MODULE 1

A PUBLIC HEALTH APPROACH TO PLANNING
(1.5 day - 10 academic hours)

Topic Overview: Planning should not be an exercise in copying last year’s plans and adding a small percentage for inflation. The keys to planning are (1) understanding the health problems of the population, (2) identifying how to address these problems, and (3) knowing how to use resources effectively to alleviate these problems. It also includes an understanding of how to balance prevention with curative services whether for reproductive health or other types of health care services.

Objectives of the Module:
1. Participants should understand that effective planning requires good analysis of the current situation, identification of trends and key constraints to health improvement and continuous monitoring of programs to ensure that results are achieved;
2. Participants should understand that increased medicalization (more and longer hospitalizations, more doctors’ visits, more medications and tests, etc.) often does not increase health but does increase cost;
3. Participants should be able to identify a health problem and develop an effective program that addresses its causes and outcomes;
4. Participants should have the skills in financial management, human resource planning and epidemiological analysis to correctly diagnose a public health problem and identify a solution, paying special attention to reproductive health.

STRUCTURE OF THE MODULE:

Lecture 1: (1 academic hour)
The Structure and Limitations of Health Systems
(T. Bossert)

Lecture 2: (1 academic hour)
Introduction to Epidemiology
(M. Mitchell)

Case 1: (3 academic hours)
Too Young to Die: Breast Cancer in Ukraine
(R. Criswell)

Lecture 3: (2 academic hours)
Planning for Health: The Basics of Health Programming
(R. Criswell)

Case 2: (3 academic hours)
Reproductive Health Program
(R. Criswell)
### The Structure and Limitations of Health Systems

**By Thomas Bossert**

<table>
<thead>
<tr>
<th>The Structure and Limitations of Health Systems</th>
<th>Some Important Characteristics of Health Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thomas Bossert, Ph.D. Harvard School of Public Health</td>
<td><strong>Embedded in Social Context:</strong> Technology conditioned by culture, history, economics, politics, and social norms</td>
</tr>
<tr>
<td></td>
<td><strong>Complexity:</strong> Many products, many actors, complex connections</td>
</tr>
<tr>
<td></td>
<td><strong>Conflict:</strong> Different participants have different objectives and interests … not always “positive sum”</td>
</tr>
<tr>
<td></td>
<td><strong>Political:</strong> Current condition reflects power in society; change incurs political process</td>
</tr>
</tbody>
</table>

### Basic Questions

- **What is a health system?**
- **Why is it important to study health systems?**
- **What are some ways experts have described/analyzed health systems?**

### How would you define a health system?

Without looking at the rest of these Power Points!

### Defining a Health System:

“…all the activities whose primary purpose is to promote, restore, or maintain health”

WHO, 2000

- Health System or Health Care System?
- Activities? Or people and institutions who carry out these activities?

### Disease Specific Programs and Health Systems

What are the basic debates?

### Disease Specific Programs

- **Examples:**
  - HIV/AIDS – Global Fund, PEPFAR
  - Pulse Polio
  - GAVI and its predecessor EPI
  - Family Planning

### Arguments in Favor of Disease Specific Programs

- Burden of disease merits its priority
- Health systems have too many problems to be able to achieve objectives in the short term
- It is too costly to improve health systems; therefore, let’s have at least one success with our scarce resources
- Evidence of success in vertical programs
Arguments in Favor of Health Systems

- More efficient as each part of system is used for multiple purpose
- Decisions of how to use funds and other resources is done on the basis of local priorities of the country rather than by outside organizations
- Prevents the stovepipe programs where there is no coordination among programs

Basic Flow Diagram for the Health System

```
Inputs
↓
Health System
↓
Outputs
↓
Outcomes and consequences
```

Economic Importance of Health Systems

- A healthy population is good for economic growth since productivity increases.
- Much of health is a function of multiple factors that go beyond individual disease prevention or cure. A system is needed.
- A health system advocates for health interventions on a global scale rather than disease specific interventions.

Components of the Flow Diagram: Examples (1)

- Inputs
- Components of the health system

```
Inputs Components of the health system
Personnel; Hospitals;
Buildings; Clinics;
Drugs; Insurance funds;
Supplies; Vaccination programs;
Regulatory authorities
```

Public Health Spending in Low and Middle Income Countries

[Graph showing the relationship between per capita income and domestically financed government health spending as % of GDR]
Lecture 1: The Structure and Limitations of Health Systems

Module 1

An Illustration of Means, Intermediate Outcomes, and Final Goals

The “Diagnostic Journey”: Identifying the Causes of Problems

- Start with performance problems as outcomes
- Find out what causes the problems by asking “why” five times
- Work “backwards” – from causes, to causes of causes, and so on… until you reach things you can change – the “Control Knobs”
- Be “evidence based”

What Do We Mean By “Problems” in “Problem Definition”?

- The health system is a means. Reformers need to be clear about the ends.
- Problems should be defined based on poor performance in terms of outcomes.
- Focus on changing things that contribute to improving poor performance.
- Defining the problem is a critical step often ignored or assumed.

Reaching a Political Decision

- Health sector reform is unavoidably political
- Politics matters throughout
- Doing better requires political skill, not just political will
- Stakeholder analysis is a starting point
- Successful reformers move from “mapping” politics to strategies to affect politics

Components of the Flow Diagram:

Examples (2)

Outputs → Outcomes & Consequences

- Prevention & Promotion:
  - Vaccinations;
  - Mass campaigns
- Clinical treatments:
  - Examinations;
  - Medical treatments;
  - Surgeries

Means
- Financing
- Payment
- Macro-organization
- Regulation
- Persuasion

Intermediate Outcomes
- Access
- Quality
- Efficiency

Health Status
Public Satisfaction
Risk Protection

Final Goals

Define The Problem
Evaluate
Identify Causes
The Health Systems Reform Cycle
Implement
Develop Options
Decide What to Do
What is a “Control Knob”?  
- A set of features of the health sector  
- These features can be altered by public policy  
- Changing the “setting” on the “knob” is likely to change the performance of the health sector

Observations on Financing  
- The amount of money a nation can raise depends on its prosperity. Not all good things are affordable in poor countries  
- Not all options will be within a nation’s technical and administrative capacity  
- Not all options will fit with a nation’s social attitudes or economic structure

Overview of the “Control Knobs”  
- Financing  
- Payment  
- Organization  
- Regulation  
- Persuasion and Behaviour Change

The Financing Control Knob  
- Each option can be seen as an “ideal type”  
  - General revenue  
  - Social insurance  
  - Private insurance  
  - Out-of-pocket payment  
  - Community financing  
  - International aid  
- Many real systems depart from any one “ideal type”  
- Most nations use a mix of financing options

The Payment Control Knob  
- Every payment system includes a unit or basis for payment and a rate  
- Payment options:  
  - Hospitals:  
    - Patient day  
    - Admission  
    - Global budget  
    - Line item budget  
    - Fee for service  
  - Doctors:  
    - Fee for service  
    - Salary  
    - Salary plus bonus  
    - Capitation  
    - Capitation plus bonus

The Importance of Financing Choices  
- Methods chosen affect funds available and distribution of burdens  
- Different approaches change who has authority over the system  
- Different approaches change what services are available and to whom

The Importance of Payment  
- All payment systems create significant incentives  
- Relative payment levels (vs. costs) lead to different services being offered  
- The more sophisticated health care managers are, the more they respond to these incentives

Observations on Payment  
- The payment system you can use depends on how the financing and delivery systems are organized  
- Contracting can be a useful alternative to a published fee schedule  
- Payment rates are always controversial - providers always want more
The Organization Control Knob

- **Macro level**
  - *who does what*; the set of delivery organizations and their functions
  - the *interactions* among those organizations
  - the *incentives* these interactions create

- **Micro level**
  - *internal structure of delivery organizations*

- Policymakers have only a *limited capacity* to make changes inside delivery organizations outside the public sector

The Regulation Control Knob

- The use of the *coercive power of the State* to get actors in the health sector to change their behaviour
- This power may be delegated to non-state actors
- **Purposes** of regulation
  - Establish markets
  - Protect consumers
  - Correct market failures
  - Achieve non-market goals

The Importance of Regulation

- Regulation is critical to the functioning of markets — effective public action is a complement to effective private action
- Health care is full of the kinds of problems that typically lead to regulatory activity; e.g. ignorant consumers
- Ineffective regulation may be worse than no regulation so governments need to choose areas for regulation strategically

The Importance of Organization

- Cost, quality, and access depend critically on macro and micro organization
- Economists who focus on incentives often do not take this point seriously enough
- If an organization is to do better, it has to have both a *reason to change its behaviour* and the capacity to change

Observations on Organization

- Changing who does what is likely to be very politically controversial
- The effect of any organizational change depends on its impact on the front line workers (and their managers) who actually deliver services
- Micro level *changes create anxiety* and impose costs on some employees and are often strongly resisted

Observations on Regulation

- Since actors prefer not to change, they will often try to resist, undermine, or derail the regulatory process
- Easiest to regulate where there is widespread consensus on both goals and rules – voluntary compliance makes enforcement more effective
- Effective management of the regulatory organization, technical competence, sufficient resources, and political support are all critical to regulatory success
The Individual Behavior Control Knob (1)

- Both patient and provider behavior are relevant—political persuasion is a different issue.
- Many possible communication channels: free media, paid media, individual contact, groups, big events, etc.
- Information alone does not change behavior. Messages need to be sophisticated as advocated by “social marketing.”

The Importance of Individual Behavior

- Health seeking behavior is very important to health sector performance.
- Patients are the first “front line workers” in treating chronic disease.
- Many important behaviors are difficult to reach with incentives or regulation or doing so is viewed as unethical.

The Individual Behavior Control Knob (2)

- Convincing patients to change their behavior is difficult.
- A “pull,” not “push,” message is essential. New behavior has to fit target’s needs and values.
- Not all patients are the same—market research is essential.

Suggestions on Developing Policy

- Look to international experience - but adapt it to your situation
- Be sceptical of ideological or self-interested advocates
- Always consider local political realities
- Always consider likely implementation problems (resources, skills etc.)

Some Conclusions

- Health systems are an increasingly important means for health and welfare gains now and in the future.
- Health systems may be the “binding constraint” for rapid, widespread improvements and for addressing priority public health issues.
- We are still at an early stage in the “science” of health systems analysis.
INTRODUCTION TO EPIDEMIOLOGY
By Marc Mitchell

Introduction to Epidemiology

Terminology
- Incidence = New cases
- Prevalence = Existing cases
- Internal validity
  - Within the study population, the observed results are unbiased estimates of the relation between exposure and outcome
- External validity (a.k.a. generalizability)
  - The observed results are an unbiased estimate of the relation between exposure and disease in the population of interest

Topics
- Study designs
- Threats to internal validity
  - Bias
  - Confounding
- External validity or generalizability

Study Design Classifications
- Associational
  - Ecologic
- Observational
  - Cross-sectional
  - Case-control
  - Prospective Cohort
  - Retrospective Cohort
- Experimental
  - Randomized Clinical Trial

Ecologic Study
- Unit of observation is generally a geographic area
- Promise
  - Fast and cheap
  - Can use existing data
- Perils
  - No control for confounding
  - Ecologic fallacy
  *Association at aggregate level often may not reflect association at individual level*

Cross-Sectional Study
- Exposure and disease assessed at same point in time
- Measures prevalence—not incidence
A PUBLIC HEALTH APPROACH TO PLANNING

Module 1

Cross-Sectional Study

- Promise
  - Cheap and fast
  - Hypothesis generating
  - Yields prevalence of many exposures and outcomes

- Perils
  - Cannot assess temporality
  - Prevalent cases may have better survival
    - Exposure pattern may be different in these persons
  - Not good for rare exposures or rare outcomes

Case-Control Study

- Select participants based on disease status
  - Compare exposure pattern in cases and controls

- Controls should be selected from the population that gave rise to the cases (the source population)
  - Exposure distribution in the controls should represent the exposure distribution in the source population
  - Potential sources of controls
    - Population (e.g., random-digit dialing), neighbors, friends, family

Case-Control Study

- Promise
  - Relatively inexpensive and fast
  - Can assess multiple exposures
  - Ideal for rare diseases
  - Good for diseases with long latency period

- Perils
  - Difficult to assess temporality
  - Inefficient for rare exposures
  - Cannot calculate incidence or prevalence, which is set by design
  - Subject to recall and selection bias

Bias

- Systematic (not random) error
- Jeopardizes internal validity of the study
- Leads to spurious results
- Two main types of bias in epidemiology
  - Information bias, or misclassification
    - e.g., Recall bias, surveillance bias, reporting bias
  - Selection bias

Recall Bias

- Accuracy of recalling past exposure is systematically different in cases compared to controls
- Threatens validity of case-control studies
- Form of differential misclassification
- Methods to avoid recall bias
  - Use diseased controls
  - Validate exposure data

Selection Bias in Case-Control Studies

- Probability of being selected into study must be related to both exposure and outcome
  - Probability of being a control depends on exposure status

- Distribution of exposure in the controls does not reflect distribution of exposure in the source population

- May create an association between exposure and outcome in the study—even if the truth is that an association does not exist
Module 1

Cohort Study
- Select participants based on exposure status
  - Compare disease pattern in exposed and unexposed
- All participants must be “at risk” for the outcome
- Two main types
  - Prospective and retrospective

Types of Cohort Studies

<table>
<thead>
<tr>
<th>Time</th>
<th>Prospective</th>
<th>Retrospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Begin Study</td>
<td>Begin Study</td>
</tr>
</tbody>
</table>

Selection Bias in Cohort Studies
- Definition requires that probability of selection be related to exposure and outcome
  - Any variables related to exposure can be adjusted for—thus, this is really a problem of confounding
  - Unlikely that participation in study will also be related to outcome given that the outcome has yet to occur
- Differential loss-to-follow-up is a greater threat

Randomized Clinical Trial
- Gold standard of epidemiologic studies
- Exposure is randomly assigned by the investigator
- Goal is to establish causation, rather than simply association

Cohort Study
- Promise
  - Can assess multiple outcomes
  - Ideal for rare exposures
  - Can establish a temporal relation between exposure and outcome
  - Incidence measures are obtainable
- Perils
  - Often expensive and require many years to complete
  - Inefficient for rare outcomes
  - Subject to loss-to-follow-up, competing risks and bias from differential loss-to-follow-up (sometimes called selection bias)

Randomized Clinical Trial
- Promise
  - Randomization minimizes confounding—of measured and unmeasured variables
  - Allows for blinding
  - Can establish a temporal relation between exposure and outcome
  - Incidence measures are obtainable
- Perils
  - Must have equipoise
  - Often expensive and time-consuming
  - Subject to loss-to-follow-up and cross-over of treatment arms
Confounding

- Creates a spurious association between exposure and outcome due to the influence of one or more other variables
- Confounding variable must be a cause of both exposure and outcome

Generalizability

- Equivalent to external validity
- The study is generalizable if the study participants are representative of the population from which they were sampled—assuming this is also the population for which you want unbiased inferences
  - e.g. A study of hormone replacement therapy in symptomatic women may not be generalizable to asymptomatic women
- This is not selection bias, nor is it a necessary consequence of selection bias

Explanations for Observed Associations

- Association = causation
  - Truth
- Association ≠ causation
  - Bias/confounding
  - Chance
Case 1: Too Young To Die: Breast Cancer in Ukraine

TOO YOUNG TO DIE: BREAST CANCER IN UKRAINE

By R. Criswell

Dr. Kravchuk shook her head sadly as she looked at the mammography results of her newest patient. The woman, Svetlana, was young—only 34 years old—with a family. Her mammogram came back showing a stage III malignant tumor. Dr. Kravchuk now found herself in a familiar but difficult position. Should she tell Svetlana and worry her? Or should she not mention the cancer and just let things progress as they will? Dr. Kravchuk had little hope that Svetlana would recover, since the cancer was in such an advanced stage. Any attempts at radiation, chemotherapy or surgery would just be expensive and traumatic for Svetlana and her family. If only Svetlana had come in earlier, then maybe Dr. Kravchuk could have caught the cancer at an earlier stage and done something about it before it was too late.

As Dr. Kravchuk sat at her desk and pondered her options, she realized that she had been in this situation before. Why did it seem like there were so many more young women coming in with severe and untreatable cases of breast cancer? It had not been like this when she had begun her work as an oncologist back in the early 1980s, or even when she became chief oncologist in the early 1990s. Was it something about modern society? Was the lifestyle of these young people that unhealthy? Maybe she had just been a naive young doctor. Her thoughts turned again to Svetlana and how to break the bad news as gently as possible.

It was not until later, when Dr. Kravchuk was visiting her brother in Chernihiv, that she began thinking about this issue again. He also worked as an oncologist and when he asked her how her work was going, she felt compelled to tell him about the recent increase in late-stage breast cancer patients she had been seeing. She felt a little ashamed telling him. Was it her fault as a doctor that so many of her patients were so sick? She was shocked when he looked at her sadly and said, “You know, I have been noticing the same thing. I see so many women who come in with complaints and when we find the cancer it is too late to do anything about it.” They both agreed that it seemed like there were more breast cancer victims than there had been in the past, but both were at a loss as to what to do.

Later that night, Dr. Kravchuk searched the internet for some information about the causes of breast cancer to try to find what could possibly be the root of this problem. While she knew that there was no single cause of breast cancer, she also knew that there were certain risk factors that could increase a woman’s chance of getting it. She found that these risk factors included:

- Having a family history of breast cancer;
- Having started menstruation particularly early;
- Being overweight;
- High alcohol use;
- Not exercising;
- Using certain medications.

She also found that a woman’s chance of getting breast cancer increases with age, which made her question why all these young women were coming in with malignant breast tumors.

Dr. Kravchuk took a look at the files for some of her recent breast cancer patients and compiled the following table to see if there was any pattern between risk factors and incidence of breast cancer:

<table>
<thead>
<tr>
<th>Age</th>
<th>City of Residence</th>
<th>Weight (kg)</th>
<th>Family History of Breast Cancer?</th>
<th>Stage of Cancer at Time of Diagnosis</th>
<th>Diagnosis method</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Kyiv</td>
<td>60</td>
<td>Yes</td>
<td>III</td>
<td>Mammography</td>
</tr>
<tr>
<td>33</td>
<td>Kyiv</td>
<td>54</td>
<td>No</td>
<td>III</td>
<td>Mammography</td>
</tr>
<tr>
<td>36</td>
<td>Chernihiv</td>
<td>57</td>
<td>No</td>
<td>IV</td>
<td>Mammography</td>
</tr>
<tr>
<td>50</td>
<td>Fastiv</td>
<td>66</td>
<td>Yes</td>
<td>IV</td>
<td>Mammography</td>
</tr>
<tr>
<td>41</td>
<td>Poltava</td>
<td>50</td>
<td>Yes</td>
<td>II</td>
<td>Clinical breast exam</td>
</tr>
<tr>
<td>33</td>
<td>Chernihiv</td>
<td>59</td>
<td>No</td>
<td>III</td>
<td>Mammography</td>
</tr>
<tr>
<td>36</td>
<td>Kyiv</td>
<td>62</td>
<td>No</td>
<td>IV</td>
<td>Mammography</td>
</tr>
</tbody>
</table>

As she searched further, Dr. Kravchuk came across something very interesting. There was an article by a team of Japanese oncologists who found a high rate of breast cancer in young women in Hiroshima and Nagasaki during the period 1950-1985. In fact, they found that girls who had been living in these cities in 1945 had a five times greater risk of developing breast cancer. She wondered if somehow this might explain the rise in breast cancer in her patients.

Dr. Kravchuk looked again at the table she had compiled. Almost all of her patients had been diagnosed at late stages of the cancer—once it had already spread to other parts of the body and was untreatable. All of her patients had been referred to her by other doctors when the women had complained of general health problems—bone aches, shortness of breath, a loss of appetite or headaches. But Dr. Kravchuk knew that breast cancer was treatable if detected early and that early signs included a breast lump, mild nipple discharge, breast tenderness or a dimpled appearance to the skin of the breast. She wished that every woman could have a mammogram at her yearly check-up. Unfortunately, there was no way to supply every medical facility with mammography equipment because it was so expensive!

Referencing her books from medical school, Dr. Kravchuk re-familiarized herself with early detection methods, such as self-breast exams—when women regularly check their breasts with their fingers and alert their doctor to any irregularities—and clinical breast exams—when a doctor or nurse performs a manual breast exam. Both were low-cost, and if performed regularly could catch breast cancer at the early stages (stages I and II) when it could still be treated. But Dr. Kravchuk only saw her patients once they were referred to her by other doctors—family doctors or gynecologists who worked at women’s health centers and did not know about the nuances of breast cancer and early detection by self examination. Besides, these doctors would prefer to use the more scientific mammogram for diagnosis.

Dr. Kravchuk’s job was to treat patients with cancer and she certainly had plenty of women coming in for treatment. Yet, when she thought about Svetlana, Dr. Kravchuk felt that it was her job to do something about preventing all these deaths from breast cancer. A 34 year old woman was too young to die from this disease. But what could Dr. Kravchuk do?
DISCUSSION QUESTIONS:

1. What patterns can you see among the seven patients that Dr. Kravchuk had assembled in the table?
2. Which risk factors would be applicable in Ukraine?
3. Which risk factors would be helpful in explaining the incidence of breast cancer in younger women that Dr. Kravchuk was noticing?
4. How would you design an epidemiological study to test your theories?
5. Can Dr. Kravchuk affect the incidence rate (the number of women who are diagnosed with breast cancer)?
6. Can she affect the mortality rate of breast cancer?
7. If you were Dr. Kravchuk, what would you do?

SUPPLEMENTAL READING:


TEACHING NOTES

Teaching Objectives:

1. Participants should understand the concept of risk factors and how these affect disease rates.
2. Participants should be able to use the results of an epidemiological study to design a public health intervention program to improve the health of the population.

The primary epidemiological phenomenon that participants should recognize in Part 1 is the connection between radiation from the Chernobyl disaster and the Japanese study about atomic bomb radiation. When participants are discussing possible risk factors, the instructor could lead the discussion by suggesting that participants look beyond individual behavioral factors, such as weight or exercise, and more toward environmental factors. The instructor might also point to the geographic location of both Dr. Kravchuk and her brother (Kyiv and Chernihiv were both particularly affected by the radiation from Chernobyl.)

When designing the epidemiological study, participants should be able to name the type of study that they believe would best accomplish the task at hand. Try to encourage participants to use the terms from the article:
• What is the risk factor?—exposure to radiation from the Chernobyl disaster before the age of 20
• What is the health outcome?—breast cancer
• What is the population that needs to be studied?—women exposed to radiation from the Chernobyl disaster before the age of 20; this could be focused in Chernihiv and Kyiv Oblasts
• Should the study be cross-sectional, cohort, or case-control?—in this case, a case-control study would be most appropriate
• Have participants define the chain of transmission:
  – Host: women exposed to radiation
  – Agent: radiation from the Chernobyl disaster
  – Environment: age, geographical location
  – Source of the agent: Chernobyl reactor
  – Portal of exit: Chernobyl disaster
  – Mode of transmission: airborne, soil, water (indirect)
  – Portal of entry.

Participants should realize that there is a difference between the breast cancer incidence rate and mortality rate. Dr. Kravchuk cannot stop patients getting breast cancer, since that has already happened, so she cannot affect the incidence rate. However, she can affect the mortality rate by intervening early.

The target group, since money is limited, should be women who were exposed to Chernobyl radiation before the age of 20.

While Dr. Kravchuk cannot have access to all women who were exposed to Chernobyl radiation under the age of 20, she does have access to people who do, such as family doctors, nurses and gynecologists. An intervention program might involve training nurses, feldshers\(^2\), gynecologists and family doctors in clinical breast examination and developing a referral system for early treatment from an oncologist. These medical professionals should also be trained in teaching women how to do self-breast examination. These skills can be taught in medical and nursing schools as well as in postgraduate programs. Other players who might have access to women in the target group are health teachers, the mass media and Social Services. These groups might be helpful in developing IEC materials to promote self-breast exams.

**Other challenges:**

• Funding;
• Social taboos—Women may not be used to talking about their breasts or touching their breasts (How can we get their husbands or partners involved?)
• Stigmas attached to breast cancer—Is it a death sentence? How can we change the message from “breast cancer = death” to “early detection = intervention” when many women do not even want to know (and many doctors do not even want to tell them) when they have breast cancer?

---

\(^2\) A feldsher is similar to a physician's assistant in the US.
Planning for Health: The Basics of Health Programming

by Rachel Criswell, “Together for Health” Program Consultant, Fulbright Graduate Student Program 2007-08

“A shoemaker should make shoes…”

- Health ministries make health policy
- Doctors and health workers provide services
- But health MANAGERS make health programming work as health practice

The relationship between health managers and operational managers—health managers need to learn to straddle the line

According to the WHO, “country health planning” is…

“a systematic, continuous national planning and programming process. It includes policy formation and the definition of priorities. It involves the preparation of programmes to give effect to these priorities, the preferential allocation of budgets to them, and the integration of different programmes within the overall health system. It also deals with the monitoring and evaluation of strategies and plan of action, as well as programmes and the services and institutions for delivering them, with a view to modifying existing plans or preparing new ones as required, as part of a continuous cycle.”

Theoretical Models of Development and Implementation of Health Programs

- Comprehensive Rationalism
- Mixed Scanning
- Incrementalism

Comprehensive Rationalism

- Analysis of the current position or problem to be solved
- Set goals
- Brainstorm of all possible courses of action and assess feasibility of each
- Decide on the most appropriate course of action
- Implement, monitor, and evaluate
- Drawbacks: does not take into account the irrationalities of funding and implementation; time- and resource-intensive

Mixed Scanning

- Broad definition of the health situation in a country
- Select priority areas where reform and planning can/should take place
- Identify alternative courses of action in the priority areas
- Decide best course of action based on feasibility and goals
- Implement, monitor, and evaluate
- Drawbacks: highly subjective and political
Lecture 3: Planning for Health: The Basics of Health Programming

Incrementalism

- Definition of a larger goal
- Small plans are implemented that will eventually get to the goal, though the connection may not be obvious
- Attention paid to “political” factors, the interests of different stakeholders
- Drawbacks: often more descriptive than prescriptive; can value the political factors over any real change

Cross-Cutting Issues

- Multisectoralism
- Client-Centered Care
- Realistic Use of Information

1 Situational Analysis

- A realistic evaluation of the health situation
- Use of demographic, epidemiological, policy, resource, quality and environmental studies to identify the areas where improvement is needed
- Analysis of the whole structure or a certain area

Realistic Rational Planning

1 Situational Analysis
2 Priority Setting
3 Option Appraisal
4 Programming and Budgeting
5 Implementation and Monitoring
6 Evaluation

The planning spiral: a continuous process

From Green, Andrew. *An Introduction to Health Planning in Developing Countries*. Oxford: Oxford University Press, 2006, 244.
Questions to be asked in Situational Analysis

- What are the characteristics of the population? Is there a large percentage of young people? Women?
- What are the physical and socioeconomic characteristics of the area? Is it easy to access? Is it a developing country or transitional?
- What is the political environment? Is health a priority for the government?
- What does the population need? What are the risk factors affecting the population? What are the causes of illness?
- What services are currently being provided and by whom?
- How effective, efficient, and equal are the services?

Cross-Cutting Issues in Situational Analysis

- **Multisectoralism**: Managers need to evaluate the services of all of the sectors, public and private, that are involved in and affect health
- **Client-Centered Care**: The bottom line that needs to be evaluated is whether the population’s needs are being met.
- **Realistic Use of Information**: Managers need to use and accept accurate information, even if it is not flattering.

2. Priority Setting

- From the information gathered in the situational analysis, what are the **goals, targets, and objectives** that you want to achieve?
- **Stakeholder analysis**: who are the players involved and what do they want?
- Be realistic: what can be achieved in the environment you’re in and with the resources you have? Realistic goals mean that they can be reached!

Overall goal: to improve reproductive health in a country…

…but reproductive health is a big field including:

- Family-planning;
- Prenatal, safe delivery, and postnatal care;
- Prevention and appropriate treatment of infertility;
- Management of the consequences of abortion;
- Sexually transmitted infections and HIV/AIDS;
- Other conditions affected by reproduction;
- Human sexuality;
- Breast cancer and cancers of the reproductive system;
- Active discouragement of harmful practices, such as human trafficking.
Identifying Priority Programs

- FAPs; Family doctors
- Local Polyclinic
- District Hospital
- Oblast Hospital
- Family Planning
- Safe Motherhood
- Youth
- Prevention Services

Need to set discrete goals for each of these areas. For example: “decrease maternal mortality by 25% by the year 2015”

Cross-Cutting Issues in Priority Setting

- Multisectoralism: What can be accomplished based on what the various players want and how much they are willing to invest?
- Client-Centered Care: What goals and objectives will ensure that the population will be able to maintain health?
- Realistic Use of Information: Decisions need to be based on the information gleaned during the previous process, not on political, social, or donor priorities alone.

3. Option Appraisal

- Examining the various methods of reaching the targets set and selecting the most feasible ways of doing so
- Evaluate each technique based on its potential impact on the target, the resources available, and the political and social climates
- Balancing cost-effectiveness against patient-centered care
- Develop a package of services and standards of care that will meet the targets; this can include target indicators
- Have champions on both ends: make sure there is someone in power who supports your selected option and that the population wants it!
Packages of Services

- Levels of system described
- Packages prioritized
- Packages defined by level
- Standards of service for each level of system
  - treatment protocols
  - staff
  - equipment, supplies
  - referral system and transportation


Packages of Services: Example of Improving Reproductive Health

<table>
<thead>
<tr>
<th>FAPs: Family doctors</th>
<th>Local Polyclinic</th>
<th>District Hospital</th>
<th>Oblast Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td>pills condoms</td>
<td>IUD injectables</td>
<td>sterilization implants</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Infertility</td>
</tr>
<tr>
<td>Safe Motherhood</td>
<td>deliveries antenatal</td>
<td>Antibiotics</td>
<td>blood, IV, surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>genetic counseling</td>
</tr>
<tr>
<td>Youth</td>
<td>employment clubs</td>
<td>family planning</td>
<td></td>
</tr>
<tr>
<td>Prevention Services</td>
<td>STI education and screening</td>
<td>Vaccinations</td>
<td>Pap smears</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>mammography</td>
</tr>
</tbody>
</table>


Description of System Levels

<table>
<thead>
<tr>
<th>FAPs Family doctors</th>
<th>Local Polyclinic</th>
<th>District Hospital</th>
<th>Oblast Hospital</th>
</tr>
</thead>
</table>


What is the referral process?

<table>
<thead>
<tr>
<th>FAPs Family doctors</th>
<th>Local Polyclinic</th>
<th>District Hospital</th>
<th>Oblast Hospital</th>
</tr>
</thead>
</table>

### Packages of Services

- Example: Safe Deliveries
- What will be done in the community?
- How will referrals be achieved?
- At what level will C-sections, blood, antibiotics, and newborn care be available? What level will provide management of high-risk pregnancies?

### Package of Services: Safe Deliveries

<table>
<thead>
<tr>
<th>FAPs and family doctors</th>
<th>Polyclinic</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assist deliveries</td>
<td>• Antenatal care</td>
<td>• Blood</td>
</tr>
<tr>
<td>• Communications</td>
<td>• Antibiotics</td>
<td>• Surgery</td>
</tr>
<tr>
<td>• Transport</td>
<td>• Referrals</td>
<td>• Antibiotics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• IV fluids</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Newborn care</td>
</tr>
</tbody>
</table>

### Package of Services: Vertical Integration/Referrals

<table>
<thead>
<tr>
<th>FAPs and family doctors</th>
<th>Polyclinic</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assist deliveries</td>
<td>• Antenatal care</td>
<td>• Blood</td>
</tr>
<tr>
<td>• Communications</td>
<td>• Antibiotics</td>
<td>• Surgery</td>
</tr>
<tr>
<td>• Transport</td>
<td>• Referrals</td>
<td>• Antibiotics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• IV fluids</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Newborn care</td>
</tr>
</tbody>
</table>

### Defining Standards

- **Standard Treatment Protocols:**
  - hemorrhage
  - fever
  - antenatal care

---

Defining Standards

<table>
<thead>
<tr>
<th>FAPs and family doctors</th>
<th>Polyclinic</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assist deliveries</td>
<td>• Antenatal care</td>
<td>• Blood</td>
</tr>
<tr>
<td>• Communications</td>
<td>• Antibiotics</td>
<td>• Surgery</td>
</tr>
<tr>
<td>• Transport</td>
<td>• Referrals</td>
<td>• Antibiotics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• IV fluids</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Newborn care</td>
</tr>
</tbody>
</table>

- **Standard Treatment Protocols:**
  - hemorrhage
  - fever
  - antenatal care


Cross-Cutting Issues in Option Appraisal

- Multisectoralism: Ensure that all players have a task that they can accomplish and that they already have a stake in.
- Client-Centered Care: The ultimate package of services needs to be the one most convenient to the client in light of the resources. There needs to exist a standard package of services that all citizens will receive.
- Realistic Use of Information: Don’t create strategies that are undoable.

4. Programming and Budgeting

- Deciding who will implement each change on what level in what time frame and with what money in order to effectively and efficiently deliver the package of services.
- Creation of a time-sensitive work plan that establishes uses for staff, supplies, and facilities that corresponds to the standards set for the country.
- Allocative planning: broad and strategic planning.
- Activity planning: planning concrete actions.
- Focus on decentralizing efforts so that each level is working in its most effective field.
- Involve partners from other sectors to affect all aspects of health.
- Establish effective budgets and financial goals for every activity.
- Make sure to pay attention to effective use of human resources and incentives for health workers.
- Have a realistic idea of risks and weak points.
Levels of Programming (Decentralization)

Health ministry
National strategic plans

Regional health organizations
Regional plans

District health organizations
District plans

NGOs
Organizational plans

Private sector organizations
Business plans

Primary care
Service plans

Primary care
Service plans

Represents an effective and continuous referral system between program levels and funding

Policy formation, technical support, standard setting and monitoring, health advocacy

Policy formation, technical support, standard setting and monitoring, health advocacy

Human resource decisions, finances

Service delivery


Budgets and Costing

- Programs need realistic budgets with reliable funding sources in order to function
- Top-down costing: divides the total cost of a program by the outputs
- Example: Dividing the total cost of a reproductive health program by the number of clients served to yield average cost per patient
- Rough estimate of costs per service delivery
- Bottom-up costing: collects cost information about inputs (staff, supplies, transport, facilities, etc) that go into each output (a normal delivery, one gyn visit, etc.)
- Requires a definition of a standard of service so that budgeters know what exactly goes into each output
- More realistic, but more complicated

Cross-Cutting Issues in Programming and Budgeting

- Multisectoralism: Ensure that all players have a financial stake in the program so that they have a vested interest.
- Client-Centered Care: Organize the decentralization process so that clients can avoid bureaucracy where possible.
- Realistic Use of Information: Create a realistic budget with reasonable prices and costs.
5. Implementation and Monitoring

- Putting the program and budget into practice through enactment of a work plan and timeline
- Deploying the money, training, and resources to the people who can get things done when they need to be done
- Activity planning and implementation
  - Managers play a large role in bridging the gap between policymakers and health staff
  - Keep long term goals in mind! Don’t just hit the implementation milestones
  - Implementation can only happen with a solid and well-planned program

Monitoring

- The manager needs to regularly collect local data on intermediate process indicators to ensure that the program activities are proceeding as they should
- Data and progress can be assessed to evaluate whether changes need to be made to the implementation process
- Monitoring also depends on regular facility visits by the manager to verify data
- Questions to be asked during the monitoring process:
  - How many facilities have met the established standards?
  - Is the work plan on schedule? How can we account and adjust for discrepancies?
  - Is the budget on target? How can we account and adjust for discrepancies?
  - Has the population benefited from the program activities?

Reasons Why Implementation Fails…

- Changes in policies or priorities from those originally programmed
- Resistance to the changes implied in the plan from within or outside of the health system
- Lack of resources, whether financial or real
- Lack of constructive analysis of intermediate process indicators
- Vaguely defined details
- Lack of adequate organizational or managerial structure

*Often, these problems can be averted with good planning in earlier stages!*
Cross-Cutting Issues in Implementation and Monitoring

- **Multisectoralism**: Employ the services of other sectors where appropriate (for example, health promotion campaigns might be best carried out in schools).
- **Client-Centered Care**: It is more important that a program meet a patient’s needs than its time targets without effect.
- **Realistic Use of Information**: Regular collection of accurate data and site visits helps to ensure that the program is progressing smoothly. Be prepared to adjust the program if data shows something to be unsuccessful.

6. Evaluation

- A thorough examination of the success and failures of the program forms the basis for the next situational analysis
- **Formative evaluations** occur while the program is still being carried out and forms the basis of **rolling planning**, which allows for reassessments of programs and the target areas (often every three years or so)
- **Summative evaluations** occur after a program has finished and allow for **perspective planning**, where a new program is developed based on past experience
- Regular financial evaluation ensures that changes in costs due to environmental factors can be adequately represented in the budget

Evaluation Methodology: Stage 1

- Identify the questions that need to be answered:
  - Did the resources arrive?
  - Were the resources sufficient to provide the planned services?
  - Were the resources transformed into services?
  - Were the services provided appropriate, relevant, and adequate?
  - What are/were the objectives of the activity?
  - Were the objectives met? Why or why not?
  - Were the any observed improvements the result of the activity?
  - Were there any other effects of the activity?
Evaluation Methodology: Stage 2

- Choose the indicators that will be used to answer these questions and establish:
  - **Baseline indicators** that describe the situation prior to the activity
  - **Outcome indicators** that describe the situation after the activity
  - **Input indicators** that describe the resources used in the activity
  - **Process indicators** that describe the progress of the activity
- Disaggregate the data according to location, gender, age, etc.
- Collect similar data from facilities where the activity has not taken place so as to have a control group

Evaluation Methodology: Stage 3

- Determine the sources and form of the information to be collected
- Data can either be **qualitative** or **quantitative**
- Sources of data include:
  - Demographic and Health Survey (DHS)
  - Hospital records
  - Vital registration
  - Focus groups and exit interviews with clients
  - Official statistics from ministries
  - Routine reports from managers
- Ensure that the data describes the facilities in question and that the sources are reliable

Evaluation Methodology: Stage 4

- Deciding by whom and how the data will be collected and used
- Need to balance skill and knowledge of the program with objectivity when choosing an evaluation team
- Possible evaluators:
  - Outside consultants
  - Service providers
  - Service users and community members
- Need to have a single team of evaluators for an entire program in order to ensure continuity

Cross-Cutting Issues in Evaluation

- **Multisectoralism:** Data must be collected from all of the sectors who are participating in the activity. Collecting qualitative data from service providers and users who are not in the health sector (i.e. NGOs) can provide a valuable perspective
- **Client-Centered Care:** While statistics are important, qualitative data collected from exit interviews and focus groups provide the best assessment of customer satisfaction. Quality of care indicators can also be employed.
- **Realistic Use of Information:** “Juicing the stats” doesn’t help anyone! Even unsuccessful program data can be useful in planning the next program.
The State Program for the Reproductive Health of the Nation to 2015 (SPRHN)

- Concept paper #244 passed by the Cabinet of Ministers on April 27, 2006
- Program passed by the Cabinet of Ministers by Decree #1849 on December 27, 2006
- Plan of Implementation passed by The Ministry of Health of Ukraine (MOH) and the Academy of Medical Sciences by Decree #372/34 on July 4, 2007

Situation Analysis of Reproductive Health in Ukraine: SPRHN (1)

- Ukraine has an abortion rate three times higher than that of the EU and a relatively low modern contraceptive prevalence rate as compared to Western Europe
- Antenatal and delivery care are very widespread in Ukraine:
  - 99% of women reported seeing a health professional at least once for pregnancy-related reasons from 2002-2007 and practically all births were attended by a skilled attendant*
- However, maternal mortality is still higher in Ukraine than in the EU


Situation Analysis of Reproductive Health in Ukraine: SPRHN (2)

- HIV/AIDS and STIs are a big concern in the region, and the incidence of both are increasing
- Ukraine has an under-five mortality rate of 17 per 1000 live births and a perinatal mortality rate of 10 per 1000 live births* and a higher infant mortality rate per 1000 live births than Western Europe**
- Ukraine has a higher mortality rate from cervical cancer than the EU and a relatively high mortality rate from breast cancer***

***Source: WHO Europe Health for All Database.

Abortions per 1,000 live births in selected European countries (2000, 2006)*

*Source: USAID-funded Together for Health project from The Rationale for Family Planning in Ukraine, Kyiv, 2007.
A PUBLIC HEALTH APPROACH TO PLANNING. Module 1

Modern Contraceptive Use in Ukraine and Elsewhere

Maternal Mortality (maternal deaths per 100,000 live births) in Selected Countries*

HIV Incidence per 10,000 People

*Source: USAID-funded Together for Health project from The Rationale for Family Planning in Ukraine, Kyiv, 2007.
Module 1

Lecture 3: Planning for Health: The Basics of Health Programming

Percentage of Men and Women in Ukraine Who Reported Having an STI in the Past 12 Months (2007)*


Infant Mortality per 1000 Live Births in Selected European Countries (2006)*


Deaths from Cervical Cancer per 100,000 Women in Selected European Countries (2006)*

*Source: WHO Europe Health for All Database.
Deaths from Breast Cancer per 100,000 Women in Selected European Countries (2006)*

<table>
<thead>
<tr>
<th>Country</th>
<th>Deaths from breast cancer (per 100,000 women)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>1.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>3.0</td>
</tr>
<tr>
<td>Romania</td>
<td>2.0</td>
</tr>
<tr>
<td>Russia</td>
<td>1.5</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1.0</td>
</tr>
<tr>
<td>European Union</td>
<td>2.0</td>
</tr>
<tr>
<td>CIS</td>
<td>3.0</td>
</tr>
</tbody>
</table>

*Source: WHO Europe Health for All Database.

Priority Setting: SPRHN

- The situational analysis resulted in a concept paper that defined ten areas where improvements could occur and how to implement improvements.
- From these ten areas, five were chosen. Based on the situational analysis, the SPRHN aims to:
  1. Make pregnancy safer
  2. Improve reproductive health for youth and teenagers
  3. Improve the provision of family planning services and information
  4. Prevent the spread of HIV/AIDS, breast cancer, and cervical cancer
  5. Create appropriate health care management systems

Option Appraisal: SPRHN

- National program that allows for oblast and district counterpart programs
- 21 oblasts have already passed district policies
- Activities were identified by planners from various sectors including:
  1. Health providers
  2. The MOH, oblast and district Health Administrations
  3. The Ministries of Education, Family, Youth, and Sport, and Finance
  4. Social Services
  5. NGO partners
  6. Statistical specialists
### National Program to Local Programs

- National program approved
- Standard package of services defined
- Training in program development in the oblasts by the MOH
- Letters sent to governors and Oblast Health Departments requesting political support
- Oblast programs developed and approved

### Programming and Budgeting: SPRHN

- **Target indicators** were set for each objective and concrete activities were defined for each player in order to reach the target indicators
- Work plans and budgets were established for each objective and activity for each player
- Money allocated from the Ministry of Finance (central), oblast, district, city, and facility budgets

### Example: Making Pregnancy Safer

The target indicator is to reduce maternal mortality by 20%

<table>
<thead>
<tr>
<th>Name of activity</th>
<th>Source of funding</th>
<th>Volume of funding (thousand UAH) including by years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ministry: MOH</td>
<td>total 2007 2008 2009</td>
</tr>
<tr>
<td>ACTIVITY 1.1.2.</td>
<td></td>
<td>total 2 027 872,63 0 212 363 222 981</td>
</tr>
<tr>
<td>Provide obstetric departments with drugs to stop bleeding during emergency cases</td>
<td>Oblast budget 709 755,42 0 74 327 78 043</td>
<td></td>
</tr>
<tr>
<td></td>
<td>district/municipal budgets 1 318 117,21 0 138 036 144 937</td>
<td></td>
</tr>
<tr>
<td></td>
<td>non budget funds</td>
<td>0,00 0 0 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>234 130</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>81 945</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>152 184</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Example (Budgeting): Making Pregnancy Safer**

The target indicator is to reduce maternal mortality by 20%

**Indicator 1**

| Decrease of maternal mortality by 20% |

**Activity 1.1.2**

Provide hemostatic drugs to maternity to be used in emergency cases

<table>
<thead>
<tr>
<th>Activity 1.1.2</th>
<th>Description of the activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>The activity provides for: Implementation of the activity within the period of 2008-2015. The activity is to be funded from the state and local budgets. Estimated number of deliveries in 2006 was equal to 12719. The estimated corresponding number of deliveries complicated by hemorrhage and requiring treatment by drugs listed in column A.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A. Drug Name</th>
<th>Price per unit or box</th>
<th>Number of patients</th>
<th>% increase/decrease</th>
<th>Number of facilities</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refortan</td>
<td>50.00 UAH</td>
<td>1272</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gelotolin</td>
<td>30.00 UAH</td>
<td>1272</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Prostaglandin</td>
<td>20.00 UAH</td>
<td>1272</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Transamcha</td>
<td>75.00 UAH</td>
<td>127</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Contrical</td>
<td>40.00 UAH</td>
<td>191</td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>0.00 UAH</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A. Drug Name</th>
<th>Price per unit or box</th>
<th>Number of patients</th>
<th>% increase/decrease</th>
<th>Number of facilities</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refortan</td>
<td>50.00 UAH</td>
<td>1272</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gelotolin</td>
<td>30.00 UAH</td>
<td>1272</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Prostaglandin</td>
<td>20.00 UAH</td>
<td>1272</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Transamcha</td>
<td>75.00 UAH</td>
<td>127</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Contrical</td>
<td>40.00 UAH</td>
<td>191</td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>0.00 UAH</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A. Drug Name</th>
<th>Price per unit or box</th>
<th>Number of patients</th>
<th>% increase/decrease</th>
<th>Number of facilities</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refortan</td>
<td>50.00 UAH</td>
<td>1272</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gelotolin</td>
<td>30.00 UAH</td>
<td>1272</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Prostaglandin</td>
<td>20.00 UAH</td>
<td>1272</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Transamcha</td>
<td>75.00 UAH</td>
<td>127</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Contrical</td>
<td>40.00 UAH</td>
<td>191</td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>0.00 UAH</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

To take the inflation index into account yes 5%

**Example: Improving the Family Planning System**

The target indicator is to increase the use of modern contraceptive methods for prevention of unintended pregnancy by 20%

<table>
<thead>
<tr>
<th>Name of activity</th>
<th>Source of funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIVITY 3.1.4.</td>
<td>Ministry: MOH</td>
</tr>
</tbody>
</table>

Procure contraceptives for eligible categories of population (youth 18 - 20; women from poor families)

**Source of funding**

<table>
<thead>
<tr>
<th>Source of funding</th>
<th>Volume of funding (thousand UAH) including by years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>7 220 871 0 418 784 659 585 784 906 969 590 1 018 069 1 068 973 1 122 421 1 178 543</td>
</tr>
<tr>
<td>Oblast budget</td>
<td>2 527 305 0 146 574 230 855 274 717 339 356 356 324 374 140 392 848 412 490</td>
</tr>
<tr>
<td>rayon/ municipal budgets</td>
<td>4 693 566 0 272 210 428 730 510 189 630 233 661 745 694 832 729 574 766 053</td>
</tr>
<tr>
<td>non budget funds</td>
<td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td>
</tr>
</tbody>
</table>

Including costs from:

- Oblast budget 131 811 700 0 146 574 168 955 192 399 215 844 239 288 263 231 286 313 177 177 177 177
- rayon/ municipal budgets 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
**Example (Budgeting): Improving the Family Planning System**

The target indicator is to increase the use of modern contraceptive methods for prevention of unintended pregnancy by 20%.

**Indicator 12**
Increase the use of modern contraceptive methods for prevention of unintended pregnancy by 20%.

**Activity 3.1.4**
Procurement of contraceptives for certain population groups (youth 18-20 years old, women from poor families).

**Description of the activity**
Funding of the activity is planned from local budgets. Estimated need in contraceptive methods shown in the table (data sources listed after the table).

**Table: Example of the activity**

<table>
<thead>
<tr>
<th>Name of goods</th>
<th>Price per unit or box</th>
<th>Number of patients</th>
<th>% increase/decrease</th>
<th>Using ratio</th>
<th>Required per year (units/boxes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COC (Combined oral contraceptives)</td>
<td>12.00 UAH</td>
<td>3204</td>
<td>5%</td>
<td>13</td>
<td>1 1 1 1 1 1 1</td>
</tr>
<tr>
<td>(POP) Progestine oral pills</td>
<td>20.00 UAH</td>
<td>289</td>
<td>5%</td>
<td>13</td>
<td>1 1 1 1 1 1 1</td>
</tr>
<tr>
<td>IUD (Intrauterine device)</td>
<td>80.00 UAH</td>
<td>1814</td>
<td>5%</td>
<td>0.2</td>
<td>1 1 1 1 1 1 1</td>
</tr>
<tr>
<td>Condoms</td>
<td>1.00 UAH</td>
<td>1635</td>
<td>5%</td>
<td>120</td>
<td>1 1 1 1 1 1 1</td>
</tr>
<tr>
<td>Injectables</td>
<td>20.00 UAH</td>
<td>37</td>
<td>5%</td>
<td>4</td>
<td>1 1 1 1 1 1 1</td>
</tr>
</tbody>
</table>

**Table: Cost calculations**

<table>
<thead>
<tr>
<th>Name of goods</th>
<th>Price per unit or box</th>
<th>Number of patients</th>
<th>% increase/decrease</th>
<th>Using ratio</th>
<th>Required per year (units/boxes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COC (Combined oral contraceptives)</td>
<td>12.00 UAH</td>
<td>3204</td>
<td>5%</td>
<td>13</td>
<td>1 1 1 1 1 1 1</td>
</tr>
<tr>
<td>(POP) Progestine oral pills</td>
<td>20.00 UAH</td>
<td>289</td>
<td>5%</td>
<td>13</td>
<td>1 1 1 1 1 1 1</td>
</tr>
<tr>
<td>IUD (Intrauterine device)</td>
<td>80.00 UAH</td>
<td>1814</td>
<td>5%</td>
<td>0.2</td>
<td>1 1 1 1 1 1 1</td>
</tr>
<tr>
<td>Condoms</td>
<td>1.00 UAH</td>
<td>1635</td>
<td>5%</td>
<td>120</td>
<td>1 1 1 1 1 1 1</td>
</tr>
<tr>
<td>Injectables</td>
<td>20.00 UAH</td>
<td>37</td>
<td>5%</td>
<td>4</td>
<td>1 1 1 1 1 1 1</td>
</tr>
</tbody>
</table>

**Table: Rate of contraceptive use**

<table>
<thead>
<tr>
<th>Risk group</th>
<th>Group size</th>
<th>Rate of contraceptive use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth (girls 18-20 y.o.)</td>
<td>50000</td>
<td>6.0% 0.5% 2.2% 30.5% 0.0%</td>
</tr>
<tr>
<td>HIV+women**</td>
<td>500</td>
<td>5.5% 0.5% 19.3% 100.0% 1.0%</td>
</tr>
<tr>
<td>Unemployed on social help***</td>
<td>1400</td>
<td>5.5% 0.5% 19.3% 18.6% 1.0%</td>
</tr>
<tr>
<td>Chernobyl disabled</td>
<td>1200</td>
<td>5.5% 0.5% 19.3% 18.6% 1.0%</td>
</tr>
<tr>
<td>Women with pregnancy risks</td>
<td>600</td>
<td>5.5% 0.5% 19.3% 18.6% 1.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk group</th>
<th>Group size</th>
<th>Rate of contraceptive use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth (girls 18-20 y.o.)</td>
<td>50000</td>
<td>6.0% 0.5% 2.2% 30.5% 0.0%</td>
</tr>
<tr>
<td>HIV+women**</td>
<td>500</td>
<td>5.5% 0.5% 19.3% 100.0% 1.0%</td>
</tr>
<tr>
<td>Unemployed on social help***</td>
<td>1400</td>
<td>5.5% 0.5% 19.3% 18.6% 1.0%</td>
</tr>
<tr>
<td>Chernobyl disabled</td>
<td>1200</td>
<td>5.5% 0.5% 19.3% 18.6% 1.0%</td>
</tr>
<tr>
<td>Women with pregnancy risks</td>
<td>600</td>
<td>5.5% 0.5% 19.3% 18.6% 1.0%</td>
</tr>
</tbody>
</table>

**Implementation: SPRHN**

<table>
<thead>
<tr>
<th>Oblast</th>
<th>Event</th>
<th>Date</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volyn</td>
<td>Oblast Coordinating Committee (OCC) meeting</td>
<td>November 8, 2007</td>
<td>Lutsk</td>
</tr>
<tr>
<td>L’viv</td>
<td>OCC meeting</td>
<td>December 14, 2007</td>
<td>L’viv</td>
</tr>
<tr>
<td>Kharkiv</td>
<td>OCC meeting</td>
<td>December 17, 2007</td>
<td>Kharkiv</td>
</tr>
<tr>
<td>Dnipropetrovsk</td>
<td>OCC meeting</td>
<td>February 15, 2008</td>
<td>Dnipropetrovsk</td>
</tr>
<tr>
<td>Vinnytsya</td>
<td>OCC meeting</td>
<td>March 21, 2008</td>
<td>Vinnytsya</td>
</tr>
<tr>
<td>Kharkiv</td>
<td>OCC meeting</td>
<td>May 27, 2008</td>
<td>Kharkiv</td>
</tr>
<tr>
<td>Poltava</td>
<td>NGO &amp; Together for Health project meeting</td>
<td>June 11, 2008</td>
<td>Kremenchuk</td>
</tr>
<tr>
<td>Volyn</td>
<td>OCC meeting</td>
<td>June 17, 2008</td>
<td>Lutsk</td>
</tr>
<tr>
<td>Vinnytsya</td>
<td>OCC meeting</td>
<td>August 28, 2008</td>
<td>Vinnytsya</td>
</tr>
</tbody>
</table>
Monitoring: SPRHN

- The SPRHN has stipulated the hiring of staff at the oblast level to manage and monitor implementation of the project
- There are formative evaluations built into the program every three years to reassess progress and steps forward

Evaluation: SPRHN

- Data collected by local managers from public facility data
- Indicators identified
- Baseline information gathered
- Target indicators established for each year

**Indicator: Reduce maternal mortality by 20% by 2015**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td>17.60</td>
<td>16.8</td>
<td>16.5</td>
<td>16.1</td>
<td>15.7</td>
<td>15.4</td>
<td>15.1</td>
<td>14.7</td>
<td>14.4</td>
<td>14.1</td>
</tr>
</tbody>
</table>

**Indicator: Increase the use of modern contraceptive methods for prevention of unintended pregnancies by 20% by 2015**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td>17.60</td>
<td>16.8</td>
<td>16.5</td>
<td>16.1</td>
<td>15.7</td>
<td>15.4</td>
<td>15.1</td>
<td>14.7</td>
<td>14.4</td>
<td>14.1</td>
</tr>
</tbody>
</table>

Indicators: SPRHN

- Data obtained by local managers from civil sources
- Indicators established
- Basic information collected
- Target indicators defined for every year

**OBJECTIVE 2. Promote RH among adolescents and teenagers**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 2.1: Reduce the rate of unwanted pregnancies for teenagers (15–17 year-old) by 20%</td>
<td>Delivery rate = 9.11</td>
<td>13.7</td>
<td>13.4</td>
<td>13.2</td>
<td>12.9</td>
<td>12.7</td>
<td>12.4</td>
<td>12.2</td>
<td>11.9</td>
<td>11.7</td>
<td>11.2</td>
</tr>
<tr>
<td>Indicator 2.2: Reduce reproductive tract diseases among adolescents (aged 15-17) with 30% (number of teenagers 15-17 y.o. diagnosed with pelvic inflammatory diseases—salpingitis / 1,000 women aged 15-17)</td>
<td>152.8</td>
<td>150</td>
<td>147</td>
<td>143</td>
<td>140</td>
<td>137</td>
<td>133</td>
<td>130</td>
<td>127</td>
<td>125</td>
<td>122</td>
</tr>
<tr>
<td>Indicator 2.3: Increase the percentage of pediatric outpatient departments certified to provide youth-friendly services</td>
<td>0</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td>60</td>
<td>70</td>
<td>80</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>Indicator 2.4: Reduce the adolescent abortion rate (ages 15-17) by 30% (number of abortions / 1,000 women aged 15-17)</td>
<td>4.93</td>
<td>4.85</td>
<td>4.75</td>
<td>4.65</td>
<td>4.55</td>
<td>4.45</td>
<td>4.40</td>
<td>4.30</td>
<td>4.20</td>
<td>4.10</td>
<td>3.95</td>
</tr>
</tbody>
</table>
Summary

1. Situational Analysis
2. Priority Setting
3. Option Appraisal
4. Programming and Budgeting
5. Implementation and Monitoring
6. Evaluation

…Involve multiple sectors, focus on patient-centered care, use realistic data…

…Leads to better service delivery and improved health for the population!
Policy makers are often very distant from the health workers who implement their plans. Managers need to walk a fine line between the two groups in order to ensure that planners keep in mind the realities of the health system and that health workers can effectively employ the vision of the planners in their work. Managers need to act as the ambassadors from one group to the other.

Planning exercises all the elements of good management. Planners have to be good managers.

For the WHO definition of country health planning, see Managerial Process for National Health Development: Guiding Principles for Use in Support of Strategies for Health for All by the Year 2000. This is a good resource for an overview of planning from a global perspective.

There are several theoretical models of health planning, but none of these really explain the process of planning. However, all approaches are cyclical and lead to further planning and improvement.

Comprehensive rationalism is the way that we all wish we could plan. In this approach, planners analyze the entire field and choose priority areas. Then they analyze all possible options for improving the situation and choose the best possible course of action. However, this approach is highly theoretical and does not take into account the political and resource climates in the environment.

This approach is a more focused version of the comprehensive rationalism model. From a broad situational analysis, planners identify target areas and undertake strategic improvements in this area. This model, however, is subject to the whims of the planner and donors. In this approach, there is a risk that less popular health causes will not receive attention.

Incrementalism involves implementing smaller plans that all aim to accomplish a greater goal. Although each individual plan may not directly relate to the overall goal, the idea is to float with the “political winds” in order to accomplish the overall goal in the long run. While this is a more realistic view of planning, it tends to be more descriptive than prescriptive. (For more information on these approaches, see Green, Andrew. An Introduction to Health Planning in Developing Countries. Oxford: Oxford University Press, 2006, 244.)

In reality, this is what planning looks like. This depiction of planning attempts to summarize the theories into a workable model of practice. Again, these are the steps, but they overlap and proceed from each other, sometimes in unpredictable way. In addition, these steps are a part of a continual process of planning, with the evaluation of a program leading to a new situational analysis. In the following slides, we will go into each step in greater depth.

As mentioned above, a realistic depiction of planning acknowledges that it is a continuous cycle of improvement.

There are a few management issues (covered in other modules of this course) that are constant threads through the whole realistic rational planning process. Throughout the planning process, managers need to be mindful of involving partners from
other sectors—gathering supporters and convincing opponents (or performing damage control with them); ensuring that the care delivered remains focused on the patient rather than on a political agenda; and using data to improve care rather than as a way to meet meaningless milestones.

**Slide 13.** Situational analysis involves evaluating the health situation in a country or in a particular sector and identifying areas for improvement. Managers can use epidemiological studies for this purpose or demographic studies, such as the Demographic and Health Surveys (DHS), in order to understand the health profile of a population. Exit interviews with patients, provider observations, facility self-assessments and other tools can provide information on the quality of health care provided. However, it is also important that a manager gets a sense of the resource availability in a country, the willingness and effectiveness of the government to cooperate, and the physical layout of the area to be served.

**Slide 14.** Using these questions, a manager can define a profile for the planning environment. For example, if the majority of a population is women of reproductive age, it might be good for planning to focus on reproductive health and maternal health programs. If the area where the program is to be implemented is a remote rural area, the program might focus on training community-based health workers rather than on central hospitals. It is also very important for a manager to define the services that are already being provided, and by whom, so as to build partnerships and not duplicate services.

**Slide 15.** One of the most important parts of this process is analyzing ALL of the partners that provide health care services, including public facilities, the private sector and NGOs. In this way, planners can get a reasonable idea of health care provision in the country/area as a whole and avoid duplicating services.

**Slide 16.** Based on the health, demographic, policy, resource and environmental profiles, the manager needs to identify areas where change needs to be and can be achieved. Fortunately or unfortunately, this process is a political process as well as a health priorities process. In order for a program to be successfully implemented, it needs philosophical and financial support. Areas chosen for improvement need to appeal to donors and partners. The difficulty of this process is balancing the health care needs of the population with "donor fads."

**Slide 17.** For example, a situational analysis of reproductive health in a country may reveal that family planning, youth issues, safe motherhood, breast cancer, infertility and prevention services are areas where improvement is particularly needed. However, if a new breast cancer project was just started by an international NGO, it might not make sense for a planner to duplicate efforts and incorporate this into their program. In addition, if the government has limited resources and needs to focus on reaching the greatest number of people, focusing on treating infertility—which tends to be an expensive and individual process—might not be the best approach.

**Slide 18.** So, if the target areas in reproductive health in a given country are family planning, safe motherhood, youth services and prevention services, then planners must establish indicator-based goals for each area. For example, based on the data gathered in the situational analysis, a goal might be to reduce maternal mortality by 25% by 2015 or to increase the number of patients receiving family planning counseling services in a certain clinic by 50% in the next year. As these goals are being established, keep in mind the various levels of care needed in order to be able to define activities in the later stages of planning. This diagram is the beginning of a "package of services" matrix that helps plan programs and activities. This part of the process defines the content of the vertical column in red.
Slide 19. Again, keeping in mind the three constant threads in planning, the manager needs to strike a balance between the desires of various structures, the needs of the country based on the data collected and the needs of the patient in terms of quality care.

Slide 20. In this stage, the manager needs to fill in the inside of the matrix and determine the services needed at each level in order to achieve improvement. These services should be defined by the potential impact, the resources needed and the political and social climate of the region. For example, if a country has significant restrictions on the sale and prescription of a certain medication, that medication should be included in the package of services at the higher rather than at the community levels. Additionally, while resource management is important, it is also necessary to balance cost-effectiveness against patient-centeredness. In the field of family planning, for example, abstinence is the most cost-effective method, since it involves no procurement, but it is not the most user-friendly method for couples wishing to prevent unintended pregnancies and STIs.

Slide 21. Defining the package of services means filling in the matrix presented earlier in this presentation. This involves assigning concrete services to each level of care and defining the treatment protocols, staff, equipment and referral system needed to make such a package work.

Slide 22. Here is an example of a completed matrix.

Slide 23. Different services will be provided at different levels of the health care system. For example, the oblast hospital can perform surgery while a family doctor in an ambulatory cannot. It is assumed that each level of the health care system can provide all the services that the levels below it provide.

Slide 24. The referral system is one of the most important parts of defining a package of services. How will patients receive the services they cannot receive where they seek care? Contacts and communication between the levels is important. Efficient and reliable transportation is also necessary for patients to seek help without being inconvenienced. For example, if a pregnant woman comes to a polyclinic with complications about the time she is due to deliver, she will receive much better care if she is provided with an ambulance to take her to the nearest central district hospital and if the doctors there are waiting for her rather than having her find her own transportation and explain her case again to the doctors at the new facility.

Slide 25. The following is an example of defining a package of services, using safe motherhood as an example. This first slide defines the questions that need to be addressed when defining a package of services.

Slide 26. At this level, the planners divide the services between the various levels of care.

Slide 27. At this level, planners decide how patients will be able to move between levels of the system when needed.

Slide 28. One of the most important parts of this process is defining the standards of care that will be applied country- and sector-wide. This involves defining the procedures that will be followed, the staff who will perform the procedures and under what circumstances the procedures should be performed. Often, international sources such as WHO can provide helpful information for defining standards of practice.

Slide 30. In this phase, it is helpful to engage all partners in order to maximize resources. As always, the manager needs to keep in mind the needs of the patient and the data gathered in the situational analysis to ensure that planning addresses real needs.

Slide 31. This is the phase that most people associate with planning. In this phase, the manager must define and assign actual activities that will lead to the successful delivery of the package of services as laid out in the previous phase. These activities can
include trainings, equipment and drug procurement, public education activities or facility renovation. The bodies that will implement these activities should be defined at this stage, and a realistic, time-sensitive work plan must be established that will define an order and time frame for the delivery of services. While it may be tempting to move right into the implementation stage (the next stage) without a complete plan, programming and budgeting are crucial to successful implementation.

**Slide 32.** Decentralization is important at this stage. It ensures that activities are being carried out at the level at which they are most effective. This involves dividing tasks among the different levels of government, the public and private sectors and NGOs, as well as accounting for the flow of money, resources and programming among them.

**Slide 33.** Budgeting makes a program real by ensuring that there is money available for every planned activity. In order to create a realistic budget, it is important to calculate the cost of each component of each activity. For example, if planning a training, a budget might include the costs of the trainers; the facility; rental of a projector or other equipment; flipcharts, manuals and other training supplies; and transportation, lodging and food, if these are provided. If five of these trainings are planned during a year, each of these costs needs to be multiplied by five.

**Slide 34.** If each player has a financial stake in the program, they will be more committed to the program’s success. However, if a non-health player is going to contribute financially to a health program, the player usually wants a well-defined budget and well-planned program, so they can see where the money is going and be sure that the program will succeed. This is just another reason why planners should create reasonable and realistic budgets and programs that lay the foundation for successful implementation and meet real needs.

**Slide 35.** This is the fun part—actually doing the things you planned! Managers take a more ambassadorial role in this phase. They make sure that the health care providers and other players involved in the activities are on board with the goals and targets and that the planners’ vision is fulfilled in reality. This may involve some diplomatic work, especially if the program involves philosophical changes in the way care is provided. As each step is implemented and indicators are met, managers should try to keep the long term goals in mind, to ensure that they are actually accomplishing what they set out to do, and not just meeting milestones.

**Slide 36.** Monitoring throughout the implementation process provides managers with an idea of how the program is progressing and whether anything needs to be revised. It is also a way for planners to keep track of progress. To do this, managers should employ process indicators that define information at the facility and program levels, rather than at a national or district level. For example, rather than looking at maternal mortality rates, a manager might look at the number of women who attended a birth preparation class prior to delivery in a particular facility. The data collection process entails close involvement on the part of the manager. He/she must be in constant contact with health facilities and local managers. If done correctly, however, the data can be used to improve the program and readjust budgeting, activities and timelines when necessary.

**Slide 37.** There are several reasons why implementation sometimes fails—these are just a few. Often, poor implementation is the result of poor planning. If a program is planned well and thoughtfully monitored, implementation should simply be a process of deploying resources.

**Slide 38.** Data collection is the most important part of this phase. If effective monitoring is carried out, planners will be able to improve the program as it is rolling out. Effective
monitoring will also keep goals, such as patient-centeredness, in focus and keep players from other sectors invested and encouraged.

**Slide 39.** Though it might be tempting to rest on one’s laurels after implementing a program, evaluation is just as important as other stages of planning because it lays the foundation for the next round of situational analysis and programming. The foundations for evaluation should be laid earlier in the planning process, so that efficient and effective data collection and feedback systems are in place when they are needed and so data can be collected during the entire programming process.

**Slide 40.** This stage should occur earlier in the planning process. In it, questions should be identified that will assess the success of the program.

**Slide 41.** Once the questions are identified, indicators need to be defined that will answer those questions. These can be standard indicators, such as maternal mortality or the contraceptive prevalence rate, or they can be less conventional indicators, such as the number of referrals in a certain district. Before the program is implemented, baseline data need to be collected so there is a basis for comparison once the program has been implemented. As the program is implemented, data on input indicators and process indicators need to be collected to describe the implementation process. Finally, once the program is completed, data on the final output indicators need to be gathered, both from facilities participating in the program and from “control” facilities that did not participate in the program. This will offer a further basis for comparison when evaluating the effects of the program. Once collected, data can be disaggregated along different demographic and facility lines in order to assess the impact of different factors on the success of the program and the effectiveness of the program with certain groups.

**Slide 42.** Information can be collected in several ways, as noted here. It is important to balance qualitative data (such as information gathered from focus groups or interviews) with quantitative data (gathered from vital registration systems, demographic surveys, hospital records, etc.) Data collection must be performed during the whole programming process.

**Slide 43.** A single team should perform the evaluation of a program. It is important that the team be both objective and knowledgeable about the area and the program.

**Slide 44.** Remember the balancing act of multiple sectors, patient-centeredness and data throughout the evaluation process!

**Slide 45.** In Ukraine, the programming process has been successfully implemented with the State Program Reproductive Health of the Nation up to 2015. This program is a good example of how the realistic rational planning cycle can, and has been, applied in Ukraine.

**Slide 46.** The process began with a situational analysis of the reproductive health sector in Ukraine. Planners—a team from the Ministry of Health (MOH), the USAID-funded Together for Health (TfH) project and others—used data from the Demographic and Health Survey, WHO/Europe’s Health for All database, Ukrainian hospital data, official statistics, focus groups and surveys. Key results are outlined in the following slides.

**Slide 56.** Based on the results of the situational analysis, the planners identified five areas that would improve the health indicators about which they were most concerned. Priority concerns: Maternal mortality; infant mortality    Action: Make pregnancy safer. Priority concerns: STIs, HIV/AIDS, abortion, low contraceptive prevalence. Action: Improve reproductive health for youth and teenagers; improve the provision of family planning services and information. Priority concerns: HIV/AIDS, breast cancer,

Slide 57. The process of appraising the options included development of a package of services that could be deployed at the national and local levels and at different levels of health care provision. For the specific packages of services identified, see the text of SPRHN in Chapter 1, Appendix 1.

Slide 58. This diagram details the development of local oblast programs from the national program.

Slide 59. Programming and budgeting was a very transparent process in the development of the SPRHN because of the involvement of many sectors and donors—everyone wanted to know where their money was going! Several sectors contributed funding; and concrete, time-bound work plans and budgets were developed that described how money and resources would be deployed by different players in certain activities. Activities were developed to accomplish each target indicator.

Slide 60. This is an example of a budget for one of the target indicators. Each activity for each SPRHN indicator has an overall budget...

Slide 61. ...and a specific budget laying out the cost of each element of each activity.

Slide 62. This is the budget for contraceptive procurement, another planned activity.

Slide 64. Implementation of SPRHN was launched with a conference for all the oblasts to explain the process of planning and implementation. Committees were formed in order to oversee the planning. This table illustrates start-up of program implementation in several oblasts. Activities are under way: condoms have been donated by USAID for free distribution to priority populations; trainings have been held for health care workers; education sessions have been conducted for the population; and some oblasts have allotted funding for various activities, like establishment of youth-friendly clinics.

Slide 65. Monitoring is an important part of the SPRHN, since one of the Program goals is to strengthen management systems. Each oblast that implements the program has hired a professional to manage and monitor the program. Every three years, the planners will gather to reassess the progress of the program, the continuing relevance of its goals and needed steps forward.

Slide 66. Again, since strengthening management systems is an important part of SPRHN, evaluation and data collection is an important part of the program. Target indicators were established early in the planning process and activities were defined to reach each target. While the target indicators for the life of the Program are ambitious, the Program sets realistic yearly targets (as shown in the following slides). If these targets are not met, planners will reassess the activities and the plan when they meet every three years.

Slide 68. Planning is one of the most important parts of a manager’s job, especially in the changing health care landscape of Ukraine. By following these concrete steps and being mindful of other sectors, patient-centeredness, and data use, managers can successfully improve the health of the population and strengthen the health system.
Ihor Petrovich sat in his office at the oblast hospital in Inhuletska* Oblast, where he was head doctor, feeling frustrated. He had just spoken with one of the doctors in the hospital who was very upset because she had just lost a patient during childbirth. Ihor Petrovich was rather shaken himself—he had heard of two other maternal deaths in his oblast that year. He could not believe it: in the 21st century, in a modern country, how could a woman lose her life during childbirth? He thought about his wife, pregnant for the second time, and worried about her safety. The birth of their daughter seven years ago had been difficult. What would the birth of this new baby be like? He knew that she would receive better care than most women, since he worked at the hospital, but what would other women do who were not in that situation? Families should be able to have children without worrying about the survival of the mother.

Ihor Petrovich tried to put his worries aside by thinking about the staff meeting held earlier that day. He had introduced his staff to the plan for a new national Program, the State Program Reproductive Health of the Nation up to 2015 (SPRHN). It sounded like an interesting Program and, as an obstetrician-gynecologist, Ihor Petrovich was always interested in new programs dealing with reproductive health. He knew from his work and a recent training he had attended with the Together for Health project that family planning and healthy children went hand in hand—even if his colleagues did not always see the connection. If couples had children when they were physically, financially and emotionally ready, childbirth was easier and they could provide the necessary care and attention to their children. He knew that from his experience with his own family. And he knew that the maternal mortality rate indicated a series of problems in the health care system.

This SPRHN was an opportunity, as far as Ihor Petrovich saw it, to start supporting programs that would address some of the weaknesses in the health care system. He was aware of the high abortion rate and low rate of modern contraceptive use in Ukraine, as compared to Western Europe. Also, the maternal mortality rate was higher in Ukraine than in Western Europe. Not to mention that HIV was rapidly becoming a serious problem in the country. As he sat at his desk, Ihor Petrovich pulled out the information that had been distributed at the staff meeting. The SPRHN had several goals, which Ihor Petrovich reviewed:

- Ensuring conditions for safe maternity
- Shaping reproductive health among youth and children
- Improving the family planning system in Ukraine
- Preserving the reproductive health of the population
- Ensuring efficient Program management

These goals, and the activities envisioned to accomplish them, were really very ambitious. In the end, though, they would benefit the reproductive and maternal health systems in Ukraine. The government planned to buy new equipment, new computers, train doctors, provide free contraception to vulnerable populations and create informational materials about family planning. The work sought to improve all aspects of the health sector and to involve new partners in health care.
work, such as Social Services and NGOs, in areas with limited resources to successfully implement projects.

Ihor Petrovich was impressed with the scope of the work that was planned and he was intrigued by the clear goals and budget. In the past, there had been a Program for improving reproductive health, but it had lacked financial backing. However, this new Program had a clearly defined budget that included contributions from oblast budgets. Ihor Petrovich remembered reading that the Program laid the foundation for complimentary programs at the oblast level. Thinking quickly, he called Vladlen Ivanovich, his colleague and head doctor at the city hospital, and told him he wanted to discuss the idea of setting up such a program in Nevsky Oblast.

Vladlen Ivanovich listened to him and laughed. “Sure,” he said, “It would be great to set up such a program, but where would the money come from?” They both knew that the Oblast Health Department was hard-pressed for funding as it was. There was not enough money to heat buildings, let alone implement a new reproductive health program. Vladlen Ivanovich did not have the time or the energy to dabble in politics. His job was running a hospital, not making policy. He had no desire to fight the politicians. Plus, his facility was considering purchasing a new ultrasound machine. Would that not contribute to improving reproductive health? Vladlen Ivanovich argued that, unlike the new program, the effects of the machine would be immediate. Besides, why was Ihor Petrovich worrying about reproductive health when there were so many other issues to deal with in the oblast?

Ordinarily, Ihor Petrovich would have agreed. But something at the training had made him think. If he wanted to help all the women in his oblast, and not just those who had access to this new ultrasound machine or those, like his wife, who had special connections at the hospital, he would have to make changes at the system-level. The rate of maternal mortality in his oblast was not the result of one or two problems, but the result of a weak health system. Improving it would require strengthening the system as a whole. There would need to be better transportation systems, more skilled professionals trained in modern health care standards, access to evidence-based medicine, better blood transfusion services, better public education about health, new technologies—and funding for all these projects. Could he combine forces with specialists from other fields to create an oblast reproductive health program that could decrease maternal mortality, increase the reproductive health of the population and improve health in general?

After hanging up the phone, Ihor Petrovich compiled data from 2006 about maternal mortality, infant mortality and abortion in his oblast and nationally.²

<table>
<thead>
<tr>
<th></th>
<th>Abortions</th>
<th>Maternal Mortality Ratio (per 100,000 live births)</th>
<th>Infant Mortality Rate (per 1,000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhuletska Oblast</td>
<td>5,498</td>
<td>25.5</td>
<td>8.3</td>
</tr>
<tr>
<td>Ukraine</td>
<td>229,618</td>
<td>15.2</td>
<td>9.8</td>
</tr>
</tbody>
</table>

He knew that these three factors negatively affected the health of the population. He also knew that they could be addressed with a reproductive health program. Ihor Petrovich looked again at the goals of the national Program and was confident that these goals could be beneficial to Inhuletska Oblast. He pulled out a piece of paper and began to brainstorm.

² “Courtesy of Together for Health Project”
DISCUSSION QUESTIONS:

1. Whose plan is more effective, Ihor Petrovich’s or Vladlen Ivanovich’s?
2. Is it Ihor Petrovich’s job as a health care manager to work on policy to improve reproductive health? Why or why not?
3. Where and to whom can Ihor Petrovich look for support? What other institutions, ministries or departments might be interested in supporting such a program? What sort of opposition will he face and from whom? How can Ihor Petrovich make the program appeal to their interests?
4. What should be the priorities for Ihor Petrovich’s program on reproductive health? How can he define targets and objectives? What sort of activities could accomplish those objectives?
5. What sort of indicators would be useful in evaluating and monitoring such a program?
6. What does success mean in a program like this? If something is unsuccessful, how could he establish feedback systems to improve things that are not working?
7. How can Ihor Petrovich solve the financial problem of implementing an oblast-wide program?
8. Should Ihor Petrovich adopt the national Program exactly as is for his oblast? If so, why? If not, how should he alter it?
9. What sort of research does Ihor Petrovich need to do before designing such a program? How can he implement it?

TEACHING NOTES:

Teaching Objectives:

1. Participants should understand the stages of planning a health program;
2. Participants should be able to identify priority areas and target objectives for improving the health of the population;
3. Participants will know which sectors are potential partners in health planning.

The instructor should use the discussion questions to have participants identify what should be done at each stage in planning this program. Participants should be able to explain how Ihor Petrovich would go about a situational analysis, priority setting, objective appraisal, programming and budgeting, implementation and monitoring and evaluation. As participants work out each of these stages, the instructor should keep the focus on the need for cross-sectoral interaction (especially when dealing with opponents), a patient-centered approach, and reliance on sound data. This case might even be taught at the end of the course, since planning a health program involves all other aspects of management.

Situational Analysis: As participants look at the national Program (see Chapter 1, Appendix 1), they may tend to apply the objectives and priorities of the national Program directly to the Nevsky Oblast program. However, as evident in the statistics, Nevsky has certain priorities that differ from the national agenda. For example, in Nevsky Oblast, maternal health is a more pressing issue than at the national level. The instructor should encourage participants to identify areas
where research needs to be conducted and data needs to be collected. In addition, the instructor should push participants to think about other sectors that need to be contacted to do a full survey of the reproductive health situation in Nevsky Oblast.

**Priority setting:** In this phase, the instructor should help participants balance the political aspects of planning with the ultimate goal of improving the health of the nation. Participants should brainstorm possible opponents and try to identify priority areas that both improve the health of the Nevsky population and appease opponents.

**Objective appraisal:** The instructor should lead participants through setting up a matrix for a package of services at different levels of health care provision, keeping in mind what is realistic for each level and what specific services can help improve priority areas. (See Appendices 1 and 2 of this module.)

**Programming and Budgeting:** Participants should be encouraged to brainstorm concrete activities that will accomplish the target set in the previous step. What sort of training is needed for staff? Should more staff be hired? Do facilities need to be altered? What sort of equipment needs to be acquired? How could that be done? The result of this section should be a rough flow chart of activities, at least for one priority area, that defines possible activities. Since planning an entire program is a large undertaking, participants could be divided into groups, with each group addressing a different priority area or objective. With regard to budgeting for each activity, participants should list the resources needed for each activity they plan. Encourage participants to look at real costs and to be realistic about including everything they need, since broad budgets with few specifics often fail.

**Implementation, Monitoring, and Evaluation:** Have participants brainstorm a list of indicators that could be used to describe the activities they have planned (see Chapter 1, Reproductive Health for Health Care Managers for ideas). Where could the information they need come from (surveys, facility data, etc)? How often should data be collected? What sorts of facilities and sectors should it include?
Every country has developed a program of reproductive health services based on the needs of the population, the resources that are available for service delivery, and the political pressures that are exerted by the various constituencies represented in a country. Yet often the process through which critical decisions are made is not explicit, with the result that services are developed in a way that does not correspond to either the real needs of the population or the realities of the country. This paper presents a way that the design process can be made more explicit and more closely meet the needs of multiple constituencies while corresponding to the limitations of budget, staffing and infrastructure that often impede implementation.

The process that is used is the development of a matrix of services that determines the boundaries of a reproductive health program in terms of the packages of services that will be delivered at each level of the health structure, including at the community level. Central to this process is the development of standards of service for each level that defines the staffing requirements, pharmaceutical and supply needs, equipment and physical infrastructure that will be required at each level of the system for each type of service to be offered.

**OVERVIEW**

This paper will lay out a six step process for the planning and management of reproductive health services. This process is based on the experience of countries around the world in the development of these programs and is a synthesis of these experiences. The steps are:

1. Prioritization of program interventions;
2. Development of standards of service;
3. Inventory of facilities/communities;
4. Development of costing standards;
5. Initiation of work plan;
6. Monitoring facility improvement and service delivery.

**1. Prioritization of program interventions**

Countries and organizations are seldom in the position of being able to plan and fund all the activities they would like. Clearly this is true with regard to health programs, including reproductive health programs, where the costs of some types of interventions are very high and budgets are traditionally very limited. For this reason, all organizations make decisions about the relative priorities of different types of programs and base their funding on this prioritization of importance. This process may be either explicit or implicit and many factors are included in this prioritization process, including disease or condition prevalence, impact on the population,
political concerns, international opinion and experience of past activities. However, the process of prioritization is frequently done without the benefit of evidence of what is most important, cost-effective or successful. There have been many attempts to develop a single index to use as the basis of prioritization. Whereas mortality was the earliest one, more attention is now placed on indicators such as Disability-Adjusted Life Years (DALYs) or Quality-Adjusted Life Years (QALYs) that incorporate both mortality and morbidity into a single measure.

Yet, while objective measures, such as mortality, burden of disease and cost-effectiveness, are important in defining priorities, many other factors are included in the final decision-making process. Programs that are highly visible or have strong constituencies may often get a higher priority and more funding. Thus, in considering what will be the priority programs to be included in a package of reproductive health services, it is important that policy makers and planners early on consider the political implications of their proposals and how to solicit the types of support that are required for successful implementation.

2. Development of standards of service

One of the lessons that has been learned about the design and delivery of reproductive health care is the importance of standards of service delivery. Standards define what exactly will be done for each type of patient or each service provided and serve as the basis of training, budgeting and monitoring. The first step in the development of standards is to decide what services will be offered at each level of the health system. For example, at what service delivery level will IUDs be provided? Will the safe motherhood program rely on village midwives and the referral of difficult cases or on supervised deliveries at rural hospitals or at the central hospital? Will community-based distribution (CBD) workers do counseling? The decisions about who will provide what services where define the array of services to be provided at each level of the system. They also define the referral network that will be required for effective programs.

An example of a matrix for safe motherhood services is given below. This example lays out the services to be provided at each level of the infrastructure in a particular country.

<table>
<thead>
<tr>
<th>Community</th>
<th>Health Center</th>
<th>Hospital</th>
<th>Referral Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted delivery</td>
<td>Antenatal care</td>
<td>Caesarian section</td>
<td>Laparoscopy</td>
</tr>
<tr>
<td>Communications</td>
<td>I.V. fluids</td>
<td>Laparotomy</td>
<td>Tertiary antibiotics</td>
</tr>
<tr>
<td>Emergency</td>
<td>Antibiotics</td>
<td>Blood</td>
<td>Amniocentesis</td>
</tr>
<tr>
<td>transportation</td>
<td>Referral</td>
<td>Secondary antibiotics</td>
<td>Fetal monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Control of eclampsia</td>
<td>Specialist obstetricians</td>
</tr>
</tbody>
</table>

Every country will have a different matrix of services, depending on the levels of the infrastructure and the decisions about how and where services are to be delivered. In the example above, the decision has been made to have uncomplicated births in the community with a trained midwife, but some countries will choose a program in which all deliveries are done in health facilities rather than in the community. Similarly, the above example limits caesarian sections to the hospital, but in countries where health centers are staffed by doctors, it may be possible to do caesarian sections at the health center level. Thus, for each country, there will be a different matrix of services based on the available facilities and the choices about how services are to be delivered. The example above shows how the services to be delivered for safe motherhood would be shown in a matrix. A completed matrix of services showing services for other elements of reproductive and primary health is shown in the table at the end of this appendix.
Once the array of services at each level is determined, the staffing requirements (including specialized training) and equipment needed for each output can be determined for each level of service delivery. For example, if counseling is to be provided at all levels, then trained staff and counseling materials will be required at all levels. If for example, Norplant (a contraceptive implant) is to be given in all health centers and hospitals, then staff with specialized training, equipment for Norplant insertion and a sterile room with adequate privacy will be required, as well as local anesthesia and take-home materials for patients about possible side effects and where to go for help, if necessary. Standards will also include patient-centered quality measures such as waiting times, cleanliness of facilities and responsiveness to patient needs.

This mapping out of services at each level of the infrastructure has important implications that go beyond service delivery. One advantage of the matrix format is that it serves to highlight non-clinic interventions, as well as clinic-based activities, so it gives a more complete picture of the total program. It also serves to highlight the connections between the various parts of the system in areas such as referrals and communications.

The hallmark of this development of standards for each level of the health infrastructure is the level of specificity that is required. By insisting on the establishment of specific requirements in terms of staffing, training, equipment, supplies and facilities needed at each level of the system for each type of intervention, the manager is now in a position to estimate the cost of such a package of services, both in terms of capital and recurrent costs. This level of specificity also facilitates the tracking of service delivery in terms of the number of facilities that have the staff, supplies and facilities that meet the standards that have been set.

3. Inventory of facilities/communities

Having defined the standards of service in terms of staffing, equipment and physical facilities, it is then necessary to know what is currently present at each facility, in order to determine what will be needed to get each facility up to standard. For this, a physical inventory of each facility is required. This inventory ascertains the extent to which standards are presently being met, and the shortcomings that will need to be addressed to get the facility up to the standard level of service and quality. Many managers may be reluctant to do this physical inventory, insisting that the information is already available or that transportation is difficult or expensive. However, a visit to every facility is a critical step in the process. This is because few managers actually do have the necessary information and a visit to each facility often uncovers many issues of which managers were previously unaware. During the inventory, it can be noted which facilities meet all the requirements for that level of service delivery or what is still needed to reach the standard. In most situations, few, if any, facilities will meet these standards on the first visit, but many may require only minimal improvements to reach this level. This inventory cannot be a once in a lifetime venture. It must become part of the regular supervisory process, done by normal supervisory staff. For the first few times, however, the supervisor may require assistance to understand the concept.

Once information is collected about the current situation in each facility, a plan can be developed for bridging the gap between what is already available and what is needed at each facility to reach the standard needed for service delivery. This plan will include training, equipping, development of improved logistics systems or other management interventions that are required so standards of service will be met and facilities are able to deliver services.

4. Development of costing standards

One of the traps that many health planners fall into is to do elaborate plans of programs, such as for reproductive health, without considering of the financial constraints that limit implementation. Many plans look more like wish lists than realistic programs, and so are never imple-
mented. One reason for this is that accurate cost information about what will be the true costs of implementing a new program have not been available, and so planners simply use figures that do not accurately represent the situation in their own country.

For this reason, there has been an increasing focus on the collection of cost data for reproductive health services and the methodologies used to determine those costs. This initially came about from discussions surrounding the International Conference on Population and Development (ICPD) in Cairo, at which time both donor and recipient countries were searching for a way to calculate the global costs of implementing the program of action of that conference. During these discussions, figures were used that were based on very approximate estimations of resource requirements, because of the lack of good data regarding actual costs to run a reproductive health program. Since then, several studies have been published measuring the costs of these services3,4, and discussing methodologies to be used for this exercise.

Cost data can be collected in two ways: top down or bottom up, and each has its advantages and disadvantages. Top down costing takes the total cost of a program, such as reproductive health or outpatient services, and allocates these costs on a per output basis. Thus, the total costs of reproductive health services might be divided by the total number of patients to yield the average cost per patient.

Bottom up costing collects cost information about each input that goes into an output. Thus, data on salaries, time spent by each staff on each type of output, supplies, use of operating rooms, transportation, etc. are collected and added together to build up the total cost of an output such as a normal delivery. It is this type of costing that is facilitated by the development of a matrix of services.

Doing bottom up costing requires a definition of what exactly is being costed: what are the specific inputs that are being included in each type of program to be costed. In other words, what are the standards of service? Having developed the standards of service needed for the matrix that is described above, it is a relatively straightforward process to develop the cost of each package of service. Further, the costing of each input, combined with the inventory of facilities that has been done, enables planners and managers to say what are the actual costs of bringing each facility from its present situation up to the level defined in the standards of the matrix. Thus, accurate budgeting and a realistic timeline can be developed for implementation of the program.

Obviously, once the costing of program implementation is done, planners may need to reconsider the feasibility of their proposed matrix. While they may wish to make caesarian sections available at each health center or each district hospital, this may not be realistic given the available budget or staffing. The matrix may need to be reconsidered in light of the cost information. Thus, the planning process is cyclical, in which plans are developed, costed and reconsidered in terms of what is realistic. This is illustrated below:

---


At the end, one should be able to develop a realistic work plan that is within both budgetary and manpower constraints and directed at the priority issues in reproductive health.

5. Initiation of work plan

Having set priorities, developed standards, done an inventory of available resources and costed what will be needed to bring all facilities and programs up to the standards developed, the program manager is ready to begin implementation of the work plan and bring facilities up to the standards described above. While the needs of the manager for the upgrading of facilities will obviously vary with the country and specific situation, as a general rule, managers will need to focus on three key areas: staff, supplies and equipment (including pharmaceuticals and contraceptives) and the physical facilities.

• **Trained and committed staff:** It is apparent that a facility cannot function without staff. Whether the service being provided is reproductive health, surgery or any other field, service delivery begins with the person delivering the service. Staff must be technically competent to provide the appropriate array of services, but this is not sufficient. Staff must also be committed to providing the patient with the best service possible. For this to occur, they must respect the patient and his/her needs and must be willing to take the extra step needed to address these needs. This is a basic element of reproductive health: to value patients' perspectives and meet their needs. This will come from effective training, good supervision, appropriate incentives, and from role modeling by senior staff in the organization. In terms of planning for this to occur, training, and other elements of personnel management will be required.

• **Supplies and equipment:** Services cannot be delivered without staff, and staff cannot function without supplies. Too many countries often leave the procurement, storage, and distribution of supplies to chance. Adequate contraceptives, drugs, supplies and equipment required for the service package are essential for the provision of services to the patient. Excellent work has been done in the area of logistics management, and assistance is available through a wide variety of sources if needed. Inept management, inappropriate financial priorities and corruption must all be addressed to ensure an uninterrupted supply of all equipment and supplies necessary to provide a full array of services.

• **Adequate physical facilities:** Facilities do not have to be beautiful or expensive to serve the needs of the patient, but they need to be functional. They must be clean, provide both visual and auditory privacy for examination and counseling. They must be sufficiently secure for equipment and supplies to be kept safely and for staff and patients to feel safe. In the case of community-based distributors, a suitable site for contraceptive distribution and counseling patients is needed—this will most often be the patients' homes. In addition, with the exception of community-based services, a reliable source of water and energy is also required.

6. Monitoring facility improvement and service delivery

Monitoring this type of approach to program implementation is relatively simple, since the focus is on the improvement of access and quality of the delivery system through the upgrading of individual facilities to a standard level. This incorporates the collection of baseline data obtained

---

2 Elaine M. Murphy, PATH, and Cynthia Steele, AVSC, *Client-Provider Interactions in Family Planning Services: Guidance from Research and Program Experience*.
3 Many donors, including USAID and WHO, can provide assistance in logistics management. Two excellent sources of assistance are Management Sciences for Health and John Snow, Inc., both located in Boston, MA.
through the inventory of facilities, as discussed in the third step. In essence, the monitoring system would include four components and associated indicators:

- Number of facilities that meet the standards set;
- Whether the work plan is on schedule, and where it is not;
- Whether the budget developed in steps 3 and 4 are on target, and what is the variance;
- Whether the population has benefited from the inputs.

With the exception of the last indicator, the data for this type of monitoring would come from the operational information collected through the implementation process, with periodic inventories being done of all facilities. In the case of population benefits, the methodology will be determined by the type of benefit that was identified in step 1 of this process and the data collected as needed.

**Conclusion**

The wide array of services defined by the ICPD Program of action has given many planners pause at how best to implement a reproductive health program. This has been compounded by the many changes that are occurring in the way that services are delivered through a decentralized health structure, using both the private and the public sectors and with an increased emphasis on the financial viability of each type of service. Further, the need to include sectors beyond health to address issues such as youth, gender-based violence, HIV/AIDS and safe motherhood have made implementation more complex and increased the management needs throughout the system. Yet, at the same time, there is a recognition that it is only through such a multi-sectoral approach that real progress will be made in reproductive health. Therefore, there is a need to develop simple approaches to the design and management of health services that will be easy to understand and use, but robust enough to work in a wide variety of settings.

This paper is an attempt to define such a system of planning and management using a matrix of services as the starting point. It is based on work that has been done in many countries around the world and is based on management fundamentals that have been shown to work in many settings over a long period of time.
Table 1: Illustration of a package of services, including reproductive health and other types of first response and preventive services

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Community/Home (workers, who have institutional contacts)</th>
<th>Clinics (or medical institutions of the lowest level that have secure facilities)</th>
<th>Health Center: (a) only surgical departments in polyclinics (b) surgical departments in clinics</th>
<th>Area of the hospital (referral services for the sick)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning</td>
<td>Counseling, giving out of condoms and oral contraceptives</td>
<td>Problems of patient treatment and referral</td>
<td>Injectables, IUDs (a) Norplant, sterilization (b)</td>
<td>Infertility</td>
</tr>
<tr>
<td>Control and treatment of infections of the reproductive organs</td>
<td>Information about safe sex; description of symptoms</td>
<td>Consultations; screening for symptoms; treatment of symptoms</td>
<td>Analysis and proven treatment of asymptomatic problems</td>
<td>Diagnostic procedures; specialized treatments; HIV screenings</td>
</tr>
<tr>
<td>Ante- and postnatal care, normal births, treatment of emergency conditions</td>
<td>Registration of pregnancy; home birth; identification of complications; provision of transportation</td>
<td>Antenatal care; vaccinations; first response; intravenous fluids; antibiotics</td>
<td>Foundations of obstetric care; emergency obstetric care (b); post abortion care</td>
<td>Universal emergency obstetric care; ectopic pregnancies</td>
</tr>
<tr>
<td>Food/nutrition</td>
<td>Diagnosis and treatment of anemia; consultations with pregnant women; vitamin A, folic acid</td>
<td>Management of artificial feeding programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of sick children</td>
<td>Advice about feeding; vitamin A; treatment of high fevers, malaria, diarrhea; seeking medical services (early detection and referral)</td>
<td>Evaluation and classification; oral rehydration therapy and feeding in case of diarrhea; antibiotics in case of infection; anti-malaria medications against fevers</td>
<td>Access and classification: cough, diarrhea, temperature (fever), special foods; treatment of coughs, fevers, malaria, diarrhea, blood in stool, ear infections; referral of complicated cases</td>
<td>Treatment of difficult and complicated cases</td>
</tr>
<tr>
<td>Vaccinations</td>
<td>Management of reports and documents</td>
<td>Vaccinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease control</td>
<td>Water; sanitation; diagnosis of tuberculosis (TB); distribution of TB medication under medical supervision; treatment of malaria</td>
<td>Identification of individuals with a predisposition to TB; distribution of TB medication under medical supervision; treatment of malaria</td>
<td>Diagnostics and treatment of various diseases; provision of medicines against malaria; treatment of complications that require medication</td>
<td>Treatment of difficult and complicated cases</td>
</tr>
<tr>
<td>Treatment services</td>
<td>Treatment of cuts, bruises, breaks and stomach pains</td>
<td>Antibiotics; intravenous fluids</td>
<td>Selected surgical interventions (needs specification)</td>
<td></td>
</tr>
</tbody>
</table>

8 Generally, services that are offered on a lower level of a health care system are also offered on a higher level as needed. Here, they are not included in this table in the columns for higher levels of the health care system.
1. BACKGROUND

During the 1994 International Conference on Population and Development (ICPD) in Cairo, two fundamental changes were introduced into the way in which population and family planning programs had traditionally been viewed. First, the scope of population policies and programs was broadened to address a wider range of reproductive health and human development goals. Second, the world was introduced to a new language for discussing reproductive health: the language of rights. However, despite enthusiasm about the concept, family planning and primary health care programs have moved slowly to include broader facets of reproductive health care. The ICPD Program of Action (POA) reminds reproductive health care program managers of their responsibility to deliver services in a way that responds to the needs of the individual patient with regard to sexuality and reproduction. The reproductive rights advocated at the conference in Cairo are expressed in terms of both freedoms and entitlements, ranging from the right to be free from coercion and abuse, to the right to adequate, accessible services and comprehensive information on all aspects of reproductive health. The problem has come in translating these rights into the delivery of services. Recent evidence from countries around the world indicates that, while most countries have responded to ICPD in reshaping their policies on reproductive health, there has been much less change in the way that services are actually delivered at the community and facility level.

There are many reasons for this:

- There is confusion about what a reproductive health program should include;
- In the context of health sector reform, there is confusion about how an integrated, patient-centered reproductive health program should be managed in a decentralized environment;
- Many countries believe it is too expensive to implement a comprehensive reproductive health program; and
- Program managers are having difficulty recruiting the political support necessary for the implementation of the ICPD goals.

This paper addresses:

- What to include in an essential package of reproductive health services, and how to make this decision, using concepts such as cost-effectiveness, Disability Adjusted

---

9 For a comprehensive summary of the historical content and policy environment prior to Cairo, see L. Ashford (1995). New Perspectives on Population: Lessons Learned from Cairo. Population Bulletin 50:1, Population Reference Bureau (PRB), Washington D.C. The paper goes on to present the broad range of topics which now form part of the population umbrella, reviews key issues, and describes in detail the actions recommended by the international community to achieve the goals specified by the POA.
A PUBLIC HEALTH APPROACH TO PLANNING. Module 1

Life Years (DALYs) and mechanisms for measuring outcomes and making resource allocation decisions;

- Approaches to service delivery, including health system issues, such as an integrated packages of services, decentralization, public-private partnerships and organizational structure;
- A matrix for designing, implementing and monitoring reproductive health services at each level of delivery, and relate this to the recent experience of several countries;
- The real costs associated with a reproductive health approach, how to balance the push toward decentralized, integrated, self-sufficient programs with the realities and needs of specific country environments; and how to assess and recruit political support for the changes that are needed to achieve the goals of the ICPD Program of Action (see Box 1).

ICPD Program of Action

All countries should strive to make accessible through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family planning counseling, information, education, communication and services; education and services for prenatal care, safe delivery, and post-natal care, especially breastfeeding and infant and women’s health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counseling, as appropriate, on human sexuality, reproductive health and responsible parenthood.

2. SERVICE DELIVERY TOOLS: PACKAGES OF SERVICES

The language of the ICPD Program of Action is very broad, calling for the implementation of “the constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems”\(^{12}\). While this is certainly the goal of all countries' programs, few if any countries have the resources available to implement the full program in the next decade. Instead they have begun implementation in those key areas that will have the greatest impact on the health and wellbeing of their populations. The methodology for prioritization will be discussed in Section 6, Epidemiological, Prioritization and Costing Tools: Allocating Resources below. The need to focus resources on actions with the greatest impact has led to the development of packages of services in which individual services are grouped together in order that resources may be used more efficiently and effectively. At the same time, this provides a more transparent mechanism for service prioritization.

Packages of services should have the following characteristics:

- They should specify what is included in the implementation of the service package. This will include staffing needs or estimates, equipment and other related resource

---

\(^{10}\) ICPD Programme of Action, paragraph 7.6

\(^{11}\) The word “services” need not necessarily be interpreted to mean publicly provided services, but could include services delivered through private providers, non-government organizations (NGOs) or community based organizations.

\(^{12}\) ICPD Programme of Action, paragraph 7.2.
requirements. It is this level of specificity that will facilitate the costing of the packages;

- They should be comprehensive and designed to achieve population-based impact targets. Thus, a package for cervical cancer would include not only pap smears or other screening procedures, but treatment measures, mechanisms for referral and follow-up for those who are identified with cervical cancer;

- They should assure equity, and state specifically who will benefit from the package, what the benefits will be, and how those benefits will be achieved. If, for example, a program for youth is to be developed, it should state whether these youth are urban, rural or both, whether in school or employed, how they will be reached by the program and how their participation in the program will make a difference in their lives.

3. DESIGN TOOLS: A PLANNING MODEL FOR A MATRIX OF SERVICE DELIVERY

Deciding what will be delivered in a package of services is only the first step. The next step is to determine how the services will be delivered at each level of the health infrastructure and how the referral system will be organized and coordinated. For example, what do we anticipate will be provided at the community level, e.g., in a safe motherhood program? What services will be provided at a health center, front line hospital or referral hospital? At what level will there be facilities for blood banking? These and other questions which map out the specifics of the delivery system must be answered as part of the planning process. Using the example of safe motherhood, therefore, a matrix of services might look like this:

<table>
<thead>
<tr>
<th>Community</th>
<th>Health Center</th>
<th>Hospital</th>
<th>Referral Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assisted delivery</td>
<td>• Antenatal care</td>
<td>• Caesarian section</td>
<td>• Laparoscopy</td>
</tr>
<tr>
<td>• Communications</td>
<td>• I.V. fluids</td>
<td>• Laparotomy</td>
<td>• Tertiary antibiotics</td>
</tr>
<tr>
<td>• Emergency transportation</td>
<td>• Antibiotics</td>
<td>• Blood</td>
<td>• Amniocentesis</td>
</tr>
<tr>
<td></td>
<td>• Referral</td>
<td>• Secondary antibiotics</td>
<td>• Fetal monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Blood</td>
<td>• Specialist obstetricians</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Control of eclampsia</td>
<td></td>
</tr>
</tbody>
</table>

For example, will the safe motherhood program rely on village midwives and referral of difficult cases or on supervised deliveries at the health center? Will CBD workers also offer counseling? The decisions about who will provide what services where define the array of services to be provided at each level of the system. They also define the referral network that will be required for effective programs.

Once the spectrum of services at each level has been decided, the staffing requirements (including specialized training) and equipment needed for each output at each level of service delivery can be determined. For example, if family planning counseling is to be provided at all levels of a health system, then staff trained in counseling and counseling materials (e.g. samples of contraceptive methods) will be required at all levels. If Norplant is to be given at all health centers and hospitals, then staff with specialized training, equipment for Norplant insertion and removal and a sterile room with adequate privacy will be required, as well as local anesthesia and take-home materials for patients about possible side effects and where to go to get help, if necessary.

13 It should be noted that this matrix assumes that each level of service delivery will include the services of the level(s) below. Thus, for example, health centers would offer assisted deliveries and emergency transportation, in addition to the services listed in the matrix.
The advantage of the matrix framework is that it serves to highlight non-clinic interventions, as well as the clinic-based activities, and thus provides a more comprehensive picture of the total program. Indeed, in designing their matrix for service delivery, providers need to consider not only those interventions which fall within the mandate of the Ministry of Health but which cut across sectors into the remit of other sector ministries (e.g. women and children's affairs, community development, education) and beyond the scope of government players. In the case of programs for youth, for example, integrated approaches which reach youth at the community level or in schools are probably of more importance than a clinic-based program. Non-facility based programs must also be planned as part of the service delivery matrix. In the case of an HIV/AIDS control program, most of the work is done outside health facilities and these, too, must be planned and integrated into the overall package.

Another advantage of this framework is that it highlights the need for connections between the various levels of the system. Referral mechanisms are critical in the case of many programs such as safe motherhood or childhood illness, and a mechanism for implementing these referrals (including transportation and communications) needs to be indicated in the matrix.

An example of a matrix is provided in a table at the end of this Appendix.

4. THE STRUCTURE OF SERVICE DELIVERY

One of the changes which has profoundly influenced how reproductive health services are to be delivered is the recognition that many government systems have not been able to provide adequate services for meeting the needs of their populations. This is true of all types of services, not just reproductive health services, and it has led to a widespread set of reforms in the health sector aimed at improving the quality and efficiency of services. While health sector reform has many facets, three stand out in terms of their almost universal adoption and adaptation by countries around the world and their impact on reproductive health. These are integrated packages of services, decentralization and public-private partnerships.

4.1 Integrated Packages of Services

Most people see an integrated package of services as fundamental to the delivery of the full range of reproductive health services. This is because an integrated package can better meet the needs of the patient. However, integration means different things to different people and this has been a considerable source of confusion, depending on who is speaking to whom.

In its most basic form, integration means the combining of separate things into a single whole. To family planning managers, integration means the merging of family planning with other reproductive health areas, such as safe motherhood or reproductive tract infection prevention. To health managers, it often means combining the various components of health, including reproductive health, into a coordinated program. To health sector reformers, integration means bringing together of multiple sectors that affect health and population as part of an overall restructuring of the health system. Each of these perspectives is equally valid, but each means different things and has diverse benefits and concerns. In this paper, the main focus is on the integration of reproductive health services with other health services so that patients can be offered a range of services to meet their immediate and long term needs.

One of the reasons that most programs have moved to an integrated package of services is that it offers the possibility of both better services and improved cost-effectiveness. Clearly it is more convenient for a patient to have all their needs met at a single facility by a single provider. Furthermore, since many health problems are related, providing integrated services increases the
provider’s ability to see these relationships and take advantage of these opportunities. Asking a patient about her family planning needs when she brings a child for a visit is an obvious example. Integration may also improve cost-effectiveness by using equipment, supplies and personnel for multiple purposes. Having one logistics system or supervisor is generally more efficient than having multiple systems.

However, although integrated systems have the potential for real benefits in both quality and efficiency, there are also some concerns about how integrated programs are managed. As an example, some experts caution that integrating reproductive health into other services may cause a loss of focus on reproductive health and dilute the resources available for reproductive health programs. It is not always true that the integrated service approach is more efficient than the dedicated one, and there are many examples that disprove this theory (such as the example of the immensely successful separate HIV/AIDS program in Uganda\textsuperscript{14}). Many service providers fear that the shift from a concentrated reproductive health program, with resources (often from donors) earmarked solely for family planning and related programs, to a broader based health program which encompasses all aspects of health, beyond the scope of a reproductive health program, will result in less attention paid to reproductive health in favor of other, possibly more visible health problems such as malaria or diarrhea.

It is also clear that the management of integrated services requires far greater management capacity, since resource allocation is more complex and staff training and supervision is more multidimensional. This is often further compounded when a system is decentralized, requiring sophisticated management capacity at each level of the health system (see Section 4.2 on Decentralization below). Nonetheless, the bottom line is that, although difficult to manage, the integrated system is probably better, if you get it right.

The table below indicates the respective advantages of the vertical and integrated approaches\textsuperscript{15}.

\textsuperscript{14} The HIV/AIDS program in Uganda is a comprehensive one, with some aspects of integration with other programs, and managed at different levels of the health system. Previously, the Uganda program was fully integrated into the reproductive health service delivery system but did not achieve a noticeable impact until it was removed and placed under the aegis of a multi-sectoral presidential commission. The unprecedented level of political support received by the HIV/AIDS program was clearly a major factor in its success. However, it will be interesting for participants to review the program and debate whether or not even greater benefits would have resulted from keeping the program integrated, but strengthened through the high level involvement, aggressive information, education and communication (IEC) strategy, and community participation and outreach efforts.

The Respective Advantages of Vertical Programs and Integrated Packages of Service Delivery

<table>
<thead>
<tr>
<th>Management System</th>
<th>Advantages of the Vertical Approach</th>
<th>Advantages of Integrated Packages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning/Budgeting</td>
<td>• Objectives are simple and straightforward.</td>
<td>• Plans made are usually more responsive to the needs of the patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Roles/Responsibilities</td>
<td>• Staff roles are better met.</td>
<td>• Patients' multiple needs are easier to identify.</td>
</tr>
<tr>
<td></td>
<td>• Performance is easier to monitor.</td>
<td>• Staff can see their contribution to the overall success of a combined program, rather than one of many vertical programs.</td>
</tr>
<tr>
<td>Supervision</td>
<td>• It is easier to supervise the performance of discrete tasks.</td>
<td>• Supervision becomes more of a team effort, as clinic staff share common goals and are trained to work together.</td>
</tr>
<tr>
<td>Logistics/Vehicles</td>
<td>• Systems can be simpler since the number of commodities is limited.</td>
<td>• Storage and transportation of items is more efficient.</td>
</tr>
<tr>
<td></td>
<td>• Managing commodities is easier, since staff keep track of a limited number of items.</td>
<td>• Stock control and ordering systems can be unified for all supplies.</td>
</tr>
<tr>
<td></td>
<td>• Dedicated vehicles for a reproductive health program means that transportation to health facilities is more readily available to women with obstetric complications.</td>
<td></td>
</tr>
<tr>
<td>MIS/Monitoring</td>
<td>• Targets are simpler to define and measure.</td>
<td>• Shared objectives and indicators promote a team effort to reach targets.</td>
</tr>
<tr>
<td></td>
<td>• Funds and other resources are easier to track to ensure that they are being used as they were intended.</td>
<td>• Reporting and information systems can be combined and streamlined so that only the most essential information is collected and monitored.</td>
</tr>
<tr>
<td>Patient Services</td>
<td>• Staff may be more knowledgeable in a particular functional area, because their responsibilities are narrowly focused.</td>
<td>• Clinics can serve multiple patient needs in one visit, thereby reducing the time and travel costs.</td>
</tr>
<tr>
<td></td>
<td>• Patient visits can be brief because they are provided with a single service.</td>
<td>• Patients can establish a relationship with an individual provider who serves all their health needs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patients can receive preventive health services such as tetanus immunizations that they might not know they need.</td>
</tr>
</tbody>
</table>
Based on the foregoing, there are some key lessons that can be learned about integration:

- Management of an integrated program requires more sophisticated skills and techniques at each level of implementation. Hence, front line staff must also be able to learn these new skills and adapt to new tasks. However, for these skills to be used to their best advantage and result in increased efficiency, a relatively well functioning health infrastructure is necessary;

- Program integration often requires confronting and dealing with vested interests: for example, front line managers who fear the loss of their “empire;” managers with sources of “additional income” that may be lost; and donors with strong attachments to single programs or certain geographical areas;

- Systems, as well as personnel, must be integrated. These include budgeting and accounting, information systems, logistics, commodity procurement and transportation systems;

- Integrated programs make it more difficult to track the outcomes of specific inputs. This makes it difficult for donors, local managers, and the government to report back on the use and impact of their funds and programs in a given country or sector. In other words, accountability is more complex.

4.2 Decentralization

Decentralization is about the delegation of responsibility and accountability from higher to lower management levels in order to bring both services and decision-making closer to patients’ needs. In so doing, it should provide many potential benefits to both providers and patients; and, for this reason, it has been actively implemented in most countries of the world. However, the form that decentralization eventually takes does not always satisfy the rationale that led to its adoption in the first place.

The transfer of decision-making, responsibility and accountability involves a transfer of power and influence. This political change means that local authorities (for example, district councils and elected local officials) have a key role to play. However, these stakeholders may be driven by diverse constituencies and they often lack the technical competence to appreciate the concerns of health providers. Planning for decentralization may therefore require a careful review of local circumstances and training for local officials.

The primary aim of decentralization is improved efficiency; however, health workers may lack sufficient grounding in the requisite administration and management skills. Again, training has to be provided to meet this need. Training may also need to include communication skills to enable health workers to relate more easily to local communities.

The above comments suggest that the benefits of decentralization are dependent on careful planning and the available capacity within a country to effectively change and manage the new system. Unfortunately, many countries where decentralization has been implemented have not had the benefit of careful planning and services have deteriorated rather than improved. Much has been written about decentralization, and this brief review will deal only with a few key issues:

- **The scope and depth of decentralization:** Management theory postulates that decisions should be made at the level of the system where the competence and in-
formation needed for making decisions exist. In reality, however, the practice might be very different; and usually is. One of the critical issues for decentralization is the management capacity of staff at the local level who frequently lack the technical or political experience needed to manage programs and who require considerable assistance to develop these skills. Before decentralization begins, therefore, there should be a careful assessment of the management capacity of the staff at each level of the infrastructure and assistance should be provided to staff to enable them to assume their new responsibilities in the decentralized environment. Furthermore, it should be noted that not all decisions need to be decentralized simultaneously; a time lag may assist staff to gradually accept the responsibility for decision making as they develop both the political and technical skills necessary for successful management.

- **What to decentralize:** Initially, decisions about what to decentralize tend to be driven by a desire to reduce a bloated central bureaucracy and/or an effort to improve the use of resources by devolving power. This is understandable when there is a universal drive to cut government costs. Increasingly, however, decentralization is also promoted as a way to contribute to strengthening democratic processes and local egalitarianism (reasons which may not necessarily be consistent with the aim of improved efficiency.) This means that decentralization can take several forms: (a) deconcentration of responsibility and accountability within the existing health sector structure; or (b) devolution of central government control to local levels. Whatever the real driving force for change, it is often cloaked in appealing rhetoric which suggests that it is principally to better meet the needs of patients. If so, then whatever form decentralization is expected to take, the decisions should be based on technical considerations and should be made by people who understand service delivery needs and the implications of alternative options. However, the reality is that national and local politics, and especially intra-government politics, play their part too. Worse still, the main decentralization decisions tend to be made at the central government level by people working outside the Ministry of Health and with insufficient consultation with stakeholders. This is not to suggest that decentralization should always be the preferred system. It should be considered, but the implications should be thought through carefully. For example, if the power to make budget and user fee decisions (together with finance and personnel resources) is placed in the hands of local institutions (such as district councils), those decisions may not always be in accord with what health staff considers to be appropriate. The Ministry of Health might therefore find that resource decisions are being determined by district budget priorities and that this is affecting the availability of hospital transport, the maintenance of health facilities and whether health staff can be released for training.

In considering what to decentralize, there are a number of guidelines that are helpful. In general, matters pertaining to staff, such as supervision, hiring and firing, promotions and, if possible, compensation., should be determined locally (although deployment of staff may still be a central government function if there are geographic areas which will not be able to recruit and retain staff). The critical issue is to motivate staff to provide quality services and to have local accountability. This cannot be done from a central administration. Finances should also be managed locally, particularly in the case of funds that are collected locally. There is evidence that patients are willing to pay fees when they see the fees going to improvements in quality, but they do not want to pay when the money disappears to a central bureaucracy.

---

18 Some examples of decentralization for political reasons might include Ethiopia (accommodating regional autonomy), Botswana (social development), and Uganda (greater local accountability).
On the other hand, there are some things that are better done centrally for reasons of efficiency and consistency. One is procurement of commodities. There are enormous economies of scale in purchasing, and a central procurement facility can be more efficient. This also pertains to issues like quality assurance of pharmaceuticals and other procurement issues. Another function that should be maintained centrally is the design of information systems. There must be consistency between decentralized units in terms of indicators to track, data definitions and computerization. Of course, data collection and most data analysis are best done locally.

**The role of the central government:** In a decentralized environment, the role of the central administration will shift from administrative control to policy formulation, technical support, standard setting and monitoring and health advocacy. However, staff at the central level may lack these skills. They may also be unwilling to relinquish the administrative control with which they are more comfortable. Therefore staff at the central level must either be provided with the requisite skills, be posted to more peripheral positions where they can use their administrative skills or they must be retired. This is obviously a difficult part of the decentralization process but, unless central staff members have the solid skills to complement the new roles they will play, they will block the decentralization of power to the periphery.

As part of the information system, the central administration should also maintain a strong emphasis on program and financial monitoring through the use of information systems. Another role of the central administration is to set the standards, which is discussed briefly in Box 2 below. Standards should be based on clinical expertise and resource allocations and therefore done where the expertise is greatest. Another area that is typically more efficient at the national rather than local level is communications, particularly in the age of radio, television and electronic communications. It is very important that there be national messages that are consistent, although local issues, such as translation into local languages or local beliefs, must also be taken into consideration.

**Accountability:** There is a general presumption that decentralization is a way to improve accountability and reduce corruption in the system. However, while decentralization can lower the level of corruption and improve accountability, it can also make it worse by multiplying the number of players with access to funds and power. One issue may be that control is assumed by local politicians, who may not always act in the best interests of those they are meant to represent. Another issue is the need to include women and women’s interests. It is very important that mechanisms be put into place that maintain transparency in the decision-making process and that give control to local people. In their design and delivery, decentralized activities and programs should provide greater opportunities for the involvement of women.

Decentralization can be a good mechanism to improve the quality and efficiency of reproductive health services, but it does not necessarily do this in the absence of solid planning and careful attention to the issues highlighted above.
A PUBLIC HEALTH APPROACH TO PLANNING. Module 1

The Role of Standards

The development of clinical standards is the basis of planning, budgeting, quality assessment and monitoring of the delivery of health services. While it is true that each patient must be treated as an individual, this is not true for each symptom, disease or preventive measure that is taken. For example, for a child with pneumonia, there is generally a best treatment and this is incorporated into a standard treatment protocol. Increasingly, countries are relying on these protocols (sometimes called practice standards) as the most efficient and cost-effective way to provide care.

Standards also provide planners with guidelines on which to base quality and budgets. Standard treatment protocols that have been developed by local or international specialists will have a higher rate of treatment success than the judgement of clinicians whose training and experience may be out of date and unduly influenced by drug companies and other biases. This has been increasingly recognized by countries and international agencies and is the basis of programs such as the World Health Organization’s (WHO) Integrated Management of Childhood Illness (IMCI), and the United Nations Children’s Fund (UNICEF)/WHO Mother-Baby Package. In addition to the clinical standards of treatment, standards will also include patient-centered quality measures such as waiting times, cleanliness of facilities, and responsiveness to patient needs.

4.3 Public-Private Partnerships

The health of a population is a common good and a human right because it is essential to stability and prosperity. Principally for this reason, governments in most countries have, for many years, been the major provider of health care services. However, recent evidence has indicated that, while the government has a major role to play in the financing and regulation of health services, government health services are often inefficient, inequitable and may not achieve the goal of better health for the population. Moreover, studies now show that in almost all countries, the private sector is by far the largest provider of health care, when all types of expenditures and services are taken into consideration. It should also be noted, however, that in many African countries a large part of the for-profit sector is comprised of traditional healers.

Because of the concerns over whether the government actually does provide effective and efficient health care services and the very large role already played by the private sector, recent policy debate has centered on the subject of the relative roles of the public and private sector and how each can best contribute to the overall delivery of health services leading to a healthier population.

One important contribution to this discussion has been the apparent separation of the public and private roles in terms of financing and provision of care. In the past, most government spending was on the delivery of government health services, while most private spending was on the delivery of private services. However, governments finance some private delivery of services while the private sector finances some public services. A good example of the former is the delivery of services through contracts, where the government contracts with a private provider (for example a mission hospital or school) to deliver services that will be included in the overall public system. As for the private financing of public services, there are many examples of charitable

trusts and foundations. The distinction between financing and provision is often viewed through the following framework:\(^{21}\)

<table>
<thead>
<tr>
<th>Financing of Services</th>
<th>Provision of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public</strong></td>
<td><strong>Private</strong></td>
</tr>
<tr>
<td>Public</td>
<td>Public health facilities</td>
</tr>
<tr>
<td>Public hospitals</td>
<td>Vouchers</td>
</tr>
<tr>
<td></td>
<td>Insurance programs</td>
</tr>
<tr>
<td></td>
<td>Social security</td>
</tr>
<tr>
<td>Private</td>
<td>User fees</td>
</tr>
<tr>
<td>Autonomous hospitals</td>
<td>Pharmacies</td>
</tr>
<tr>
<td></td>
<td>Insurance</td>
</tr>
<tr>
<td></td>
<td>Contracts</td>
</tr>
</tbody>
</table>

This model shows that funding for health services may derive from two sources: (i) the government general revenue budget, i.e., taxes; or (ii) private funds, which may be either a fee for service, employee based or private insurance. The diagram shows the same division for provision of services; either the government provides the service directly in the facilities owned and operated by the government itself, or there is private service provision by for-profit or non-profit organizations. In this model, the government can pay for the service but may use private providers as, for example, in contracting with a private provider. Equally, the government may provide services but not finance them through general revenues as, for example, when a government operates an autonomous hospital but requires that the entire operating budget come from direct patient revenue.

However, the distinction between private and public financing and provision is not as clear as we might think. First, services funded and provided by the government are financially supported by taxpayers' money (and also, in some countries, by donor support)—essentially, all the funding originates from the population.

Second, it is commonly thought that the goal of the private sector is profit, while that of the public and non-profit sector is service. This is inaccurate: the goal of all service providers, whether government, non-profit or private-for-profit, is ultimately profit of some sort, be it political, altruistic or financial; hence, all have an interest in delivering services which meet the needs of their patients. While it is true that there are private companies which provide medical services for fees calculated to earn a (market) return on capital investment, many private providers are non-profit organizations while others, especially large industries, have a vested interest in the good health of their employees, and so ensure that their workers have access to on site clinics with good medical services.\(^{22}\) Indeed, worldwide, employers and managers are becoming more aware of the importance of a healthy workforce with families who have access to good medical facilities and are prepared to invest in it for the sake of their businesses. The perceived difference in goals, usually a financial one, must be accounted for if the government and private sector are to work together toward a common aim. Government must, for example, understand that the private sector will not cooperate if it is not profitable – directly or indirectly – for them to do so. This applies not only to


\(^{22}\) For example: (a) large mining companies often provide health services for free or minimal fees in support of their commercial activities; and (b) the Dole pineapple processing plant in the Dominican Republic runs its own medical facilities.
financial profits but also to other considerations, such as consumer confidence. Building on those considerations is an important step in fostering the public-private partnership.

Third, the accounting policies adopted by the government tend to understate the real cost of health services and exaggerate the difference in costs between so-called private and public services. Governments (except for New Zealand) do not account on an accruals basis and budget entirely on a cash basis. The private sector applies more prudent accounting policies, including charges for depreciation, which, even in an inflationary environment, should provide for replacement of assets. Governments’ costing systems tend to be elementary and ignore central overheads, while private organizations cannot. Hence, there has been wide misunderstanding about the differences in the apparent costs of governments and private organizations providing similar services. In a nutshell, governments under-budget, and the real costs of public sector services are not so far removed from those of private organizations. To add to the complexity of this discussion, there are several admissible approaches to costing services and an increasing range of revenue raising techniques.

It is useful to ask why public-private partnerships are seen as necessary to the development of effective and efficient health systems, and why neither strictly public nor strictly private systems are appropriate. It is a reasonable hypothesis that governments can never be as efficient as non-profit or private-for-profit organizations because governments always have the problem of political considerations, which affect the availability of funding, prioritization, the coverage of services across the health sector and so on. Non-profit or private-for-profit organizations are more focused, know their priorities, and are more consistent in following them through.

Some reasons, therefore, why the public health sector might consider developing its collaboration with the private sector:

• Government budgets are strained worldwide, particularly in developing countries. This has affected the level of investment over time. In addition, the availability of donor funds has not kept pace with the demand for services in the social sector. Competing priorities make it extremely unlikely that public funds will, in the foreseeable future, be adequate to pay for all health care needs. This means that governments need to find and use alternative sources of funding, including those of the private sector, to provide adequate resources for all essential services.

• In most countries, the private sector has a long history of involvement in both the provision and financing of health care. Private sector involvement includes the provision of health care by doctors and health facilities, the supply of pharmaceuticals and the creation and operation of health insurance schemes, as well as traditional providers. However, private provision is often of limited scale. It is particularly inadequate in the prevention and control of infectious diseases. For-profit organizations avoid the delivery of services to those either too poor to pay or too remote to make it profitable to deliver services. In countries where equal opportunities are not enforced, women are less likely to be covered by employer-based insurance, as much of their work goes unrecognized in the market or so-called productive sector.

• In many cases, governments have not succeeded in efficiently providing the full range of good quality health care services to large portions of the population. Also in many countries, government-operated health programs commonly fail to reach significant segments of the population at all. In their paper, Birdsall and James argue that government programs do not base decisions on the public good, but rather on the needs of the bureaucracy and the individuals in that bureaucracy. Furthermore, they note that government rules typically increase the cost of services, contributing toward the inefficiency of the services. Other

---

23 Birdsall and James, op. cit.
authors have also noted that government service provision, with its lack of accountability, leads to less innovative and lower quality services, especially where the infrastructure and supervisory systems are weak.

- Unregulated private sector involvement in health care can lead to serious quality and equity problems. As the for-profit private sector is, to a large extent, motivated by the pursuit of financial returns, an inherent feature of unregulated private provision is that providers will ration care to those whose willingness and ability to pay allows providers to make their required profit. Women (and other vulnerable groups such as adolescents), by and large the major users of reproductive health services, are often unable to pay. When private providers cannot make profits (or, as individuals, earn enough money from health care activities), the government must consider taking charge of either the provision, the financing, or both, for specific health care needs.

- One role the government plays is to provide a safety net for hard to reach, difficult to treat, unprofitable parts of the population. Poor women are most likely to be missed, and it has often been said that, in reaching the hard-to-reach, non-profit organizations have been the most successful. Given the high costs of reaching this population, a government program will necessarily look less efficient than a private system that can choose its domain of services and patients. For this reason, measures of efficiency must be carefully scrutinized for comparability. In order to attract private providers to those populations where service delivery is inherently unprofitable, the government will have to find ways to provide incentives.

The above points argue for a closer partnership between public and private providers in order to deliver services to the widest possible population in the most cost-effective way. Neither the private nor the public sector is in a position to provide this alone. Together, there is a chance that this can be achieved.

5. LISTENING TOOLS: FOCUSING ON THE PATIENT

Perhaps the single greatest achievement of the ICPD was the consensus developed around the importance of understanding and meeting the needs of the patient, and of developing a patient-centered approach, to reproductive health interventions. These concepts were embodied in the International Planned Parenthood Federation’s (IPPF) Charter on Sexual and Reproductive Rights (see Box 3).

International Planned Parenthood Federation (IPPF) Rights of the Patient

1. INFORMATION: to learn about the benefits and availability of family planning.
2. ACCESS: to obtain services regardless of sex, creed, color, marital status or location.
3. CHOICE: to decide freely whether to practice family planning and which method to use.
4. SAFETY: to be able to practice safe and effective family planning.
5. PRIVACY: to have a private environment during counseling or services.
6. CONFIDENTIALITY: to be assured that any personal information will remain confidential.
7. DIGNITY: to be treated with courtesy, consideration and attentiveness.
8. COMFORT: to feel comfortable when receiving services.
9. CONTINUITY: to receive contraceptive services and supplies for as long as needed.
10. OPINION: to express views on the services offered.

On one level, this was translated into the shift from the use of demographic indicators for family planning to the measurement of meeting the needs of the individual’s reproductive health intention. It also means that, rather than providing services in a way that is convenient for the provider or the bureaucracy, services should be delivered through an approach that is appropriate to the patient’s needs. Hence the composition of services and their provision should be determined by the needs of the individual patients and the population at large, rather than the interests and political whims of the government. Finally, quality is to be determined not only by technical criteria, but also by patients’ perceptions and needs.

Unfortunately, although the rhetoric of most countries supports these shifts towards patient focus, the reality faced by most patients has changed very little in the years since ICPD. There are many reasons for this:

• Bureaucracies, especially governmental bureaucracies, change slowly if at all, especially when the changes affect the fundamental character of the organization. In an environment where top down decision-making and autocratic, personalized management styles predominate, it is difficult to reorient managers to the bottom up style required for a patient-centered approach.

• Although many countries have adopted the ICPD’s policies, the implications of these policies at the local service delivery level have not been readily understood. Having never seen one in practice, few primary care providers really understand what is meant by a patient-centered approach, which is often different from the traditions with which they grew up. In most societies, men have control, while women have little say in decision making; yet the crux of a patient-centered approach in reproductive health is that women decide what is best for their bodies. For many male providers, supervisors and managers, this is a difficult concept to understand and accept.

• In most countries, primary care providers are underpaid, under-trained and unsupported, leading to demotivated staff and high turnover. Moreover, there is evidence to suggest that many recent changes resulting from health sector reform, such as charging fees for services, have further undermined providers’ confidence and motivation. If fees truly undermine provider motivation, is it because fees are not kept at the local level? Or does instituting fees undermine previously unregulated payments to providers? Conversely, the need for adequate compensation may mean that charging fees, which go toward supplementing meager salaries, means improved quality of services. In some countries, moreover, it was found that fees were an incentive to keep workers in remote areas and, when managed in a transparent manner by local communities, motivated workers to provide better quality services (for example, in Uganda and Tanzania).

• In some regard, the central element of health sector reform is the reorientation of the bureaucracy to the needs of the patient and the provider through a process of reform. Furthermore, it should be noted that the shift to a patient-centered approach is not simply a response to a political mandate. Recent evidence suggests that listening to the concerns and choices of a family planning patient, and meeting her needs and concerns, leads to increased contraceptive continuation rates and has a greater impact on fertility than a more doctor-centered approach. A recent paper which reviewed the impact of a patient-centered approach on program effectiveness concluded the following: “Research and program experience suggest that improvements in patient-provider interactions – especially in the provision of patient-centered information and services -- will lead to increased adoption,  


Appendix 2: The Tools for Adapting to Change

more effective use and continuation of family planning methods as well as to increased patient satisfaction. Here we find a happy convergence of programmatic and demographic goals with principles of informed choice and human rights.\textsuperscript{29} Where structural problems inhibit the new patient-centered, or as stated in the paper “client-centered,” approach, structural changes are required.\textsuperscript{30} An example of this may be found in some countries in Francophone West Africa, where the maternity services are both physically and organizationally separate from the child health services and cannot be accessed simultaneously. Although difficult, the required changes are not impossible, and several countries have begun the journey with considerable success.\textsuperscript{31}

6. EPIDEMIOLOGICAL, PRIORITIZATION AND COSTING TOOLS: ALLOCATING RESOURCES

Countries and organizations are seldom in the position of being able to plan and fund all the activities they would like. Clearly this is true with regard to all health programs, including reproductive health programs, where the costs of some types of interventions are very high and budgets are traditionally very limited. For this reason, all organizations make decisions about the relative priorities of different types of programs, and base their funding on this prioritization of importance. This process may be either explicit or implicit and many factors are included in it, such as disease or condition prevalence, impact on the population, political concerns, international opinion and past experience.

Increasingly, countries are being encouraged to use evidence-based methods for prioritization. Through this process, a variety of quantitative measures are used to weigh alternatives. Perhaps the most common such measure to be used is cost-effectiveness (also known as “technical efficiency”), which is a measure of the ratio of the costs of an output and the effectiveness of the same output. It requires information about both costs and effectiveness, so both types of data must be collected. It should be noted that this focus on quantitative measures undervalues the importance of qualitative measures, such as patient satisfaction.

There are a number of ways of looking at costs, each of which will provide different answers to costs of individual services. For example, a simple approach to costing reproductive health services in a given period of time would be to take the total cost of reproductive health services and divide that amount by the total number of patients to yield the average cost per patient. The apparent advantage of this approach is that only basic data are required and it is simple to understand. However, it is not really that simple. There are many costs that are not directly attributable to reproductive health services but which are shared costs; for example: the costs of the central administration of the Ministry of Health and shared hospital facilities. Different bases for allocating shared costs can be applied, which can result in significant variations in the calculated costs of individual services. Another disadvantage of the simple approach is that it does not inform managers and decisions makers of the costs of individual services, such as a normal delivery or a single clinic visit. A more rigorous approach, which would yield the required detailed cost information, is much more difficult in practice. It demands a relatively sophisticated costing system to be able to allocate costs to specific outputs, and it requires several different costing methodologies to be used to estimate the range of costs. Despite the apparent simplicity of bookkeeping, costing is


\textsuperscript{30} The distinction between “patient” and “client” will be discussed in Module 5 of this manual.

\textsuperscript{31} A good example is Iran, where a complete shift in perspective by providers and managers alike has led to substantial improvements in the quality and effectiveness of the services. Other examples can be seen in the private sector where a more patient-centered approach is central to the ability to market services to patients.
complex and is not an exact science. The only known accurate costs are what accountants refer to as the direct variable costs. So, unless we are using a marginal costing system, when we refer to “actual” (total) costs of delivering specific services, we are referring to a concept, not an exact figure. When amounts are quoted, they are calculated estimates. Nonetheless, cost information is a necessary tool to help managers to better understand the individual inputs that go into each output and, thus, improve planning, logistics and general management.

In addition to cost data, there is a need for data on the potential impact of programs on the population as a measure of effectiveness. More so than cost data, this information has been difficult to both define and measure. The earliest measures relied solely on mortality (such as infant mortality, child mortality or maternal mortality), but mortality data is obviously inadequate to measure the impact of most programs. Polio, for example, is clearly an important health issue but accounts for little mortality. Thus, efforts have been underway to develop more complete measures of not only the mortality but also the morbidity of a particular condition in the population. A very popular measure that is currently being used looks at the total Burden of Disease using a measure of Disability Adjusted Life Years or DALYs. This measure, employed by both The World Bank and WHO, uses sophisticated modeling techniques to develop a single measure that includes both mortality and morbidity. There are, however, serious concerns about the use of DALYs for measuring the impact of programs, especially in reproductive health. These concerns include the following:

- Many interventions in reproductive health are preventive rather than curative, and the DALY methodology does a poor job of factoring prevention into the calculations. The result can be that the most cost-effective preventive programs are not given a high priority using DALY calculations;
- Data are inadequate for good estimates of the prevalence and impact of many of the reproductive health problems in most developing countries, and the collection of this type of data would be extremely expensive;
- The calculations used by WHO are based on a set of assumptions that may not relate well to conditions in most developing countries. One example is life expectancy, where rates from Japan are used. This simplifies the calculations but may yield numbers that are inconsistent with the realities of most developing countries.

Despite these concerns about the use of DALYs, they appear to be the best methodology to measure the epidemiological basis of program effectiveness to date. Work continues to develop a better measure of effectiveness but, for the moment, many countries are using DALYs.

Costs to users or non-users should also be included because these may be what are preventing patients from using services if, for example, the costs (traveling and waiting time, costs of transport and time taken from other activities) are greater than the benefits.

Once data is collected on the costs and effectiveness of potential program interventions, cost effectiveness can be helpful in comparing different alternatives. It may also be used to make informed decisions about what types of programs, activities or medications will have the greatest impact per dollar spent. Cost effectiveness is a powerful tool, as it demystifies the decision-making process and the assumptions underlying the various alternatives. Nevertheless, it is not the only factor in considering how resources should be allocated and identifying priority interventions. Many other considerations such as patient preference, political considerations and feasibility are also factors in resource allocation. Abstinence, for example, is the most cost-effective method of contraception, but it is not necessarily the best method for most people.

---

7. ADVOCACY AND POLITICAL TOOLS: THE POLITICAL DIMENSION

Thus far, issues of the design and delivery of reproductive health have been discussed from a technical perspective. We have raised questions about what works best, what is the underlying medical or managerial evidence to support a particular approach and what will best serve the patient. However, in reality, decisions about what to fund, who will hold power and who will benefit from new programs are largely made in the political arena, not the technical one. The role of the technocrat is to influence the decision-making process rather than attempt to control it. Moreover, with the changes of decentralization, staff at all levels of the system must be more skilled at influencing political decisions and know how information and an understanding of the political process may be used to have the greatest impact. This reality is often overlooked by the technocrats who search for the optimal solution but neglect the need for political support for change. Experience has shown that even the best technical solutions will not be adopted unless attention is given to the development of a political strategy to accompany the technical one.

Most political strategies begin with a stakeholder analysis. Stakeholder analysis typically has three stages:

1. **Players**: Identification of the groups (or individuals) who will be impacted by the decision, and how the decision is likely to be received. In health reform, these will often come from the following groups:
   - Political leaders, religious leaders;
   - Service providers: doctors, nurses, equipment and drug manufacturers;
   - Consumers: individuals, women’s groups and community-based organizations;
   - Payers: this may include employers, government;
   - Ideological groups: political parties, issue advocates, etc.;
   - Health-development groups: donors, banks, NGOs

2. **Power**: Assess the political resources of each group or individual. Are they in a position to block or strongly support the policies? What resources do they have at their disposal? How committed will they be to this issue, either for or against? What are the reasons they support or oppose a particular proposal? Sources of power are varied but often include the following:
   - Money;
   - People, organization, votes;
   - Skills, expertise;
   - Information; and
   - Visibility, legitimacy, influence.

3. **Position**: What stance will each group or individual take towards the particular issue? Will these people be supporters, opponents or indifferent to the decision and how they likely are they to be strongly committed?

   With this type of stakeholder analysis, policy makers are in a position to map out a strategy to gain support for reform. The first thing to do is to take stock of who will be natural supporters of the changes. These people will need to be cultivated so that they could provide visible, tangible support for the changes. Important potential supporters are frequently unaware of either the proposed changes or the implications that would cause them to support such an issue. Potential supporters need to be educated and solicited to gain their support.
Once supporters are recruited, the next step is to see whether some potential opponents can be convinced to either change their position or at least remain neutral. Often, compromises are possible that will not materially affect the reform but will gain important support from those who would otherwise oppose the changes. Opponents of user fees, for example, may change their views if the fees are to be used for specific improvements in health services. While it is naive to think that every opponent can be made into a supporter, it is worth exploring how much potential there is for this.

A third step in the process is to mobilize support for your position or change and try to directly influence decision makers. Politicians may resist reforms that threaten the status quo of their friends, but may be influenced if enough popular support at a grass roots level can be organized. There are a wide variety of ways that decision makers can be influenced depending on the nature of the political system, the type of decision being made and the political and other resources available to the various players. This is particularly true in the area of health reform, in which one can often appeal to the universal “good” of such reforms in terms of better health, better productivity and national pride. However, one should not underestimate the strength or drive of vested interests in derailing even the best reform agendas. Most reforms threaten at least some very powerful and often very rich players. These players can be counted on to actively resist the change. In the end, the success or failure of the reform process depends on the skills, determination and foresight of the reform advocates.

8. CONCLUSION

With the introduction of the concept of reproductive health, the world has taken a much broader look at the needs of both women and men in terms of how they can best achieve their reproductive and health goals, and how these goals relate to the epidemiological and demographic patterns in each country. We have become more aware of the need for programs that span well beyond the boundaries of any one sector, and the need to recruit support and advice from a wide multitude of stakeholders. We have also begun to understand the need for wide ranging reforms in the way that services are planned and delivered in order for services to be more efficient, more effective and more focused on meeting the needs of the patient rather than the rules of the bureaucracy. Yet we know that while these changes can greatly improve the health, happiness and productivity of the world’s poor, the shifts needed at the political and policy implementation level will never become a reality without leadership and support from all strata of the system.

We also know that, even when policies are changed to be consistent with this global perspective of reproductive health, a wide gap will still remain between policy and practice until managers develop the necessary tools for planning, implementing and monitoring the actions which are required to put policy into practice.

This paper is an attempt to highlight some of the tools that are needed for the successful implementation of a reproductive health program. It is meant as a guide for planners and implementers of reproductive health programs who are looking for ways to accelerate the progress that has been achieved since the 1994 International Conference on Population and Development. The Program of Action was deliberately ambitious and has provided the basis for fundamental reappraisal of the way in which health services are delivered in most countries. However, today, it is time to move from policy and rhetoric to better practice and results.
## TABLE OF SERVICES IN BURKINA FASO

<table>
<thead>
<tr>
<th>Service</th>
<th>Home/Community</th>
<th>Clinic</th>
<th>Health Center</th>
<th>Regional Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family planning</strong></td>
<td>• Community support groups; • Distribution of condoms, oral contraceptives, etc.</td>
<td>• Consultations; • Initial screenings; • Distribution of condoms, oral contraceptives, etc.</td>
<td>• Further screenings; • IUDs, Norplant; • Sterilization</td>
<td>• Infertility</td>
</tr>
<tr>
<td><strong>STIs</strong></td>
<td>• Screening; • Information; • Treatment</td>
<td>• Consultations; • Symptom screenings; • Treatment of symptoms</td>
<td>• Consultations; • Symptom screenings; treatment</td>
<td>• Diagnostic procedures; • Alternative medicine treatments; • HIV screenings</td>
</tr>
<tr>
<td><strong>Safe motherhood</strong></td>
<td>• Normal births, • Identification of problems (transport, communication)</td>
<td>• Manual placenta removal; • Pitocin injections, • Transport, • Intravenous fluids, • Antibiotics</td>
<td>• Surgical procedures; • IV fluids; • Post abortion care; • Ectopic pregnancies</td>
<td>• Blood; • Complicated surgeries; • Complicated rehabilitation</td>
</tr>
<tr>
<td><strong>Child health and vaccinations</strong></td>
<td>• Monitoring of food</td>
<td>• Vaccinations</td>
<td>• Treatment of malnutrition and dehydration</td>
<td></td>
</tr>
<tr>
<td><strong>Disease prevention</strong></td>
<td>• Distribution; • Chlorine quinine treatments at home; • Water, waste disposal</td>
<td>• Tracking of TB cases; • Treatment of diarrhea; • Treatment of infections; • IV fluids; • Chlorine quinine; • Antibiotics</td>
<td>• Treatment of complicated illnesses; • Second-line malaria medications</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment services</strong></td>
<td>• Treatment of cuts, bruises and fevers</td>
<td>• Antibiotics; • IV fluids; • Asthma</td>
<td>• Surgical interventions</td>
<td></td>
</tr>
</tbody>
</table>