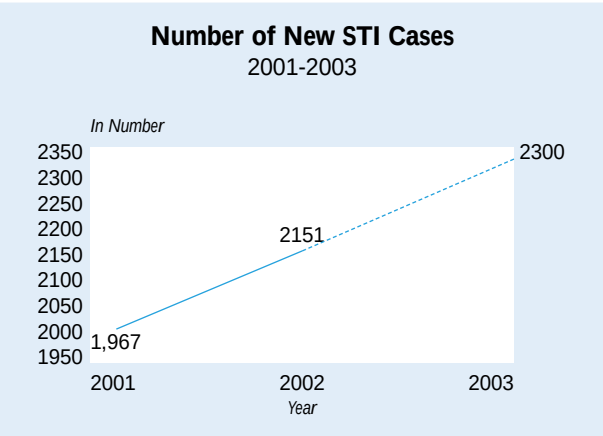
Example of targets for SRH performance for a district with 206,397 population

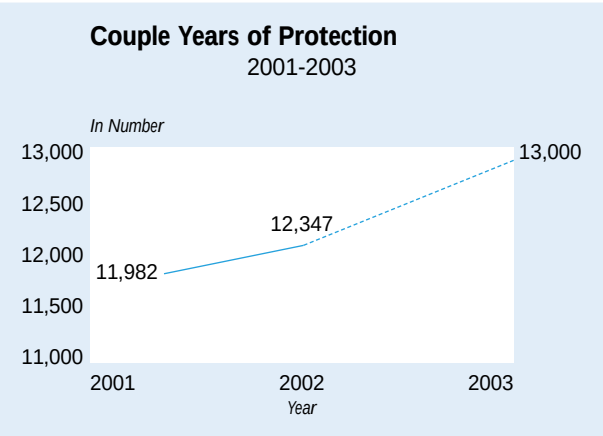
Indicator for each element of the SRH package	Coverage/Performance			Targets		
	2001 actual	2002 actual	Change per Year	2003	2004	2005
Maternal health (antenatal, postnatal, delivery, EOC)						
Number of deliveries attended in a health facility	1,367	1,275	-92	1,400	1,550	1,700
Percentage of pregnant women receiving ANC at least once from skilled personnel	47%	51%	4%	60%	65%	70%
Number of maternal complications treated	490	419	-71	500	600	700
Percentage of C-sections performed out of total number of expected births in the district	1%	2%	1%	2%	3%	4%
Number of pregnant women with severe anaemia (haemoglobin levels below 10g)	1,033	1,180	147	1,050	950	800
Neonatal health						
Number of new-borns born in health facility with low birthweight (<2.5kg)	57	64	7	55	50	45
Complications from abortion						
Total number of admissions for abortion related complications (spontaneous and induced)	238	215	-23	250	300	350
RTI/STI/HIV/AIDS						
Number of HIV+ new cases	0	89	--	250	300	400
Number of new STI cases	1,967	2,151	184	2,300	2,500	2,700
Adolescent SRH						
Number of 15-19 year old girls attending ANC (first visit)	976	1,011	35	1,100	1,200	1,400
Family planning						
CYP	11,982	12,347	365	13,000	14,000	15,000
Number of postpartum women accepting FP	435	446	11	550	600	650
Sub-/Infertility						
Number of new sub-fertility cases	0	0	-	0	0	0
Fistulas and other RH issues						
Number of new fistula cases	0	0	-	0	25	75
Complications from FGC						
Number of FGC new cases	258	290	32	340	400	500
Gender-based violence						
Number of clients coming to health facilities for injuries/problems related to violence	136	180	44	200	225	250

Example of graphs showing trends in performance for two years with dotted line showing targets for next year









Exercise 3c: How do we analyse the strengths and weaknesses of current SRH strategies and activities?

Expected outcome

By the end of this exercise, we will have analysed the strengths and weaknesses of existing SRH strategies in order to develop improved or new strategies. It is easiest to begin with one or two SRH elements, and once these have been completed, to work down the list of elements based on priorities among the district staff. Please note, our example is not a full analysis. To do a full analysis, two additional columns are added, labelled "Threats" and "Opportunities". We will not do this here.

Participation

This exercise should involve the DHMT and SRH partners in the district, including health facility staff, local NGOs, CHWs, etc. A district manager or planner is best placed to facilitate this exercise.

Duration/Venue

This is an exercise that is likely to require a morning or an afternoon of concentrated work. It can be organized at the DHMT office. Please note, this exercise initiates the real planning part of the management cycle, where partner participation is essential. It is best done in combination with earlier exercises (Exercises 2d, 2e, 3a, 3b).

Materials required

- Newsprint/flip chart paper/regular size paper
- Different colour markers, tape

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

List the SRH elements that are currently being provided as part of the district SRH package in the left-hand column (this can be taken from any one of the earlier exercises). Across the top, label the next three fields in the upper row as "Current strategies", "Strengths" and "Weaknesses".

Step two

For each of the SRH elements, summarize in the "Current strategy" column the key strategies that are currently in place in the district. It may well be that currently no strategies are implemented for some of the elements. This should be indicated on the paper.

Step three

Once all the strategies are listed in this column, ask participants to identify strengths and weaknesses for each strategy, and list them separately on a large piece of paper. At this point, do not go into long discussions but just write them down. Consider issues such as coverage, access, availability of trained staff, quality, etc.

Step four

Only when all the responses are listed, should we read them aloud and discuss them. For each strategy, make a choice of up to three of the most important strengths and weaknesses. Enter these in the next two columns of the matrix.

Step five

Analyse the results. Discuss how we can use the strengths of current strategies to further improve the SRH programme, and how we can overcome existing weaknesses (or gaps) in strategies by devising improved or new strategies. Complete the last column of the matrix.

The list of new or improved strategies forms the basis for strategic action in SRH. We will use the list to develop the work plan for Year 1. First, however, we decide on priorities.

Example analysis of strengths and weaknesses of current SRH strategies

SRH element	Current strategies	Strengths	Weaknesses	New or improved strategies for the next three years
Maternal health: antenatal and postnatal care	ANC/PNC services available at all service delivery points on Tuesdays and Thursdays	Trained personnel provides ANC/PNC	- Availability only twice a week - Coverage is very low - Services not integrated	- Provide ANC on a daily basis, and integrate into all services - Strengthen postnatal services focusing on community IEC
Maternal health: assisted deliveries, including obstetric first aid and basic EOC	Assisted deliveries in health centre and hospital. Obstetric first aid in health centre	Availability of normal safe delivery with trained staff in selected sites	- Coverage is very low - No basic EOC in the district - Limited staff capacity	- Ensure that all staff are capable of providing obstetric first aid - Improve routine monitoring of deliveries - Improve community awareness on danger signs and symptoms
Comprehensive EOC	Comprehensive EOC available at district hospital only	Quality of care is good as case fatality rate in facilities has been consistently low (less than 1%)	- Limited staff capacity - Coverage is very low (for C-sections around 1%)	- Ensure around-the-clock comprehensive EOC including anaesthesia and blood
Neonatal care	New-borns are checked immediately after birth in health facility	Immediate action can be taken in case there are problems	- Coverage is very low	- Include neonatal care in outreach activities
Complications from abortion	Basic care available at all levels. Referral to hospital Some IEC in communities.	Availability of treatment is good	- Health workers have not received specific training to manage complications from abortion	- Ensure that all facilities have necessary equipment and supplies
RTI/STI/HIV/ AIDS	STIs are syndromically diagnosed and treated. No active BCC and counselling on STIs Suspected HIV cases are referred to regional hospital for testing	Availability of trained staff for clinical diagnosis Referral system with regional hospital functions well	- Staff are not trained in counselling - Laboratory facilities are weak - Insufficient drugs for proper treatment of STIs - HIV testing is done only at the regional level and services are inaccessible to many clients	- Integrate counselling and BCC in clinical activities - Upgrade laboratory facilities - Ensure that annual orders for drugs include sufficient STI drugs - Introduce availability of VCT at district hospital

SRH element	Current strategies	Strengths	Weaknesses	New or improved strategies for the next three years
Family planning	Condoms, pills, IUCDs and injectables are available at all service delivery sites Community-based distribution in few sites Strong IEC efforts	Nearly 100% of staff has been trained on modern FP methods Access to FP methods is good Availability of different methods is good	- Perceived quality of counselling/ information is low - IEC has focused on pills and IUCDs and less on other methods	- Improve availability of FP services through community-based distribution and EPI outreach - Involve the private sector to broaden contraceptive choice - Ensure health workers promote appropriate method mix - Improve counselling and IEC for all methods
Adolescent SRH	No programme activities	---	---	- Explore working with youth groups and teachers. - Explore integration of SRH in secondary school clinics - Introduce YF services in selected health facilities
Sub-/Infertility	No activities except clinical and counselling services at hospital level	---	---	- Expanding work in this area is unlikely
Life cycle SRH issue (fistulas)	Minor repair at district hospital Referral for complicated cases No IEC and counselling	This meets the most basic needs	- Coverage is low - Referral service is inconsistent	- Include information on services for fistula in outreach activities - Explore partnerships with women's groups to sensitize staff to the issue
Complications from FGC	Minor repair at district hospital Referral for complicated cases No IEC and counselling	This meets the most basic needs	- Coverage is low - Simple curative treatment is not addressing the problem - No activity in the community	- Explore partnerships with women's groups to sensitize staff to the issue - Ensure treatment and referral are accessible and discrete - Ensure linkages with the regional hospital are efficient
Gender-based violence	No direct services provided No IEC	--	--	- Ensure health staff is trained in counselling - Explore partnerships with women's groups to sensitize staff to the issue

Exercise 3d: How do we prioritize and select SRH strategies?

Expected outcome

At the end of this exercise, we will have reviewed the list of SRH strategies for the next three years, and ranked them according to a series of criteria. We will have an updated list of priority strategies.

Participation

This exercise should involve the DHMT and its partners, including women's groups, NGOs, the private sector, CHWs, etc. A district manager or planner is best placed to facilitate this exercise, building on Exercise 3c.

Duration/Venue

This exercise is likely to require a full day of concentrated work. It can be organized at the DHMT office. This exercise is part of the real planning part of the management cycle where partner participation is essential.

Materials required

- Newsprint/flip chart paper/regular size paper
- Coloured markers, tape

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Draw a matrix that lists the SRH elements in the first column. Copy the list of strategies from Exercise 3c. Brainstorm on the various strategies in turn, considering issues like: is it realistic? Is it likely to be financed? etc. After a first round of brainstorming to hear about people's ideas, write down the strategies that seem most feasible. Additionally, consider if the element and/or the strategy is a national priority, which often means support from national level can more easily be mobilized.

Step two

If there is still a long list of possible strategies, consider the following criteria to decide on priority strategies:

- **Equity**
  In practice, this means focusing on access. Interventions affect population groups differently; some will particularly benefit the young, others women, men or the elderly. The goal is to ensure that services are balanced to meet the needs of all population groups.
- **Effectiveness**
  We can think about effectiveness by considering: i. how significant is the SRH problem in the district (look at records); and ii. whether effective interventions are available.
- **Costs/Affordability**
  Some interventions will cost more than others, yet may yield little extra benefit. Think about interventions that achieve maximum improvement in health at the lowest possible cost. It is less expensive to build on existing services and make gradual improvements than to develop new ones.
- **Technical and organizational feasibility**
  When selecting interventions, try to be realistic about the capacity in the district. Be aware of the limitations in human capacity. Also consider resource constraints, and the time needed to develop infrastructure, find equipment, ensure supplies, organize outreach, etc.

Step three

Go back to the list of strategies and decide on the ones that should be implemented. Rank them according to priority, using the criteria above as a guiding principle.

Update the list of selected strategies, dropping the ones that were ranked as least important. We will use the final list of strategies to develop the work plan for Year 1.

Example of priority ranking of SRH strategies

SRH element	Improved strategies for the next three years	Ranking*
Maternal health: antenatal and postnatal care	- Provide ANC on a daily basis and integrate into all services - Strengthen postnatal services, with emphasis on the mother	---
Maternal health: assisted deliveries, including obstetric first aid and basic EOC	- Ensure that all staff are capable of providing obstetric first aid - Improve routine monitoring of deliveries - Improve community awareness on danger signs/symptoms	1 3 2
Comprehensive EOC	- Ensure around-the-clock comprehensive EOC including anaesthesia and blood	--
Neonatal care	- Include neonatal care in outreach activities	--
Complications of abortion	- Ensure that at least one worker per health facility can manage complications of abortion - Ensure that all facilities have necessary equipment and supplies	--
RTI/STI/HIV/AIDS	- Integrate counselling and BCC in clinical activities - Upgrade laboratory facilities - Ensure that annual orders for drugs include sufficient STI drugs - Introduce availability of VCT at district hospital and other sites	4 3 1 2
Family planning	- Improve availability of FP services - Involve the private sector to broaden contraceptive choice - Ensure health workers promote appropriate method mix - Improve counselling and IEC for all methods	1 3 4 2
Adolescent SRH	- Explore working with youth groups and teachers - Explore integration of SRH in secondary school clinics - Introduce YF services in selected health facilities	1 3 2
Sub-/Infertility	No activities	---
Life cycle SRH issue (fistulas)	- Include information on services for fistulas in outreach activities - Explore partnerships with women's groups to sensitize staff to the issue	---
Complications of FGC	- Explore partnerships with women's groups to sensitize staff to the issue - Ensure that treatment and referral are accessible and discrete - Ensure linkages with the regional hospital are efficient	1 2 3
Gender-based violence	- Ensure health staff is trained in counselling - Explore partnerships with women's groups to sensitize staff to the issue	--

* 1=high priority; 2=important; 3=less important; 4=least important
Where there are less than three strategies, we do not need to rank them

Exercise 3e: How do we develop a learning and training plan for SRH?

Expected outcome

At the end of this exercise, we will have developed a learning and training plan for staff in the district on specific SRH issues.

Participation

This exercise should involve DHMT and SRH partners, including women's groups, NGOs, the private sector, etc. Some health facility staff should also participate.

Duration/Venue

This exercise should take a few hours and can be done at the DHMT office.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/tape
- District profile (Exercise 2a)
- District health training plan (if available)

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Draw up a matrix with the following columns: SRH elements (copy from earlier exercise); learning and training needs; staff category; costs of training; source of funds; and technical assistance.

Step two

Using the district profile, brainstorm on areas where learning and training needs exist. List them in the second column.

Step three

Complete the matrix indicating the staff categories that need to receive training. If possible, indicate costs, and whether funds are available or required for this training. We will do this in more detail in Exercise 3f. Where there is no money available, brainstorm with partners about possible sources of financial support for the training.

Remember, this training plan needs to be put side-to-side with training needs for other health and disease control activities.

It may be difficult to implement some of the desired training activities. We should therefore be realistic and carefully consider human and financial resources. The SRH learning and training plan should be incorporated into the overall district health training plan, to decide on priorities for on-the-job and refresher training for all staff.

Example of a learning and training plan for SRH

SRH element	Learning and training needs	Staff category	Costs of training	Source of funds	Technical assistance
Maternal health: antenatal and postnatal care	- PNC and counselling - Nutrition	All health facility staff and VHWs	Costs of 3 batches of refresher training (12 pp per batch)	DHMT budget	District health team
Maternal health: assisted deliveries (including obstetric first aid and basic EOC)	- Obstetric first aid: stabilizing and referral - Use of the partograph	Aux. health worker, nurse midwife, health assistant	Costs of training for 14 pp	Mission hospital or regional health office	Mission hospital and regional level
Comprehensive EOC	- Comprehensive EOC: signs, symptoms and treatment of complications	Physician	Costs of training for 1 pp	DHMT budget Mission hospital?	Mission hospital and central level
Neonatal care	- Basic care for new-born	All staff including VHWs (and TTBAs)	Costs of 3 batches of training (12 pp per batch)	Mission hospital?	Mission hospital and central level
Complications from abortion	- Techniques for the surgical management of incomplete abortions - Post-abortion care and counselling	Nurse midwife, health assistant, doctor	Costs of training for 5 pp	DHMT budget NGO/private clinic staff	NGO and private clinic consultants
RTI/STI/HIV/ AIDS	- Partner referral and follow-up - Syndromic management - STI counselling - VCT	Aux. health worker, nurse midwife, health assistant, physician	Costs of training for 15 pp	Mission hospital	Mission hospital staff
Adolescent SRH	- Peer-training on adolescent SRH	Nurse midwife	No costs	NGO	FP-NGO
Family planning	- Client counselling - Method mix				
Sub-/Infertility	- Basic orientation	Nurse midwife, health assistant	Uncertain?		
Life cycle SRH issues	---				
Complications from FGC	- Symptoms and complications - Basic care and counselling				
Gender-based violence	- Signs and symptoms - Basic care and counselling skills				

Exercise 3f: How do we develop an annual SRH work plan within the context of the district health plan?

Expected outcome

At the end of this exercise, we will have a detailed annual work plan with activities for each of the SRH elements identified in the package.

Participation

This exercise should involve the DHMT, health facility staff, and as many partners as possible. We may also invite someone from the regional and/or national level.

Duration/Venue

This exercise can take place at the DHMT office, and can be done in a morning or an afternoon. It is best to include this exercise as part of ongoing planning activities in the district.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Calendar
- Overview of staff working in the district and their work plans (if available)
- List of selected SRH strategies (Exercise 3d), learning and training plan (Exercise 3e)

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Look at the SRH strategies identified in Exercise 3d, and copy them into column two of the matrix. Column 1 simply lists the SRH elements of the package.

Step two

List all activities for each strategy, for example to increase skilled attendance at delivery (strategy) we want to train a certain number of health workers this year (activity).

Step three

Decide who will be responsible for each activity. Do not assign too many activities to just a few people and before finalizing the plan, make sure that everyone will have the time to do it.

Step four

Determine when each activity should be completed. Indicate the month.

Step five

For each activity, list the source of support. Besides financial resources, it may be wise in some cases to look at human or other resources. These should be routinely available or easily mobilized. Include technical assistance in the last column.

Step six

Discuss and agree on the work plan with those who are responsible for certain activities. Send a copy of the work plan to all SRH partners in the district and to the central health office. Refer back to the work plan during staff meetings or discussions with health workers and communities.

Everyone must feel responsible and accountable for his/her area of work. Make sure all partners in the district and the central health office have a copy of the work plan. We will monitor progress in implementing the work plan in Chapter 4.

Example of an annual SRH work plan within the context of the district health plan

SRH element	SRH strategy (copy from Exercise 3d)	What? (activities)	Who?	When?	Source of support
Maternal health: antenatal and postnatal care	- Provide daily ANC and integrate into all services including during EPI outreach - Strengthen PNC with emphasis on the mother	- Run ANC clinics in five facilities on a daily basis (pilot) - Review content of PNC package for postnatal messages - Emphasize follow-up of low birthweight babies and postpartum FP	Health facility in-charge and relevant staff	October	DHMT
Maternal health: assisted deliveries (including obstetric first aid and basic EOC)	- Improve capacity to provide obstetric first aid - Improve routine monitoring of deliveries - Improve community awareness on danger signs/symptoms	- Train selected health staff in obstetric first aid - Introduce and train health facility staff in use of partograph - Develop IEC strategy	Mission hospital staff District medical officer Partner NGO	February April Beginning in June	Mission hospital Partner
Comprehensive EOC	- Ensure around-the-clock EOC	- Train physician - Assess what equipment and supplies are lacking and fill gaps	Mission hospital District procurement officer	June? June	Mission hospital
Neonatal care	- Include neonatal care in outreach activities	- Train all staff in essential neonatal care	Health facility in-charges	September	
Complications of abortion	- Ensure that at least one worker per health facility can manage abortion-related complications - Ensure that all facilities have necessary equipment and supplies	- Training in surgical techniques for the management of incomplete abortions - Training in post-abortion care and counselling - Assess what equipment and supplies are lacking and fill gaps	DHMT and regional health coordinator District procurement officer	November June	DHMT
RTI/STI/HIV/ AIDS	- Integrate counselling and BCC in clinical activities - Upgrade laboratory facilities - Ensure that annual orders for drugs include sufficient STI drugs - Introduce availability of VCT at district hospital	- Train staff in counselling - Review laboratory infrastructure - Review essential drug list and procurement procedures - Train hospital staff in VCT	Health facilities in-charges and DHMT District procurement officer Mission hospital/NGO	August September November	National STI Control Programme National HIV/AIDS Control Programme
Adolescent SRH	- Explore working with youth groups and teachers - Introduce YF services in selected health facilities (for in and out-of-school youth)	- Meet with representatives from youth groups/teacher/ parents to discuss SRH - Visit NGO clinic already providing YF services, and introduce their method in selected health facilities	Nurse midwife Health facility incharges, district medical officer and nurse midwife	December	- No financial cost involved as nurse lives next door to school - Once visit has been made, assess implications for DHMT budget

SRH element	SRH strategy (copy from Exercise 3d)	What? (activities)	Who?	When?	Source of support
Family planning	- Improve availability of FP services through community-based distribution - Involve the private sector to broaden contraceptive choice - Improve counselling and IEC for all methods	- Establish a CBD network in six communities - Training of all staff on counselling skills	DHMT and health facility in-charges District medical officer Health facility in- charges	December June	DHMT budget Explore with Population Services International about extra condom needs
Sub-/Infertility	- Expanding work in this area is unlikely	---	---	---	---
Life cycle SRH issues (e.g. fistulas)	- Include information on services for fistulas in outreach activities - Explore partnerships with women's groups to sensitize staff to the issue	- Information on services for fistulas included in outreach activities - Standards and procedures for referral reviewed	All staff District medical officer	November April	No additional costs No costs
Complications of FGC	- Ensure health staff is trained in counselling - Explore partnerships with women's groups to sensitize staff to the issue	- Orientation for staff on signs and symptoms - Initiate discussions with different groups	All staff District medical officer	September April	No additional costs No costs
Gender-based violence	- Explore partnerships with women's groups to sensitize staff to the issue - Ensure that treatment and referral are accessible and discrete - Ensure linkages with the regional hospital are efficient	- Initiate discussions with different community leaders and women's groups	All staff	December	No costs

Exercise 3g: How do we plan and manage SRH supply and equipment needs?

Expected outcome

At the end of this exercise, we will have calculated next year's needs for each of the essential SRH drugs and for some of the minimum SRH equipment and IEC materials.

Participation

This exercise should involve the DHMT including the logistics officer, pharmacy staff and health facility staff. Those partners that are involved in provision of SRH services can also be invited.

Duration/Venue

This exercise can take place at the DHMT office and can be done in two to three hours.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Calculator/ruler (or computer with spreadsheet programme)
- Stock records from the district medical store
- Inventory of health facilities (existing equipment and supplies)
- Health facility records (last year's consumption) if available
- Target population data (Exercise 2b)

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

On a big piece of paper or in a computer spreadsheet, list in the left-hand column (column A) all the SRH supplies and equipment used in the district.

Step two

Collect stock records from district stores and monthly service statistics for the last year. Come to a consensus on how to estimate quantities consumed in the current year. This does not have to be an exact figure. Put the estimated consumption for each item in column B. Agree on the best way to project consumption for next year for each item, and complete column C.

Step three

If there is a national standard for buffer stock, use it (for example, 25% extra supplies should be available in the district store). If no national standard exists, use the best judgement and decide on a percentage which is felt would be appropriate to keep as buffer stock. Put this percentage in the top of column D. Calculate the buffer stock required for each item and complete column D.

Step four

Agree on the best way to assess what stock is available in health facilities and in the district stores, and make an estimate for column E.

Step five

Once the stock on hand is known, calculate how much must be ordered prior to the start of next year by adding the % buffer stock in Column D to the projected consumption in column C, and then subtracting stock on hand (column E). Put the totals required in column F.

Please keep in mind that all these figures do not have to be exact, but should be in the range of plus or minus 20% for the district for the year.

This table provides a forecast of essential SRH supply and equipment needs. We can expand the table to include other commodities, and work on overall commodity security for the district. Estimates and needs should be reviewed annually and, if possible, assistance sought from partners to fill the gap.

Example of estimated SRH commodity requirements for a district with 11 health facilities (excluding private providers) and a population of 206,397

Selected essential drugs, supplies and equipment for the SRH package A	Estimated consumption current year B	Projected consumption for next year C	Buffer stock required @ 25% D	Available in health facilities or in stock at district stores E	To be ordered before next year (include 25% buffer stock) F
	Formula to calculate needs (F)				C+D-E
Maternal health care					
1) Stethoscope (normal): 3 per facility		33	8	23	18
2) Vacuum extractor: 2 per health centre/hospital		22	6	3	25
3) Autoclave: 2 per facility		22	6	14	14
4) Disposable syringes/needles (1, 2, 5cc): 200 each per facility		2,200 2,200 2,200	550 550 550	1,800 2,300 3,500	950 450 -750
5) Delivery set: 30% of expected deliveries		3,096	774	145	3,725
6) Blank partograph forms: 30% of expected deliveries		3,096	774	10	3,860
Emergency obstetric care					
7) Oxytocin (10iu/ml injection): 5% of expected deliveries	350	516	129	210	435
8) IV solution set: 5% of expected pregnancies	640	516	129	356	289
9) Sedatives (diazepam, 2 ml injection): 5% of expected deliveries	220	516	129	35	610
10) Antihypertensive drugs (hydralazin, 5mg injection): 5% of expected deliveries	110	516	129	7	638
11) Suture, needle and gauze set: 5% of expected deliveries	210	516	129	280	365
Complications from abortion					
12) Dilation and curettage set		20	5	10	15
13) Metronidazole injection/tabs	529	1,000	250	450	800
RTI/STI/HIV/AIDS					
14) Ciprofloxacin (500mg tabs)	500	1,800	450	235	2,015
15) Doxycycline (100mg tabs)	670	500	125	450	175
16) Tetracycline (250mg tabs)	330	500	125	1,050	-425
17) Metronidazole (250mg tabs)	1,700	500	125	875	-250
18) Cotrimoxazole (vaginal cream)	1,400	2,000	500	380	2,120
19) HIV testing kits	2,250	4,000	1,000	575	4,425

Selected essential drugs and supplies and equipment for the SRH package A	Estimated consumption current year B	Projected consumption for next year C	Buffer stock required @ 25% D	Available in health facilities or in stock at district stores E	To be ordered before next year (include 25% buffer stock) F
	Formula to calculate needs (F)				C+D-E
Family planning					
20) Condoms	224,000	300,000	75,000	85,000	290,000
21) Pills/oral contraceptives	72,800	85,000	21,250	12,500	93,750
22) Injectables	10,080	12,000	3,000	4,600	10,400
23) IUCDs	2,240	2,500	625	1,700	1,425
Adolescent SRH					
24) IEC materials: 100 sets per facility	50	1,100	274	0	1,374
Sub-/Infertility					
25) Brochures on referral: 50 per facility	0	550	138	0	688
Life cycle SRH issues					
26) Posters and brochures on breast cancer: 10 per facility	100	110	28	0	138
Female genital cutting					
27) Posters and IEC materials: 10 per health facility	0	110	28	10	128
Gender-based violence					
28) Posters and brochures on symptoms and referral: 10 per facility	0	110	28	0	138

Exercise 3h: How do we develop a routine monthly health facility schedule?

Expected outcome

At the end of this session, we will have developed a routine monthly schedule for each health facility in the district.

Participation

This exercise is best done during a routine meeting of the health facility staff, CHWs and outreach staff. Ideally, each health facility prepares its own monthly schedule and shares it with the DHMT.

Duration/Venue

This exercise can take place at the health facility, and can be done in two to three hours.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Calculator/ruler
- Calendar
- District and health facility catchment area maps for all health facilities (Exercises 2b, 2c)
- SRH work plan (Exercise 3f) and the overall district health plan

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Draw up a matrix as shown in the example. Split the days of the week into morning and afternoon.

Step two

Review current activities in the catchment area, and consider new SRH activities together with the overall DHMT annual health plan. This is the basis for adding or removing health facility activities.

Step three

Brainstorm on the most cost-effective use of human resources to increase coverage and quality of SRH services. Develop a practical monthly schedule for the health facility. Include disease surveillance, coverage surveys and routine contacts with clients.

Step four

Check the proposed monthly schedule with the DHMT, to make sure funds are available for logistics/transport support for outreach and supervision. Confirm which individual(s) and which mode of transport will be used and write this in the "Remarks" column.

Step five

Reproduce two large and easy-to-read monthly schedules for each health facility. One can be kept at the health facility, the other one at the DHMT office.

Optional steps

1. Translate the monthly schedules into monthly work plans for each staff member.
2. On a week-by-week basis, copy the schedule and post it on a notice board for clients and staff.
3. It is useful to create a Gantt chart to include non-routine activities. In this chart, divide activities according to categories such as service delivery, human resource development, planning, monitoring and supervision, etc.

The monthly schedule provides a quick overview of the main activities taking place at each health facility. The combined schedules of all health facilities provide the DHMT with a monitoring and supervision tool to assess progress on a regular basis.

Example of a routine monthly health facility schedule for SRH

Activity/Time	Monday	Tuesday	Wednesday	Thursday	Friday	Remarks
Week 1 Morning	Integrated services	Integrated services	Integrated services	Integrated services	Integrated services	
Afternoon	Monthly team meeting	Outreach 1 and TTBA/CHV supervision	Outreach 2 and TTBA/CHV supervision	Outreach 3 and TTBA/CHV supervision Staff training	Reporting National Immunisation Day preparation	Transport on foot - Health assistant
Week 2 Morning	Integrated services	Integrated services	Integrated services	Integrated services	Integrated services	
Afternoon	Administration Community meeting	Outreach 4 and home visiting/ follow-up of defaulters	Outreach 5 and home visiting/ follow-up of defaulters	Outreach 6 and home visiting/ follow-up of defaulters	Reporting Meeting with school/parents	Transport by bicycle - Auxiliary health worker or health assistant
Week 3 Morning	Integrated services	Integrated services	Integrated services	Integrated services	Integrated services	
Afternoon	Administration	Outreach 7 and TTBA supervision	Outreach 8 and TTBA supervision	Outreach 9 and TTBA supervision	Reporting Record review	Public transport - Nurse midwife
Week 4 Morning	Integrated services	Integrated services	Integrated services	Integrated services	Integrated services	
Afternoon	Administration Visit of district health manager	Outreach 10 and home visiting/ follow-up of defaulters	Outreach 11 and home visiting/ follow-up of defaulters	Outreach 12 and home visiting/ follow-up of defaulters	Reporting Meeting with SRH partners	Transport with district reserve ambulance - Health assistant

We suggest to note down in the remarks column how (mode of transport) and who (staff individual) will conduct outreach and supervision.

Exercise 3i: How do we develop a financial plan?

Expected outcome

At the end of this exercise, we will have a complete overview of resources and sources of financing available for SRH. For the first year, estimates are used to make a budget, and thus they need to be accurate. For the remaining years, rough estimates are fine; the plan can always be adapted to changing circumstances or experience.

Participation

This exercise should involve the DHMT and finance and logistics officers.

Venue/Duration

This exercise is likely to take two to three hours and can be done at the DHMT office.

Materials required

- Flipchart/newsprint paper/regular size paper
- Calculator
- Coloured markers/pens/pencils
- Information on prices and previous expenditures and costs
- Strategies (Exercise 3d), learning and training needs (Exercise 3e), and SRH work plan (Exercise 3f), equipment and supply needs (Exercise 3g)
- A computer with a spreadsheet programme, if available

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Draw a matrix that lists SRH activities needing financing in the left-hand column. Use Exercise 3d and Exercise 3f. Make additional columns for: Units (A); Number of units (B); Unit costs (C); Total costs (D); Year 1; Year 2; Year 3; and Sources.

Step two

List the resources required for each activity planned and complete column A. For training, use the results from Exercise 3e and the annual SRH work plan, as appropriate. For commodities, use the results from Exercise 3g. For other inputs, look at previous experience and/or technical guidelines.

Step three

Identify the amount of resources (units) required to provide SRH services and complete columns B and C. Examine previous usage to make estimates. Discuss if existing resources can be used more efficiently before planning extra resources. Also think carefully how the resources will be spread out over the years. Capital expenditure might start early on before activities start. Items like salaries may only require finance when capital and infrastructure are in place.

Step four

Collect as much information as possible on cost and prices for the SRH package, and estimate the total cost over three years. The formula is simply: total units (B) x unit cost (C) = total costs (D). At the end, add a certain percentage for "miscellaneous" or "contingencies" (5%, for example). In general, inflation should not be included in the various estimates. However, we can expect real prices to vary from the plan in Years 2 and 3. When inflation is low this can be absorbed by the allowance for contingency. If inflation is considerable, include a sentence in the budget to indicate that revisions may be needed at a later date. The financial plan should be presented in rounded figures, in local currency.

Step five

Last, identify the sources of financing.

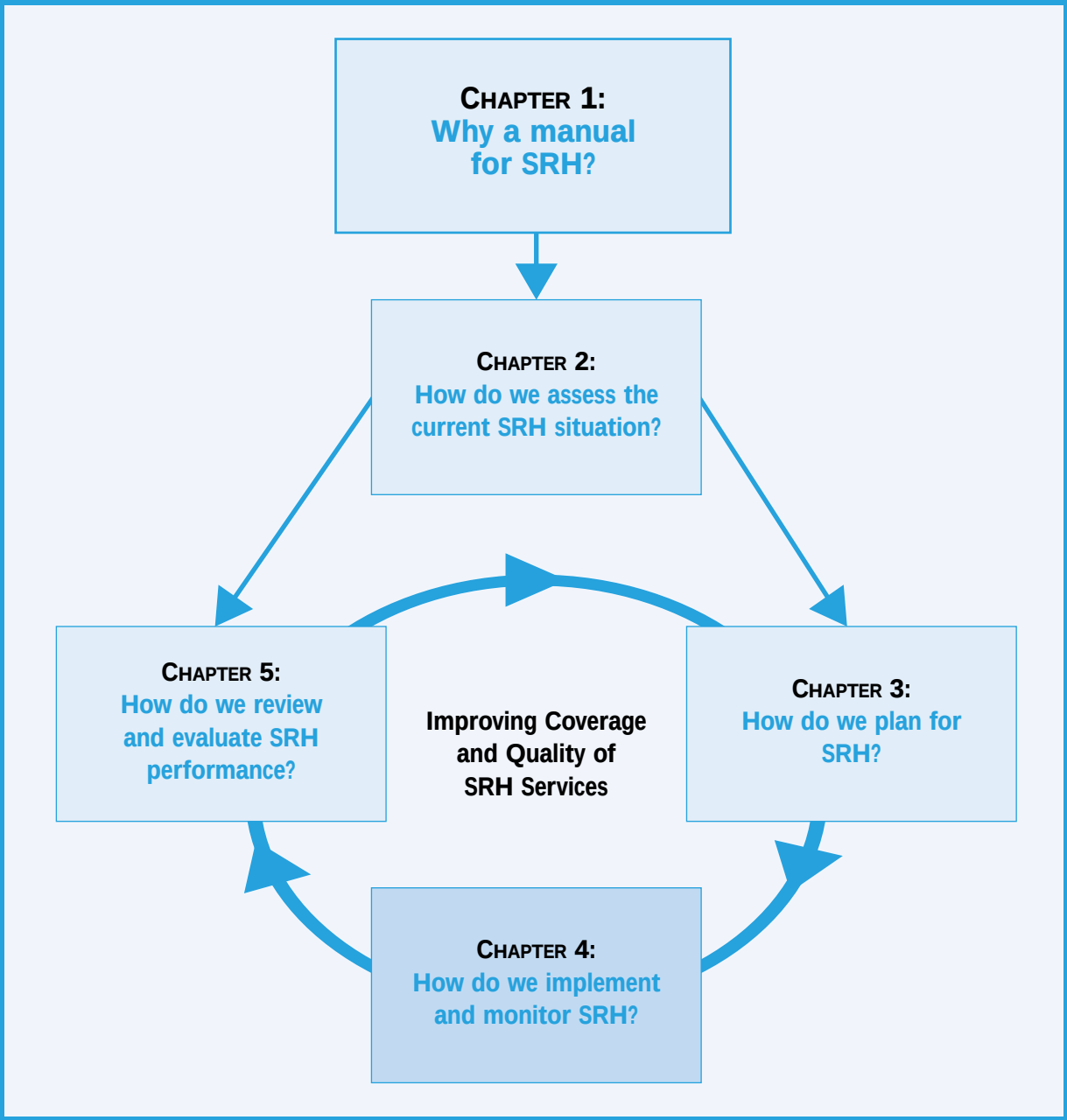
The financial plan should be reviewed and updated regularly. When the final costs are calculated, compare costs with other activities and previous expenditure to assess whether the financial plan looks efficient, and the activities seem good value for money.

Example of a financial plan for selected SRH activities

SRH activities	Units	Total # of units	Unit cost	Total costs	Year 1	Year 2	Year 3	Source
	A	B	C	D	E	F	G	H
Formula								
Maternal health: assisted delivery								
Training of health workers in obstetric first aid and basic EOC (14 pp)	Training sessions	1	1,000	1,000	500	500	-	Mission hospital and regional health office
Distribution of safe delivery (SD) kits	SD kits	3,000	2	6,000	2,000	2,000	2,000	DHMT
Supervision of TTBAs	Staff years Vehicles	12 2	5,000 20,000	60,000 40,000	20,000 40,000	20,000 -	20,000 -	DHMT UNFPA
Subtotal				**107,000**				
Remarks: need to discuss the most cost-effective strategy to distribute safe delivery kits. Organize a meeting with the DHMT and partners to discuss this as soon as possible.								
Family planning								
Increased availability of FP commodities	Condoms	6,000	1	6,000	2,000	2,000	2,000	NGO/DHMT
	Oral pills	6,000	1	6,000	2,000	2,000	2,000	DHMT
Increased availability of female staff	Nurse years	2	4,000	8,000	2,000	3,000	3,000	DHMT and regional health office
Subtotal				**20,000**				
Remarks:								
RTI/STI/HIV/AIDS								
Training of health workers (15 pp)	Training sessions	3	1,000	3,000	1,000	1,000	1,000	Mission hospital
Educational materials	Posters	3,000	1	3,000	1,000	1,000	1,000	DHMT
Drugs	Antibiotics	3,000	2	6,000	2,000	2,000	2,000	DHMT
Subtotal				**12,000**				
Remarks: inflation is likely to affect the cost of imported drugs in particular. Revision of estimated drug costs might be necessary.								
Total				**139,000**				
Miscellaneous/contingencies				**7,000**				
Grand total				**146,000**				

CHAPTER 4:

How do we implement and monitor SRH?



By the end of this chapter we will have:

- developed a matrix to coordinate partnerships in the district (Exercise 4a);
- created and/or maintained an operational plan (Exercises 4b, 4c, 4d, 4e) to:
  - improve quality and efficiency of SRH service delivery;
  - monitor quarterly progress in the SRH workplan;
  - monitor expenditures; and
  - manage quality (through supervision).

CHAPTER 4:

How do we implement and monitor SRH?

4.1 Introduction

This chapter is about coordination, implementation and monitoring. With the work plan and the financial plan that were developed in Chapter 3, we now know what activities should take place next year. Chapter 4 is organized as follows:

- We review ongoing SRH activities with partners in SRH, and draw up a partner matrix, to see how we can work together more effectively (Exercise 4a).
- We look at the day-to-day functioning of the SRH programme. We pay attention to the quality and efficiency of SRH service delivery (Exercise 4b). Important management functions such as monitoring performance and finances are discussed in the context of SRH (Exercises 4c, 4d, 4e).

4.2 Managing SRH partnerships and coordination

The starting point for joint coordination and planning is the district health plan, and the SRH annual work plan and financial plan. Collaboration with other partners increases the chance of success in meeting community needs and completing the planned activities. It also provides an opportunity to standardize service delivery, use resources efficiently, and advocate for additional funds.

The DHMT usually takes the lead in defining what the SRH programme will look like, and in communicating with partners. The DHMT also frequently provides the incentives, the environment and sometimes the resources (for example for drugs and training) for strong collaboration. This allows all partners to reach their organizational goals and targets. There are several ways to do this:

- Identify partners, and remain informed about their SRH activities. An active information and knowledge exchange is perhaps the most important element of successful coordination.
- Inform partners about activities/meetings, etc., and provide supporting documents that may help them in their work. This includes, for example, a national SRH policy, clinical guidelines, IEC materials, the district health plan, SRH work plan, and health facility schedules.
- Provide a supportive environment for everyone working in SRH.

Partnerships require careful attention. We need to agree on joint objectives and outcomes to have an effective partnership. Exercise 4a helps prepare a matrix that shows each partner's contributions, as a basis for expanding current partnership arrangements.

It is important to provide information about SRH activities and budgets to the local government authority in charge of preparing or approving the comprehensive district health plan (city, municipal councils, towns, district councils). Similarly, we need to ensure that they are involved in the preparation of the district (SRH) plan, and in monitoring and evaluation of the various plans.

For some activities, such as HIV/AIDS, participation of other line Ministries is needed to address cross-cutting concerns. One effective way to coordinate SRH activities, including HIV/AIDS, is by creating an SRH Coordinating Committee. Several countries have introduced such a mechanism, both at national and at district level. The box on the next page gives an example of the composition and agenda of such a committee. It is important that the DHMT reviews the advantages and disadvantages of having a separate SRH Coordinating Committee. In any case, SRH coordination issues should be discussed regularly in district health team meetings.

4.3 Monitoring the coverage and quality of the SRH programme

A good quality SRH programme may mean different things to different people. Providers, for example, might be most interested in clinical competence of services, whereas clients may care much more about confidentiality and privacy of services. In general, quality of care is not about reaching targets.

Purpose of Committee	Frequency and Proposed Agenda of Meetings	Chairperson and Participation
The SRH Coordinating Committee is responsible for functional coordination between all partners in the district SRH programme.	The district SRH Coordinating Committee will meet **four times per year.** During this meeting, the following agenda points may be considered: **1** Presentation of the previous quarter's activities/progress. **2** Review and revision of the (integrated) work plan and activities for the next quarter. **3** Identification of resource gaps and partners who can be mobilised to help fill the gaps. **4** Making policy and strategy recommendations for review by national level (primary health care, planning, district coordination, etc.). **5** Any other matters (training, seminars, workshops).	**Convened by** District Health Officer **Participants** DHMT members, women's group, youth group, private practitioners, NGOs, community representatives, District Offices of the Ministry of Local Government, the Ministry of Education, National AIDS Control Programme, etc.

Instead, it emphasizes the creation of client-friendly services that take into account the social context, and gender and life cycle issues. Key determinants of quality of care include:

- professional and technical competence of providers;
- interpersonal skills of providers;
- availability of supplies and equipment, and logistics;
- accessibility of services (opening hours, fees for services);
- quality of physical infrastructure and facilities;
- safety for provider and client;
- integration of services;
- functional referral systems;
- continuity of care (linking preventive and curative services; client follow-up); and
- informed decision-making based on quality IEC and counselling.

To ensure quality health care, each country should have a set of technical guidelines and clinical protocols for service delivery. Where available, refer to these for service delivery standards.

4.3.1 Service delivery

Several day-to-day management functions of the SRH programme need close attention. Many of these functions are already addressed in the context of the broader district health programme. Some of them may require new ways of thinking about or organizing services.

An important element to consider, for example, is the *integration* of SRH services. Integrated services provide comprehensive care rather than specialized care. For example, if a mother comes with a sick baby, health workers will first want to check the baby and take care of its needs, and then offer the mother a check-up, FP and breast-feeding counselling, and other PNC services.

To do this, we need to link curative and preventive services, discuss workloads and shared tasks, delegate responsibilities, develop common work schedules and duty rosters, etc. We may also have to change the organizational set-up of the facility; for example, do we provide clients with enough privacy? Is the waiting time acceptable? Can clients move as efficiently as possible from one place to the next?

Exercise 4b helps us to think about ways to improve quality and efficiency of SRH service delivery.

4.3.2 On-the-job training

To maintain the quality of work according to minimum standards, we need sufficient personnel with the right skills in the health facilities to carry out the planned activities. We also need to motivate health workers, and provide them with incentives that help make the work rewarding and interesting.

Health staff will need refresher and on-the-job training to maintain quality standards for SRH and

What are the advantages of integration?

- **Convenience**
  It is often a lot easier for clients to come to the health facility and receive all services at once, rather than to come on different days for different services.
- **Efficiency**
  Since the most commonly needed services are provided during one visit, work is spread more evenly through the week, rather than having some very busy days and some very slow ones. Human and financial resources are well used to serve the community.
- **Avoiding missed opportunities**
  If SRH services are available on all days, staff maximises each opportunity of client contact.
- **Increasing team work**
  If services are more integrated, staff can work together more frequently and efficiently, leading to less conflict, and greater motivation and satisfaction.

primary health care services. They need to know about national SRH and primary health care policies, be familiar with guidelines and protocols for routine and new SRH services, use the information system for recording and reviewing, and have access to health learning materials. Regular study visits and on-the-job coaching is one way to help health workers maintain and update their skills. Usually the DHMT is responsible for this kind of training.

An important aspect of monitoring and supervision visits is to pay attention to training. The plan for learning and training needs developed in Exercise 3e is a good starting point. One easy activity during routine monitoring or supervision visits is to check if staff has received training since the last visit, and if so, in what topic. Supervisors should also look at the impact of training on quality of work. Exercise 4c shows how such information can be systematically documented in a table.

4.3.3 Monitoring

Throughout the year we need continuous information on service delivery performance. Routine monitoring can help identify problems early, so that timely action can be taken. We check on what was agreed, and reassess the likelihood of reaching targets. Often adjustments need to be made.

Everyone should be involved in monitoring. This includes programme staff, managers and health facility staff, using their own records and registers.

Even at community level, health workers and community representatives can undertake simple monitoring activities. Monitoring is part of on-the-job learning, and is done in all phases of programme implementation.

Remember that monitoring is a routine activity. Monitoring serves to track changes over time in inputs (for example, the number of condoms purchased), processes (changes in systems) and outputs (for example, the number of married and unmarried adolescents receiving FP services). We can also monitor efficiency of the programme, by comparing what inputs were required to achieve a certain output. For example, what human, financial, and time resources (inputs) are needed to increase the number of FP acceptors (output) in the district?

Little extra time is needed for monitoring when enough time is set aside during staff meetings and visits to health facilities to discuss progress, problems and possible solutions. Exercise 4c describes how quarterly monitoring can be done for selected SRH activities, including training.

Just as with activities, we need to monitor finances. For this, we refer back to the financial plan (Exercise 3i). Where over-expenditure is observed, we check whether this is due to a higher-than-planned level of activity, or to rising costs. If expenditure is lower than planned, we assess the reserves. Exercise 4d shows how to monitor expenditures.

There may be a difference between the planned budget and the actual allocations that are provided to the district. The DHMT needs to ensure that SRH services are given sufficient priority for the available finances, in line with the district profile and the annual SRH work plan. This requires negotiation and decisions on priorities within the context of the district health plan.

4.3.4 Supervision

Supervision of health workers is perhaps the key to motivation, performance and results. A good supervisor will provide continuous support and facilitate collaboration between the various levels of the health system, health facilities and the community. The supervisor is really a mediator who knows the priorities, monitors results, proposes action on bottlenecks and reports observations and progress.

Successful supervision provides health workers with skills training, the necessary equipment and drugs, and supportive guidance. Integrated supervision is often most efficient, as this means that the supervisor(s) support the implementation of several health interventions or clusters of activities (such as immunizations, child health, SRH, nutrition).

Integrated supervision will work best with clear guidelines and checklists, as the persons supervising may not necessarily be specialists/experts in all areas. Exercise 4e indicates some of the steps involved in developing a supervisory schedule. An example of an integrated supervisory checklist is included in Annex 1. It is important to note that supervision almost always requires follow-up. As the example in the annex shows, each issue/problem identified must have a recommendation that specifies who is to do what, when and with what resources.

4.3.5 Logistics

The district health plan and a proper budget are the backbone of a well-functioning logistics system. Adequate supplies, equipment and transport/communication must be available at all times. SRH logistics requirements are part of the district health logistics system, but if there are separate programmes, for example for HIV/AIDS, then these must be considered separately. We need to find the most efficient way to distribute supplies from separate sources and programmes to health facilities, which may mean combining them at some point, often during transport. Generally, having one logistics system that takes care of all programmes works better than having different logistics systems for different programmes.

CHAPTER 4: Summary/Key Lessons

Good collaboration and partnership are vital to achieve targets. Information from monitoring should be available in the district. Often, data are collected locally, and processed and disseminated at national level. Feedback to the district should be systematic. Managers and health workers at district level should have access to their own data, so they can take responsibility for monitoring progress.

Supervision must be supportive in identifying and solving problems. It is important to document observations and suggestions for each health facility at the end of the visit, and to ensure follow-up. One person should be made responsible to do this, with a timetable and a source of financial support.

EXERCISES CHAPTER 4:

How do we implement and monitor SRH?

Exercise 4a: How do we organize SRH partnership in the district?

Expected outcome

At the end of this exercise, we will have developed a partnership matrix that shows how each partner contributes to selected SRH activities.

Participation

This exercise should involve the DHMT, partners such as women's groups, NGOs, youth groups, community representatives and private practitioners, and other Ministries at district level (Education, Local Government, Welfare, Sports, Youth, etc.). The type and number of participants will vary, depending on the partnership.

Duration/Venue

This exercise can take anywhere from one or two to a series of meetings or planning sessions, depending on the topic. It can take place in many different locations. Rotating the meeting place may increase a broad sense of ownership.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Tape/ruler/stapler

It is advisable to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

As a first activity, define the areas where collaboration and partnership are needed. Discuss who should be involved in the partnership. Draw up a list of names of organizations and/or individuals that will be part of the partnership. Make this the top row of the matrix.

Step two

Brainstorm with all partners on the overall purpose of the programme/intervention/activity, and define the objectives. Make sure that the objectives are realistic and time-bound. List purpose and objectives in the first box of the matrix.

Step three

Define roles and responsibilities of each partner. Decide together on the resources (finances, transport, drugs, human resources, IEC, advocacy, etc.) that each partner can contribute: how much and for how long. In the left-hand column of the matrix, list all the different activities that will be part of the partnership. Put a tick mark (a) or X in the corresponding box for each partner that is involved.

Step four

Brainstorm with all partners on key elements of a successful partnership. Keep a list of issues that are mentioned. For example: keeping to deadlines; coming up with a joint work plan; sticking to budget agreements; solving problems as a team; sharing monitoring results, etc. These are the partnership rules that everyone should respect. Reproduce them and provide each partner with a copy.

Step five

Finalize working arrangements, making sure that consensus is reached on issues like management, coordination and decision-making structures; meeting schedules; the appointment of a chairperson and secretary; developing feedback links to each partner; monitoring tools, etc.

Step six

Make a copy of the work plan for all partners and agree on it as a group.

Remember that problems are likely to occur. Openness and flexibility will help secure the long-term benefits of the partnership. These should not be jeopardized by short-term challenges.

Example matrix of activities and partners: adolescent health and welfare programme

Purpose: To establish a well functioning youth programme in the district, with emphasis on skill development, sexuality education and youth-friendly health services.

Objectives:
- To create a SRH clinic with integrated services for adolescents with specific focus on STIs and HIV/AIDS;
- To provide weekly literacy classes for adolescent girls (out-of-school youth);
- To provide youth in the district with opportunities to plan, manage and monitor their own activities.

Activities/ Services	District Ministry of Health	District Ministry of Education	District Ministry of Employment	District Ministry of Youth and Sports	Adolescent and youth volunteers	UNFPA supported NGO	Local FP-NGO in district
1. SRH clinic with FP, STI services and counselling	✗						✗
- Referrals	✗						
- Peer education in SRH					✗		✗
- Drug supplies							✗
- IEC materials						✗	
- Training in adolescent SRH						✗	
2. Literacy, classes		✗					
- Internet technology training			✗				
- Peer education - Life skills	✗	✗			✗		
3. Job counselling			✗				
4. Recreation activities				✗			
5. Day Care		✗					
Centre construction and management (potentially)	✗	✗	✗	✗	✗	✗	✗

NB. An ✗ in a cell means that the partner is involved in this activity.

Exercise 4b: How do we improve quality and efficiency of SRH service delivery?

Expected outcome

At the end of this exercise, we will have come up with suggestions to improve the quality and efficiency of SRH service delivery at the health facility.

Participation

This exercise is specifically designed for health facility staff, together with the DHMT, and those partners that are directly involved in SRH service delivery.

Duration/Venue

This exercise can be done for each health facility in the district. Completing the matrix does not take more than two to three hours, including discussion time. Developing the follow-up plan takes more time, especially when it includes reorganization of clinic space, developing staff rosters, etc.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Tape/ruler
- SRH work plan and monthly health facility schedule (Exercises 3f, 3h)
- Results from any client survey or client interviews, if available
- Overview of staff schedules, leave days, job descriptions, and standards and guidelines for service delivery

It is recommended to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed

Step one

On a blank piece of paper, list all SRH related services that are provided at the moment. This is likely to be different for each type of health facility.

Complete the left-hand column of the matrix. Create additional columns for "Daily provision", "Staff availability and capacity", "Supplies and equipment availability", "Client-oriented set-up", "Integration with other (SR) health services", and "Integration of tasks/referral system".

Step two

For each SRH element, discuss if the required inputs are available at the health facility. This includes staff capacity (availability and skills).

Step three

Use the SRH work plan and the health facility schedule, and include newly introduced changes in service delivery, staff training, distribution/logistics, or other upcoming events. Refer back to Exercises 3d, 3f and 3h. For supplies and equipment, refer to existing guidelines to determine what items should be available.

Step four

Complete the matrix and assess where opportunities exist to better integrate SRH information and service provision, and to improve quality and efficiency. This can be done in several ways, for example:

- Draw up a plan of the physical lay-out of the clinic and discuss how services can be better organized, keeping in mind the client's need for privacy and confidentiality.
- Review registers and records to determine when most clients come for FP, and discuss whether more time can be created for the nurse to provide counselling.
- Review working hours and opening times of the health facility, and explore possibilities to include one evening for services to adolescents.
- Make a schedule of staff duties per day and per week to ensure that tasks are well divided and shared, and that each staff person has a varied workload.
- Review the time each staff member spends on record keeping, and discuss whether this can be done more effectively.
- Discuss whether STI control and FP can be integrated more effectively, and how this can be done. Similarly, integrate all counselling/IEC with direct service provision.

- Assess supply and equipment needs using a checklist/inventory to determine what items are not available or outdated, etc.

Step five

On the basis of the discussions, make a plan to improve quality of services and efficiency of service provision at the health facility. Clearly indicate when certain activities can take place. Also make sure that everyone on the team is informed, and has agreed to the proposed changes. Designate specific people for specific tasks.

Optional step

If there is no good information about what clients like or don't like about the services, think about developing a short questionnaire to elicit their opinions and suggestions as they leave the facility (health facility exit interview).

Agree on the next time to meet for a discussion on the changes that were made, and on the effects this will have on issues such as time spent with clients, staff motivation, and efficiency in record-keeping. It is important that lessons learnt in one facility are shared with the DHMT and staff at other health facilities.

Example analysis at a health facility (health center)

Existing SRH services for health center	Daily provision	Staff availability and capacity	Supply and equipment availability (checklist)	Client oriented set-up	Integration with other (SR) health services	Integration of tasks/Referral system
Safe Motherhood - Antenatal care - Postnatal care - Normal delivery care	Daily delivery care ANC/PNC twice weekly unless for emergency	Nurse and health assistant available	Inventory being made Essential supplies and drugs missing for delivery care	Delivery room is clean and private For ANC and PNC set up is noisy	**Yes** (health education; hygiene; FP counseling; breastfeeding and nutrition)	Screening, care and IEC together; record keeping separate. Immunisation integrated, but not for all clients
Safe Motherhood* - Obstetric first aid - Basic EOC	No basic EOC, only obstetric first aid	Staff needs training on basic EOC	Inventory being made	Depending on client load/time of arrival, operation theatre is not always available	**N/A** **NB.** Insufficient IEC on danger signs during ANC sessions	In-take and emergency care at the same place. Record keeping and referral separate
Neonatal care	Immediate care available all days. PNC twice weekly. EPI according to fixed schedule	Nurse and health assistant available	Inventory being made. Essential supplies missing	Often waiting areas very noisy. PNC not always in the same place	**No** PNC and EPI schedules do not always match	Screening, care (including weighing) and IEC together. Record keeping separate. Immunisation separate
Complications from abortion	N/A	Nurse and health assistant available, but need training	Inventory being made. Supply and drugs shortage	Depending on client load/time of arrival, examination room is not always available	**Not always** Care provided in maternity ward or emergency room versus FP counseling at outpatient area	Intake and care together. Record keeping and referral separate
RTI/STI/HIV/ AIDS	RTI/STI related services available daily. No VCT	Nurse and health assistant available for management, counseling and referral	Inventory being made. Drug supply shortages noted in the past 6 months	STI treatment private. Counseling separate at outpatient area	**No** Treatment at Dermatology section. Screening for syphilis not standard component of ANC	Screening and (partner) counseling in different location from treatment. Records at dermatology
Family planning	All services available daily, except referral for surgical contraception	Nurse and health assistant available. Training in counseling needed. More attention for male methods	Oral contraceptives and condoms always available. IUDs post expiry dates	Private sessions with clients can be arranged, but are not standard. Men still embarrassed	**Yes** health education, nutrition **No** counseling following abortion complications	Services and counseling together, including record keeping
Adolescent SRH	No special services	Nurse midwife to be trained	No IEC materials	Services not set up for young people	**Yes** In this case, it would be better to organise special times for youth	At the moment, young people are treated no different from other clients
Gender based violence	Treatment and referral available at all times	Staff needs orientation			**No** Lack of counseling and psychological support. No attention for violence during ANC	Difficult to assess given the sensitivity of the issue. Records are not kept on this subject

* There is no comprehensive EOC available at this health center.

Exercise 4c: How do we monitor quarterly progress in the SRH work plan?

Expected outcome

At the end of this exercise, we will have monitored the implementation of the SRH work plan, and determined how far we are in implementing the planned activities. The monitoring plan needs to be updated at the end of each quarter.

Participation

This exercise should involve the DHMT, partners such as women's groups, youth groups and NGOs, and central/regional level staff whenever available.

Duration/Venue

This activity should be carried out every three to four months, depending on staff meetings, visits to health facilities and communities, etc. It does not take more than three hours, including discussion time.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Tape/ruler/stapler
- Training plan and SRH work plan (Exercise 3e, 3f)
- Routine monthly health facility schedule (Exercise 3h)
- Health facility records and registers

It is recommended to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Draw up a matrix that lists the elements of the SRH package in the left-hand column. Review the SRH work plan that was developed in Exercise 3f. Copy activities for Year 1 in the second column.

Step two

In the third column, include basic indicators for each activity. These can be fairly simple, as the example shows: number of women referred, number of staff trained, number of meetings, etc.

Step three

For each activity, indicate in the next two columns what was planned for the quarter and what was actually achieved. Analyse why certain activities were implemented according to plan, while others were not.

Step four

In the last column, include comments from analysis and any follow-up actions that the DHMT (or other partners) should undertake. Assess if the targets will be achieved at the current rate of implementation, and identify specific follow-up actions.

Step five

Discuss the results with partners in the district, health facility staff and those at central level who should be kept informed. Note that a similar monitoring sheet can be used for all district health activities.

Quarterly monitoring is a routine exercise that should not require a lot of time. It is important to remind oneself regularly of the remarks and follow-up actions that were noted in the monitoring plan. Remember to update the matrix each quarter by reviewing the annual work plan, and to report on progress.

Example of quarterly monitoring plan

SRH element	Activities Year 1	Activity indicator	Planned activities this quarter (Target)	Status of implementation this quarter (Achieved)	Follow-up action and/or Remarks
Safe Motherhood: antenatal and postnatal care	- Run ANC clinics in five facilities on a daily basis (pilot) - Review content of PNC package for postnatal messages - Emphasise follow-up of low birth weight babies and postpartum FP	- # of health facilities providing ANC on a daily basis - # of women attending PNC including # of home visits and follow-up	- Review set up in all facilities and introduce integrated ANC in two clinics	Set up reviewed in six facilities Integrated ANC in 1 clinic PNC package reviewed and changes proposed	Discuss with in-charges of remaining health facilities to start process
Safe Motherhood: assisted deliveries (including obstetric first aid and basic EOC)	- Train one person in each facility in obstetric first aid - Introduce and train hospital staff on use of partograph	- # of health workers trained in obstetric first aid - # of deliveries where partograph is used - # of staff trained in use of partograph	- Identify staff for training and review training curricula - Partograph introduced	Staff identified Partograph being used for normal deliveries	Meeting planned with mission hospital
	- Assess what equipment and supplies is lacking	- # of health facilities equipped with EOC first aid drugs/ supplies	- Questionnaire designed to look at supplies and equipment		Need to share questionnaire with DHMT/partners for feedback
Comprehensive EOC	- Train physician - Assess what equipment and supplies is lacking and fill gaps	- Physician trained - # of health facilities equipped with drugs/supplies - Blood screening	- Questionnaire designed to look at supplies and equipment		
Neonatal care	- Train all staff in essential neonatal care	- # of newborns seen within five-ten days following birth	- Review training content		
Complications of abortion	- Train health workers in manual vacuum aspiration (MVA) - Train health workers in care and counseling	- # of staff trained in MVA - # of staff trained in care and counseling	- 15 health workers trained in MVA	Nine health workers trained in MVA	
	- Assess what equipment and supplies is lacking	- # of health facilities with essential equipment and supplies	- Questionnaire designed - Seven health facilities sampled	Three health facilities sampled	
RTI/STI/HIV AIDS	- Train hospital staff in VCT - Review laboratory infrastructure and assess where this can be upgraded - Review essential drug list and procurement procedures	- # of health workers trained in VCT - # of laboratories reviewed - # of health facilities with sufficient stock of essential STI drugs			

SRH element	Activities Year 1	Activity indicator	Planned activities this quarter (Target)	Status of implementation this quarter (Achieved)	Follow-up action and/or Remarks
Adolescent SRH	- Meet with representatives from youth groups/ teachers/parents - Visit NGO clinic already providing YF services, and introduce their method in selected health facilities	- # of meetings held with youth groups, teachers and parents - # of health facilities providing YF services - # of deliveries to girls < 18 yrs old - # of contraceptives provided to girls < 18 yrs old			**NB.** Nurse invited to national seminar on Youth-friendly services.
Family Planning	- Establish a Community Based Distribution network in six communities - Training of all staff on counseling skills	- # of communities with CBD network - # of CYP distributed thru CBD network - # of staff being reoriented			Need to work on demand creation and reduce community resistance to FP
Sub-/Infertility	N/a	N/a	N/a	N/a	
Life cycle SRH issues (e.g. fistula)	- Information on services for fistula included in outreach activities - Standards and procedures for referral reviewed	- # of staff who have discussed fistula issues during outreach - # of women referred - standards and criteria reviewed			
Complications of FGC	- Orientation for staff - Initiate discussions with different groups	- # of staff oriented - # of meetings with different community groups	- Review existing standards and procedures.		
Gender based violence	- Initiate discussions with different community leaders and women's groups	- # of discussions held with different groups	N/a		

Exercise 4d: How do we monitor SRH expenditures?

Expected outcome

At the end of this exercise, we will have monitored the expenditures of the SRH work plan and examined how these relate to the activities that were carried out. This monitoring plan needs to be updated at the end of each quarter, adding new activities and removing completed ones.

Participation

This exercise should involve the DHMT and finance officers/accountants.

Duration/Venue

This exercise should either take place once every three months or be based on regular reporting procedures. This activity does not take more than two to three hours, including discussion time.

Materials required

- Financial records
- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils
- Tape/ruler/calculator/computer with spreadsheet programme
- SRH work plan (Exercise 3f), monthly monitoring reports (Exercise 4c), financial plan (Exercise 3i)

It is recommended to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Refer back to the SRH work plan and financial plan that were developed in Exercises 3f and 3i. Copy those activities and expenditures that are to be initiated or implemented in the current quarter/reporting period onto one sheet, to use as a basis for discussion and analysis.

Step two

Draw a matrix as shown in the example, summarizing all expenditures and the under/overspend. Calculate the total under/overspend for each major activity and for the work plan as a whole.

Step three

Explain each under/overspend. This should be done in conjunction with the work plan monitoring report (Exercise 4c). Discuss which under/overspends can be explained by activities varying from plans, and which under/overspends are due to changes in costs and prices. Write down comments in the last column of the matrix.

Step four

Decide on action. If necessary, consider whether plans need to be changed or adapted, costs cut, or more funds requested. Assess whether funds need to be moved from other activities.

Step five

Discuss the results together with the results from the monitoring Exercise (4c) with partners in the district, health facility staff and those at central level who should be kept informed.

This quarterly monitoring is a routine exercise that should not require a lot of time. It is important to regularly check the remarks noted and to follow up on actions that are needed.

Example of monitoring SRH expenditures (first quarter only)

SRH element	Source	Resource	Plan	Expenditure	Difference	Explanation/ Remarks
Maternal health: assisted deliveries	Mission	Training sessions	250	0	-250	No activity
	UNFPA	Supplies: safe delivery kits	500	0	-500	No activity
	DHMT	Staff years	5,000	6,000	1,000	Salary increase
	UNFPA	Vehicles	40,000	45,000	5,000	Plan underestimated
Sub-total			**45,750**	**51,000**	**5,250**	
Family Planning	NGO	Supplies: condoms	500	0	-500	No activities
	DHMT	Supplies: oral pills	500	0	-500	No activities
	DHMT and region	Staff years	3,000	3500	500	Salary increase
Sub-total			**4,000**	**3,500**	**-500**	
RTI/STI/HIV AIDS	Mission	Training sessions	500	500	0	
	DHMT	Supplies: posters	250	100	-150	Activities started late
	DHMT	Supplies: antibiotics	500	200	-300	Activities started late
Sub-total			**1,250**	**800**	**-450**	
TOTAL			**51,000**	**55,300**	**4,300**	

Exercise 4e: How do we develop a supervisory schedule for SRH?

Expected outcome

By the end of this exercise we will have developed a supervisory schedule to support staff in their efforts to improve coverage and quality of SRH services. This schedule can easily be expanded to include other primary health care activities.

Participation

This exercise should involve the DHMT, health facility staff, and central/regional level staff whenever available.

Duration/Venue

This exercise can be done at the DHMT office, and takes only two to three hours if information is easily available.

Materials required

- Supervisory checklist (see Annex 1)
- Routine health facility schedule (Exercise 3h)
- Monitoring reports/progress reports (Exercises 4c, 4d)

It is recommended to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Draw up a list of all health facilities in the district, and identify the level of supervision they typically receive. These are the first two columns of the matrix (labelled "From" and "To"). Each health facility should be visited regularly by a team of supervisors from a higher level. This also means that villages receive support/supervision from health posts, etc. It is optional to include visits from regional or national level.

Step two

Make additional columns labelled "Who" and "When, Transport". Include in the "Who" column the names/titles of the people responsible for the supervision. List in the "When/Transport" column how regularly supervision is taking place from one level to the next. Also include transport that is needed.

Step three

Include another column for "Problems/Issues". Indicate if there are special issues that need attention. This information can be gathered from supervisory reports, or from discussions with health facility staff.

Step four

In a sixth column, labelled "Action/Follow-up", address the points noted in step three. Include relevant observations from the supervisory records and from discussions with staff. Note these in the column labelled "Action/Follow-up".

This information should be recorded at the end of the supervisory form or checklist that is being used. It is important to provide oral and/or written feedback to all health facilities that were visited. This can be a simple summary of findings, observations and issues discussed.

Step five

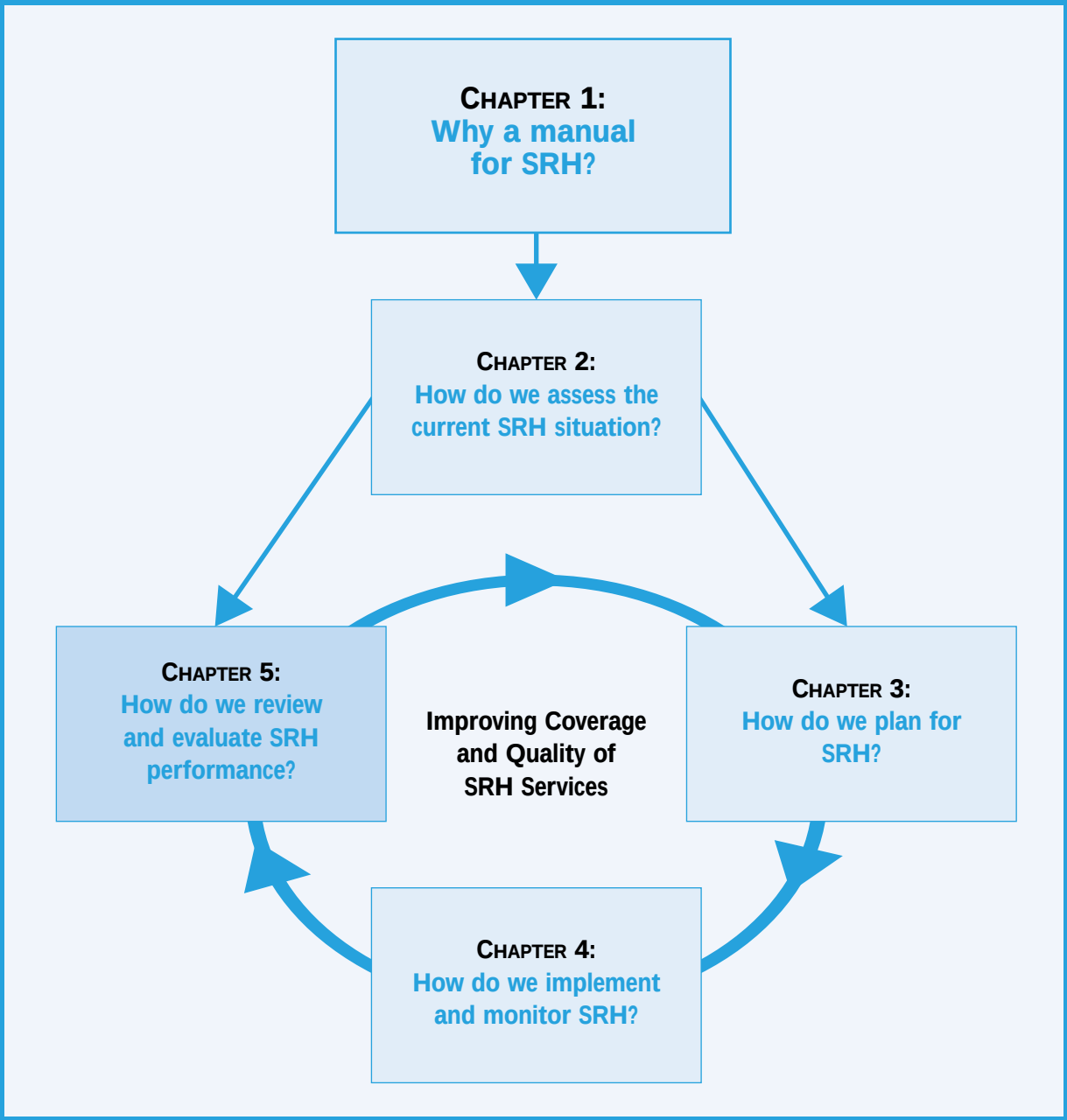
Keep a copy of the supervisory schedule at the DHMT and make sure to update it regularly. As supervision schedules are likely to change frequently, it is a good idea to copy the schedule onto a whiteboard so that changes can be made quickly. It can also be copied into a spreadsheet.

The supervision schedule should be a flexible tool. It is important that it is kept up-to-date, that people are informed in advance of changes, and that every effort is made to visit all health facilities regularly throughout the year. Supportive supervision is key to health worker motivation, and to meeting targets and performing according to standards.

Example of a supervision schedule for SRH

From	To	Who	When/ Transport	Problems/ Issues	Action/ Follow-up	Report available
Central level (optional)	District health team	National STI officer, national programme officer	February and April Own transport	Discuss clinical protocols and partograph	Discussion with all health staff	Central level will send report
Region (optional)	District health team	Regional health officer, HIV/AIDS consultant	October DHMT vehicle?	Discussion on VCT training	Review training materials	Regional level will send report
DHMT	Health centre 1	Procurement officer Medical officer Nurse midwife	Quarterly Vehicle available	Check quality of drug storage Routine supervision	Discuss with in-charge	Checklist completed
DHMT	Health post 1	Nurse midwife	Quarterly	New reporting forms difficult for staff to complete		Reporting forms completed
	Health post 2	Health assistant	Quarterly Motorbike	Increase in deliveries with safe delivery kit noted	Continue community discussions	Records on safe delivery kit available
	Health post 3	Aux. health worker	Quarterly Motorbike	Low staff morale noted	Check possibility of staff transfer	
	Health post 4			Many FP defaulters		
Health centre 1	Health post 1					
	Health post 2	Aux. health worker	Quarterly Motorbike	Lack of FP supplies/IEC materials		
	Health post 3	Aux. health worker	Quarterly Bicycle	Incidents of sexual violence reported in community		
	Health post 4		Quarterly			
	Health post 5					
	Health post 6					
	Health post 7			Stock-outs common		
	Health post 8			Outreach not taking place as planned		
	Health post 9				Check collaboration with TTBA and CHWs	
Health post 1 (outreach)	Village 1		Weekly			
	Village 2	Community outreach worker	Weekly Bicycle	Male attitudes toward FP negative	Supply IEC materials. Community meeting	Report filed
Health post 2 (outreach)	Village 3		Weekly	No PNC in the past 6-8 months	More support for CHWs and TTBAs	Report filed
	Village 4		On foot	Strong interest in surgical contraception		
	Village 5		On foot	Women request counselling/IEC on safe motherhood		
	Village 6					
Health post 3	Etc.					

CHAPTER 5:
How do we review and evaluate SRH performance?



By the end of this chapter we will have:

- conducted an annual SRH performance review (Exercise 5a);
- developed the steps for a process evaluation (Exercise 5b); and
- developed an advocacy strategy for SRH (Exercise 5c).

CHAPTER 5:

How do we review and evaluate SRH performance?

5.1 Introduction

This chapter is about reviewing progress of the SRH work plan developed in Chapter 3. On the basis of actual achievements, performance targets are modified and a subsequent (draft) work plan for next year can be developed. Two other issues discussed in this chapter are evaluation, which is undertaken at specific times in the management cycle, and advocacy. Chapter 5 is organized as follows:

- We review progress on an annual basis to determine performance levels, modify targets, and plan for next year (Exercise 5a).
- We look at evaluation. Once every few years, we want to assess the relevance, performance and success of ongoing and completed SRH activities. The steps involved in a process evaluation are presented (Exercise 5b).
- We wish to maintain commitment and support for the SRH package. An advocacy strategy for one (or more) element of SRH is developed (Exercise 5c).

5.2 Conducting an annual performance review

An annual performance review takes half a day to three days. It consists of a review of last year's performance, and a forward look aimed at doing things better next year. Ideally SRH issues are reviewed within the context of overall district health performance, but it can take place separately if an integrated review is not planned.

A performance review serves to assess progress in meeting the targets that were set for the current year. It also helps to answer many important questions in preparation for next year's work plan.

There are basically three main reasons for conducting an annual performance review:

- To assess annual progress in reaching targets.
- To analyse facilitating and constraining factors that help explain why targets have or have not been reached, and to use the results of this analysis for the next management cycle.
- To demonstrate what actually happened in the district this year, thus showing accountability to the community and to national/regional level.

An annual performance review must be planned and budgeted for from the start of the PM&E cycle. Early on – and preferably when the annual work plan is developed – the DHMT and its partners should decide on the type of performance review to be organized that year, and what information on indicators will be required.
At that time, the dates of the review should also be determined. Thus, the review is built into the annual work plan of the DHMT, and into the calendar of partners and the local community.

The performance review is usually held at the time that decisions must be made about next year's planning and budgeting.

All partners should be involved in the performance review. It is a good opportunity to hear from everyone about progress and challenges, to learn what can be done better or differently, and to discuss coordination and collaboration for next year.

Exercise 5a shows how a performance review can be conducted and what can be expected from such a review.

5.3 Evaluation

Every two to three years, an in-depth analysis of programme performance should be undertaken to evaluate, for example, the availability of resources and their use, and the acceptability, accessibility and efficiency of activities. Such a process evaluation helps to answer why and how results were (or were not) achieved; they are also very useful to highlight good practices and lessons learnt. The results are important for future strategies, needs and priorities.

How do we organize an annual performance review? Dos and Don'ts.

In organizing and conducting an annual performance review, **DO:**

- decide who will be responsible for the overall management/coordination of this task
- develop an action plan for what needs to be done, when, and by whom
- announce well in advance the dates of meetings and workshops, and when information or reports from facilities and stakeholders and partners will be required
- remember to include a separate budget line for the annual performance review!

What should we not do?

In organizing and conducting an annual performance review, **DO NOT:**

- expect complex statistical reviews or elaborate analysis: this is a simple review of indicators and activities
- aggregate data by gender and age: we want to know what is different for men, women and adolescents
- allow any single partner or stakeholder to dominate the discussion: we want to hear from everybody
- focus only on the articulate and well informed: we must not ignore the poorest of the poor, the marginalized and socially excluded
- exaggerate differences or changes (both positive and negative): analyses must be objective and self-assessment critical
- fail to ask the `But why?' questions: data alone do not tell us much; we must ask WHY there were certain successes and failures this year
- fail to plan sufficiently in advance so participation becomes token: we want as many stakeholders and community people to be there and to be active in this review
- fail to be clear about the purpose and objectives of the annual review: transparency and accountability are the reasons why we want to do such a review with other stakeholders

They also demonstrate accountability to partners. Exercise 5b presents the steps involved in preparing for a process evaluation.

Evaluations are typically carried out at the middle and end of a programme, or whenever issues need further analysis so as to strengthen intervention strategies, and solve problems. When there is no clear-cut end or beginning of a programme, as in the case of ongoing planning and implementation cycles, it is still good to budget for an evaluation at least every few years. If an evaluation is taking place next year, a separate budget line should be included in the annual financial plan.

In addition to process evaluations, we may be interested in *effect* (or outcome) evaluations. These are often carried out in order to assess changes in SRH knowledge, attitudes and practices on the part of the population. For this kind of evaluation, we need to collect baseline data at the start of the programme, and compare them with end-of-the-programme data. Observed changes are assumed to be the result of the programme; to be certain, a similar comparison is needed in a control area without the programme, which is very expensive and for that reason not done often.

The last type of evaluation is an *impact* evaluation. These evaluations assess the long-term impact of the programme against its ultimate goal. Measures of impact include, for example, a reduction in the number of unwanted pregnancies, a reduction in the number of new HIV infections, and a reduction in maternal mortality/morbidity. Impact evaluations are costly, time-consuming and very complex.

An evaluation typically requires the development and use of information-gathering tools. The kind of tools needed depends on the methods used for data collection. Most evaluations look at both quantitative and qualitative data. Some of these

Examples of research questions

For programme managers:
- What is the quality of FP services from the users' perspective?
- How satisfied are clients with delivery of care?
- What is the effect of IEC activities on FP acceptance?
- What is the role of the district hospital for EOC referral and how can it be strengthened?
- What, if any, is the impact of staff transfers for continuity of the SRH programme?

For service providers:
- What has been the impact of new guidelines for syndromic management of STIs?
- How well does the referral system for FGC and/or fistulas work?
- How effective has integration of services been at facility level?

For clients:
- How well is the outreach programme meeting client needs?
- What is the effect of the change in opening hours on accessibility of services?

For community leaders/local politicians:
- What is the effect of school-based IEC for adolescent SRH?
- How good is community acceptance of health staff discussing GBV?
- Are outreach activities (both advocacy and services) targeting men?

data, especially the quantitative data, can be taken from the HMIS, progress reports and other routine sources of information. For qualitative data, we may need to conduct interviews and focus group discussions, or to observe client-provider interactions.

There are ways to make evaluations participatory, so that ownership increases over activities and results. In the long run, this will build the capacity of the district to use results for improved programming, and it will promote the sustainability of the SRH and overall health programme.

Participatory evaluations are perhaps less scientific, but they have the advantage that they improve both communication and collaboration among all partners, and efficient allocation of resources. Different people can be involved at different stages of the evaluation, including: agreeing on the focus of the evaluation; interpreting the findings; and ensuring follow-up action.

5.4 Advocacy: maintaining commitment and momentum for SRH

Public support for health - and SRH in particular - is key to making services better, more responsive and client-oriented. Some of our partners are already closely involved in the district SRH programme, while others need to become involved more actively. Advocacy assists in coalition building and gradual expansion of the support base for SRH.

The purpose of advocacy is to change common views of what is acceptable and what is not. People can and will change their behaviour more easily when the social environment is supportive of that change. Exercise 5c presents steps to develop key components of an advocacy strategy for a selected SRH issue.

With regard to HIV/AIDS, it is especially important to include people living with HIV/AIDS in advocacy work. They represent a key group of actors who can break the silence that often surrounds HIV in communities, and promote care and support for those living with HIV/AIDS. The urgency of district responses to HIV/AIDS needs to be brought into everybody's life.

CHAPTER 5:
Summary/Key Lessons

An annual performance review provides an excellent opportunity to discuss achievements and challenges with all involved. It is also a forum for solving problems, and planning for the next year.

Evaluation provides more in-depth information on key policy, management or programmatic issues. In general, an evaluation can help determine if programme inputs (human resources, financial support, materials, etc.) have improved outputs/ performance (improved ANC attendance, consistent supply of drugs, etc.) and/or resulted in an effect (better knowledge and practice related to safe delivery among women and their families in the district, etc.).

Both annual performance review and evaluation are important components of the PM&E cycle, and should involve all stakeholders to ensure follow-up of recommendations.

Even with the best possible advocacy, it takes time to change knowledge and attitude, and even more so to change practice or behaviour. Where possible, advocacy efforts should build on cultural values that reinforce sexual and reproductive health and rights. Use these values as an entry point and look for sensible ways to introduce new ideas.

EXERCISES CHAPTER 5:

How do we review and evaluate SRH performance?

Exercise 5a: How do we conduct an annual performance review?

Expected outcome

At the end of this exercise, we will have reviewed, for each element of the SRH package, the performance during the current year and the targets for the next.

Participation

This exercise is best facilitated by the DHMT and should involve SRH partners, including women's groups, youth groups, NGOs, health facility staff, the private sector, donor agencies, and national/regional level managers. It is possible to have a one-day "internal" meeting to review achievements, and to invite partners for the second day when decisions are made about revising targets and actions to be taken.

Duration/Venue

Conducting an annual performance review requires a half to three-day workshop.
Ideally, all districts have a joint review, which will feed into a national (or regional) review that consolidates the results and observations of the respective districts.
The district review is best done in the days prior to the development of annual work plans and budgets.

Materials required

- Flipchart/newsprint paper/regular size paper
- Coloured markers/pens/pencils/tape, etc.
- Service data, SRH targets, annual SRH work plan (Exercises 2e, 3b, 3f)
- Routine monthly health facility schedules, quarterly monitoring plans (Exercises 3h, 4c)
- Registers and records
- Financial plan/budget overview (Exercise 3i)

It is recommended to do this exercise on a separate piece of paper first, and to copy the results onto the blank worksheet provided in the back of the manual once the exercise is completed.

Step one

Make a large matrix on paper, with the elements of the SRH package in the left-hand column, and complete the columns labelled "Coverage/Performance data" (for the past two years) and "Target" (for the current year). All this information can be copied from Exercises 2e and 3b.

Step two

Review in small groups what has been achieved in the current year, using information from records and registers to determine actual performance level. The same formulas that we used to determine past performance and to set targets can be applied.

Facility staff can be asked to prepare this information in advance and bring it to the meeting. This will save a lot of time. They should bring raw data so that we can see how estimates and achievements were obtained.

Step three

With this information, complete the columns labelled "Achievement" (for the current year) and "% achievement". The percent achievement is simply achievement divided by target. This can be more than 100%. Discuss what the implications are for the target that was set for next year. Modify the target as necessary. Complete the column labelled "Revised target". Repeat this for all SRH elements for which information/data are available.

Step four

With the completed matrix, analyse the trend in the percent achievement column for each indicator, and discuss what needs to be done in the coming year to achieve new targets for SRH. Indicate actions or comments in the last column.

This information will be useful when we develop the SRH work plan for next year.

Step five

Update the sheet with three-year targets for the SRH programme (Exercise 3b). As a result, targets are adjusted for the next three-year period (i.e from 2004-2006 for the sample district).

An annual performance review is an expanded monitoring exercise that includes strategic discussions with partners. The recommendations from the annual performance review are the basis for next year's planning cycle.

Example of results from an annual performance review

Indicators for the SRH package (from Exercise 3b)	Coverage Performance data		Target (T)	Achieve-ment (A)	% Achieve-ment	Revised target	Analysis/ Action to be taken
	2001	2002	2003	2003	(A/T)	2004	
Maternal health							
Number of deliveries attended in a health facility	1,367	1,275	1,400	1,180	84%	1,300	Need to decrease target to more realistic levels
Percentage of pregnant women receiving ANC at least once from skilled personnel	47%	51%	60%	55%	92%	65%	Steady increase observed. Clients like integrated ANC. Introduce daily ANC in all health facilities
Number of maternal complications treated	490	419	500	387	77%	450	One of two nurse midwives was transferred. District commissioner to request urgent replacement
% of C-sections performed out of total number of expected births in the district	1%	2%	2%	1%	50%	2%	Anaesthetist went abroad for training. Replacement has been requested. Needs urgent follow up
Number of pregnant women with severe anaemia	1,033	1,180	1,050	1,155	>100%	1,100	Nutrition counselling needed. Order sufficient iron & folic acid. Increase expected due to persistent food shortages
Neonatal health							
Number of new-borns born in health facility with low birthweight (<2.5kg)	57	64	55	68	>100%	65	Nutrition advice during ANC and PNC needs more attention. More outreach!
Complications from abortion							
Total number of admissions for abortion-related complications	238	215	250	213	85%	250	Decrease possibly due to increased IEC/counselling on FP and FP outreach services. Need more on quality of care
RTI/STI/HIV/AIDS							
Number of HIV+ new cases	0	89	250	146	58%	200	Work with other sectors on HIV prevention. VCT must be combined with better access to treatment!
Number of new STI cases	1,967	2,151	2,300	2,355	>100%	2,450	Improved diagnosis/ treatment
Adolescent SRH							
Number of 15-19 year old girls attending ANC (first visit)	976	1,011	1,100	1,166	>100%	1,200	Some facilities successfully working on YF issues. More outreach needed for girls

Indicators for the SRH package (from Exercise 3b)	Coverage Performance data		Target (T)	Achieve-ment (A)	% Achieve-ment	Revised target	Analysis/ Action to be taken
	2001	2002	2003	2003	(A/T)	2004	
Family planning							
CYP	11,982	12,347	13,000	12,002	92%	13,000	CBD network just started. Expect modest increase in CYP next year
Number of postpartum women accepting FP	435	446	550	461	83%	500	Staff is more confident following counselling training. Better integration of FP and postpartum services still needed
Sub-/Infertility							
Number of new sub-fertility cases	0	0	0	-	-	-	
Fistula (life cycle SRH issues)							
Number of new fistula cases	0	0	20	0	>100%	45	IEC during outreach well received. Referral data still incomplete
Complications from FGC							
Number of complicated FGC new cases	258	290	340	322	95%	360	Referral system and reporting improving. More IEC needed
Gender-based violence							
Number of clients coming to health facilities for injuries/problems related to violence	136	180	200	235	>100%	260	Good progress with community leaders. Integrate screening with ANC services?

Exercise 5b: How do we prepare for a process evaluation?

Expected outcome

At the end of this exercise, we will have a clearly defined research question, an evaluation workplan and research budget. Most importantly, we will have a plan for use of findings to improve coverage or quality of the district SRH programme.

Participation

The DHMT is responsible initially to identify the need for an evaluation, as well as other partners who should be involved at various stages of the evaluation process.

Duration/Venue

Carrying out an evaluation is not a simple task. It may take several meetings before the research question is identified, a workplan and budget are developed. Since this does not happen every year, it is best to see this as a special activity for which a small task group can come together as needed.

Materials required

- Regular size paper, pencil, whiteboard, markers
- Data from most recent performance review (Exercise 5a)
- Tape, ruler, calculator

Step one

Decide with selected partners why evaluating the SRH programme, or selected elements/activities thereof, is important at this moment, and what exactly should be evaluated. This will become our research question.

Step two

Develop methodology and data collection tools with partners. Data collection tools may include focus groups, exit interviews, key informant questionnaires, reports, records, etc.

Step three

Together with partners, prepare a detailed evaluation workplan that includes:

- Pre-test tools, and orient/train evaluation team as required
- Start of data collection
- End of data collection
- Data processing and analysis
- Write up of findings
- Share draft report with partners
- Incorporate feedback and final write-up
- Disseminate findings (workshop)
- Incorporate findings and recommendations in district SRH work plan

Step four

Once the evaluation workplan has been finalized, prepare an evaluation budget. Include budget lines for:

- Personnel including travel and per diem
- Logistical support including transport
- Admin support including supplies and equipment
- Communication including photocopying and printing
- Dissemination including workshop with partners

Step five

Once the evaluation is underway, meet regularly to discuss progress. Check that time schedules are adhered to, and that expenses are well monitored.

Step six

With the findings from the evaluation, sit down as a team (with selected partners), and incorporate recommendations into the district SRH work plan. If timing works out, we can do this as part of our annual performance review or other PM&E related meeting.

An evaluation is an important opportunity to find out what has been done and how, and what we can do better and how. We will use the findings and recommendations to improve our district SRH workplan. Make sure to share the evaluation report with relevant partners.

Example of key steps in a process evaluation

Research context and research question	Methodology/tools	Main findings
Context Staff morale and related issues keep coming up during all supervisory and monitoring visits, as well as the annual performance review **Research question** What can be done with existing district resources to improve staff morale?	Literature review - MOH human resource strategy - Health sector human resource planning and management	- There is no clear policy on staff transfers other than *"after some time, staff posted in rural areas may be assigned to an urban duty station"* - Health sector human resource literature includes some good ideas for more effective management of district health staff
	Key informant interviews - Regional health administrator - Regional health director - MOH director of personnel and administration	- There are no clear guidelines for staff rotation from rural "under-privileged" districts to urban settings where there are more possibilities for staff development - Staff often work after hours in "private clinics" to supplement their salary
	Interviews with random sample of staff from each staff cadre - 5 auxiliary health workers - 5 nurses - 5 midwives - 5 medical assistants - 2 doctors - 5 administrative/ finance staff	- Salary is insufficient to pay school fees and maintain a household - There are limited opportunities for upward mobility - Training possibilities are ad hoc, and there is no formal career development strategy - There are limited options for good schooling in the district - Housing is of poor quality - Staff transfers are often politically motivated
	Focus group discussion with community groups on: - staff attitudes - staff availability - how staff morale can be improved	- Staff are often perceived as being under pressure - Facilities are sometimes closed unannounced - Staff needs better housing to improve their living conditions - Community leaders should regularly invite health staff to attend meetings, and feel part of the community they work in

Action to be taken:

- District medical officer to discuss with regional health director and draft a letter to Director General requesting clear policy guidelines on staff transfers and career development
- District medical officer to write WHO country office for additional literature on human resource development
- DHMT to convene a meeting with all staff, and update staff files including requests for transfers
- DHMT to contact local housing authorities to solicit support for upgrading staff quarters at health facilities

Exercise 5c: How do we develop an advocacy strategy for SRH?

Expected outcome

At the end of this exercise, we will have defined the objective, target groups and messages to advocate for positive change for one SRH issue. We will have decided how to take these messages to the public, and to evaluate the impact of the advocacy work.

Participation

Throughout the development, implementation and evaluation of the advocacy work, as many partners as possible should be consulted and included. Consider working with local NGO partners, as they often know the communities well, have experience dealing with sensitive issues, and can help promote wide dissemination of messages. Involve and consult with community representatives to enlist their support for an advocacy campaign. For some activities, we need people with certain technical skills (artists, producers, etc.).

Duration/Venue

Developing an advocacy strategy takes time and investments of many people. It is hard to estimate how much time is needed. Most likely, it will be a phased process involving meetings and working groups across sectors. Meetings can take place anywhere at the district level, and the venue can rotate between different groups involved in the design, implementation and evaluation.

Materials required

This depends on the content of the advocacy strategy. For planning purposes, materials include:

- Flipchart/newsprint paper/regular size paper/wallpaper/whiteboard
- Coloured markers/pens/pencils, etc.
- Examples of existing IEC/advocacy materials
- Video recorder (to see other tapes as examples), radio cassette player, etc.

Step one

Discuss as a team what the priority SRH issue(s) is for advocacy. Refer back to community discussions (Exercise 1b), to review important issues identified by community members.

Step two

Clearly define the problem and assess the magnitude and impact this has on SRH in the district. In doing so, consider health impact and socio-cultural impact. Analyse what factors may contribute to the problem.

Step three

Develop objectives of the advocacy strategy, and decide on target groups. Gather key information on existing knowledge, attitude and practice among the target group. This will serve as a baseline, so we can evaluate changes later on.

Step four

Develop key messages to reach the target groups with essential information. Fieldtest the message to make sure the target groups understand it correctly.

Step five

Decide what channel will be best to take the message to the public. The type of channel we select depends very much on the target group(s). This can be printed materials, radio, video/TV, etc.

Step six

Develop the product(s), and decide on a dissemination strategy. Make sure to fieldtest the product(s) before they are introduced on a large scale.

Step seven

Decide when and how the effect of the product (posters, radio messages, TV add, etc.) will be evaluated. This evaluation can be as simple as a survey among client/users/community groups, complemented by interviews with local politicians, NGOs, civil society or other representatives of the target group(s). Evaluation tools will depend on the issue, the kind of products that were developed, and the time and resources available.

Step eight

If necessary, train those who will be using the materials (for example, health workers, CHVs,

women's groups and the media) on how to use and promote them in their work. It is extremely important that everybody understands and delivers the same message to the target group.

Step nine

Throughout the implementation period, make sure to monitor if the materials are available, accepted and liked, and if they are being used and promoted as we intended.

Step ten

Assess whether the materials have contributed to a change in knowledge and attitude. Use findings from the baseline to compare, and identify any changes.

Well-designed advocacy messages are consistent, simple, focused and action-oriented. They inform people about the actions they can take or support to change behaviour, and emphasize the positive effects of behaviour change. Repetition, reminders on key points and consistency will increase the chance that the target groups will remember the messages, and act accordingly.

Example of different components of an advocacy strategy to address gender-based violence

Objective of the advocacy work: To address gender-based violence among women and girls by sensitizing politicians, the media and community leaders about the health consequences of violence.

Magnitude of the problem	Target group	Channel	Messages	Evaluation tools
Gender-based violence is very common in the district	Local politicians and the media	Direct visits	Did you know? Violence at home and in the community causes serious and long lasting mental and physical health problems for its victims.	Brief questionnaire
Health providers do not see it as a health problem	Health providers	Posters	You too can do something! Violence is a health issue. When coming across a victim of violence, treat with compassion, counsel and refer.	Anonymous survey
Women and girls are scared and shy to seek help, and don't know where to go	Women and girls	Radio campaign	Afraid and don't know where to go? There are places where you can go for help.	Interviews with listeners and support groups
Local leaders sometimes blame women when violence occurs, and are unaware of health consequences	Local leaders	Direct visits, radio campaign	Did you know? Violence at home and in the community causes serious and long lasting mental and physical health problems for its victims.	Interviews
Alcohol use is related to violence	Local leaders	Direct visits, community talks	Violence is not tolerated in our community.	Anonymous survey, interviews

Annexes

Annex 1: Example of an integrated supervisory checklist (Ghana)

Date _____

Name of institution: _____, District _____ Region _____
Name of supervisor: _____, District _____ Region _____

1. Staff

Health assistant___ Nurse___ Midwife___ Physician _____
Community health worker___Logistics/Procurement officer___
Others _____

Written job description for any of the above? (yes/no) _____

Action to be taken	By whom	By when	With what resources

2. Evidence of teamwork

3.1 Anecdotal _____
3.2 Factual _____
3.3 Team planning _____
3.4 Work schedule curative y/n preventive y/n

Action to be taken	By whom	By when	With what resources

3. Daily integrated services

			Comments
4.1	ANC	yes___ no___	_____
4.2	PNC	yes___ no___	_____
4.3	FP	yes___ no___	_____
4.4	STI/HIV	yes___ no___	_____

Action to be taken	By whom	By when	With what resources

4. Outreach activities

of sites _____
Frequency of visits _____

Action to be taken	By whom	By when	With what resources

5. Catchment area

Area mapped with outreach locations? yes___ no___
Population specified by village yes___ no___

Action to be taken	By whom	By when	With what resources

6. Operational targets

6.1 Targets evident yes___ no___
6.2 Evidence/analysis of attainments yes___ no___

Action to be taken	By whom	By when	With what resources

7. Management information systems

Comments

7.1 Antenatal register _____
7.2 Delivery register _____
7.3 Postnatal register _____
7.4 Family planning register _____

Action to be taken	By whom	By when	With what resources

8. Transportation

Mopeds/Bicycles yes___ Qty (___) no___
Used for : _____
Maintenance problems: _____
Sufficient fuel available _____
4 -wheel drive yes___ Qty (___) no___
Vehicle Schedule yes___ no___ Comment_____
Vehicle Logbook yes___ no___ Comment_____

Action to be taken	By whom	By when	With what resources

9. Contraceptive supplies

	Last month clinic issues	# months stock on hand	Overstocked (understocked)
Oral	_____	_____	_____
Oral	_____	_____	_____
Condoms	_____	_____	_____
IUCDs	_____	_____	_____
Injectables	_____	_____	_____
Other: ____	_____	_____	_____

Action to be taken	By whom	By when	With what resources

10. IEC/BCC Campaign activities

Description of activities: _____
_____
_____

Action to be taken	By whom	By when	With what resources

11. Supervision

11.1 When was last supervisory visit (date)? _____
11.2 What follow-up action was taken? _____
11.3 Feedback from DHMT on reports? _____

Action to be taken	By whom	By when	With what resources

12. Others (specify)

12.1 Percentage of drugs given free of charge _____%
12.2 Stores
- Ledgers up to date (y) (n)
- Tally cards up to date (y) (n)
- Status of supplies _____
- Expired stock _____

Action to be taken	By whom	By when	With what resources

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Blank Exercise Worksheets

Exercise 1a: How do we define the current SRH package?

SRH element by institutional level						

Exercise 1b: How do we discuss the SRH package with the community?

Community map

Problems identified	Ideas to address gaps

Exercise 2a: How do we make the district SRH profile?

Existing SRH services	National policy support	Number of sites where SRH services are currently being provided						Number of staff working on specific SRH issues in the district						Partners working in SRH in the district (planning, provision and/or financing)
													Total staff	
Total facilities and staff														

Exercise 2b: How do we calculate SRH target populations?

Target population (calculation)	Total population	Family planning	Antenatal, delivery and postnatal care	Maternal complications	Caesarian sections	Tetanus toxoid
	A	**B**	**C**	**D**	**E**	**F**
Formula						
District total						
Name of health institution						

Exercise 2c: How do we map existing SRH services in the district?

H	Hospital			-------	District boundary
HC	Health centre	CBD	Community-based distribution of FP supplies	----------	Health facility catchment area boundary (approximate)
HP	Health post	FP	Family planning services	==	Paved road
CEOC	Comprehensive EOC			- - -	Dirt track passable by motorized vehicle
BEOC	Basic EOC			+ + + +	Foot path
EOFA	Emergency obstetric first aid[5]			·····	Communities
TTBA	Trained traditional birth attendant	*		■	
Y	Youth-friendly services	①		□	

Exercise 2d: How do we use data to assess current SRH services?

SRH indicator for the elements of the SRH package	Service data for ____ , ____ and ____ years		

Exercise 2e: How do we analyse SRH service data with partners?

Indicator for each element of the SRH package	Service data for ____ , ____ and ____ (from previous Exercise)				BUT WHY ? Institutional factors (staffing, supplies, training)	BUT WHY? Community factors (summary of Exercise 1b)
	____	____	____ Expect.	____ Actual		

Exercise 3a: How do we formulate SRH objectives?

In this district, we are committed to:

Exercise 3b: How do we define targets for SRH performance?

Indicator for each element of the SRH package	Coverage/Performance			Targets		
	____	____	Change per Year	Year 1	Year 2	Year 3

Exercise 3b - continued: How do we define targets for the SRH package?

District performance and target graphs for selected SRH elements

_____

Year ____

In Percentage

Year

_____

Year ____

In Percentage

Year

_____

Year ____

In Percentage

Year

_____

Year ____

In Percentage

Year

_____

Year ____

In Percentage

Year

_____

Year ____

In Percentage

Year

Exercise 3c: How do we analyse the strengths and weaknesses of current SRH strategies and activities?

SRH element	Current strategies	Strengths	Weaknesses	New or improved strategies for the next three years

Exercise 3d: How do we prioritize and select SRH strategies?

SRH element	Improved strategies for next three years	Ranking*

* 1=high priority; 2=important; 3=less important; 4=least important

Exercise 3e: How do we develop a learning and training plan for SRH?

SRH element	Learning and training needs	Staff category	Costs of training	Source of funds	Technical assistance

Exercise 3f: How do we develop an annual SRH work plan within the context of the district health plan?

SRH element	SRH strategy (copy from Exercise 3d)	What? (activities)	Whom?	When?	Source of support

Exercise 3g: How do we plan and manage SRH supply and equipment needs?

Selected essential drugs and supplies and equipment for the SRH packagein A	Estimated consumption current year B	Projected consumption for next year C	Buffer stock required @ ___ % D	Available in health facilities or in stock at district stores E	To be ordered before next year (include ___ % buffer stock) F
	Formula to calculate needs (F)				C+D-E

Exercise 3h: How do we develop a routine monthly health facility schedule?

Days of the week						
Activity/Time						
Week 1 Morning						
Afternoon						
Week 2 morning						
Afternoon						
Week 3 morning						
Afternoon						
Week 4 morning						
Afternoon						

We suggest to note down in the remarks column how (mode of transport) and who (staff individual) will conduct outreach and supervision.

Exercise 3i: How do we develop a financial plan?

SRH activities	Units	Total # of units	Unit cost	Total costs	Year 1	Year 2	Year 3	Source
	A	B	C	D	E	F	G	H
Formula								
Subtotal								
Remarks:								
Subtotal								
Remarks:								
Subtotal								
Remarks:								
Subtotal								
Remarks:								
Total								
Miscellaneous/contingencies								
Grand total								

Exercise 4a: How do we organize SRH partnership in the district?

Purpose: **Objectives:**							
Activities/ Services							

Please note, an X in a cell means that the partner is involved in this activity.

Exercise 4b: How do we improve quality and efficiency of SRH service delivery?

Existing SRH services	Daily provision	Staff availability and capacity	Supply and equipment availability (checklist)	Client oriented set-up	Integration with other (SR) health services	Integration of tasks/Referral system

Exercise 4c: How do we monitor quarterly progress in the SRH work plan?

SRH element	Activities Year 1	Activity indicator	Planned activities this quarter (Target)	Status of imple-mentation this quarter Achieved)	Follow-up action and/or Remarks

Exercise 4d: How do we monitor SRH expenditures?

SRH element	Source	Resource	Plan	Expenditure	Difference	Explanation/ Remarks
Subtotal						
Subtotal						
Subtotal						
Total						

Exercise 4e: How do we develop a supervisory schedule for SRH?

From (level)	To (level)	Who	When/ Transport	Problems/ Issues	Action/ Follow-up	Report available

Exercise 5a: How do we conduct an annual performance review?

Indicators for the SRH package (from Exercise 3b)	Coverage Performance data		Target (T)	Achieve-ment (A)	% Achieve-ment (A/T)	Revised target	Analysis/ Action to be taken

Indicators for the SRH package (from Exercise 3b)	Coverage Performance data		Target (T)	Achieve-ment (A)	% Achieve-ment (A/T)	Revised target	Analysis/ Action to be taken

Exercise 5b: How do we prepare for a process evaluation?

Research context and research question	Methodology/tools	Main findings
Context		
Research question		
Action to be taken:		

Exercise 5c: How do we develop an advocacy strategy for SRH?

Objective of the advocacy work:				
Magnitude of the problem	**Target group**	**Channel**	**Messages**	**Evaluation tools**