MANAGING PROGRAMMES
TO IMPROVE CHILD HEALTH

MODULE 2

Planning Implementation

World Health Organization

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Managing Programmes to Improve Child Health

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Planning Implementation

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ARI	Acute respiratory infection
ART	Antiretroviral therapy
ARV	Antiretroviral
CAH	Child and Adolescent Health and Development
CRC	Convention on the Rights of the Child
CHW	Community health worker
DHS	Demographic and Health Survey
EBF	Exclusive breastfeeding
EPI	Expanded Programme on Immunization
ETAT	Emergency triage, assessment and treatment
Hib	Haemophilus influenzae Type B
HIV	Human Immunodeficiency Virus
HMIS	Health management information system
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPT	Intermittent preventive therapy
IRIS	Immune reconstitution inflammatory syndrome
ITN	Insecticide-treated bednets
IYCF	Infant and young child feeding
LBW	Low-birth-weight
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MNCH-HHS	Maternal, Newborn, and Child Health – Household Survey
MOH	Ministry of Health
NGO	Nongovernmental Organization
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
PMTCT	Prevention of mother-to-child transmission (of HIV)
SBA	Skilled birth attendant
SPA	Service Provision Assessment
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Figure 1

Programme Planning and Management Cycle

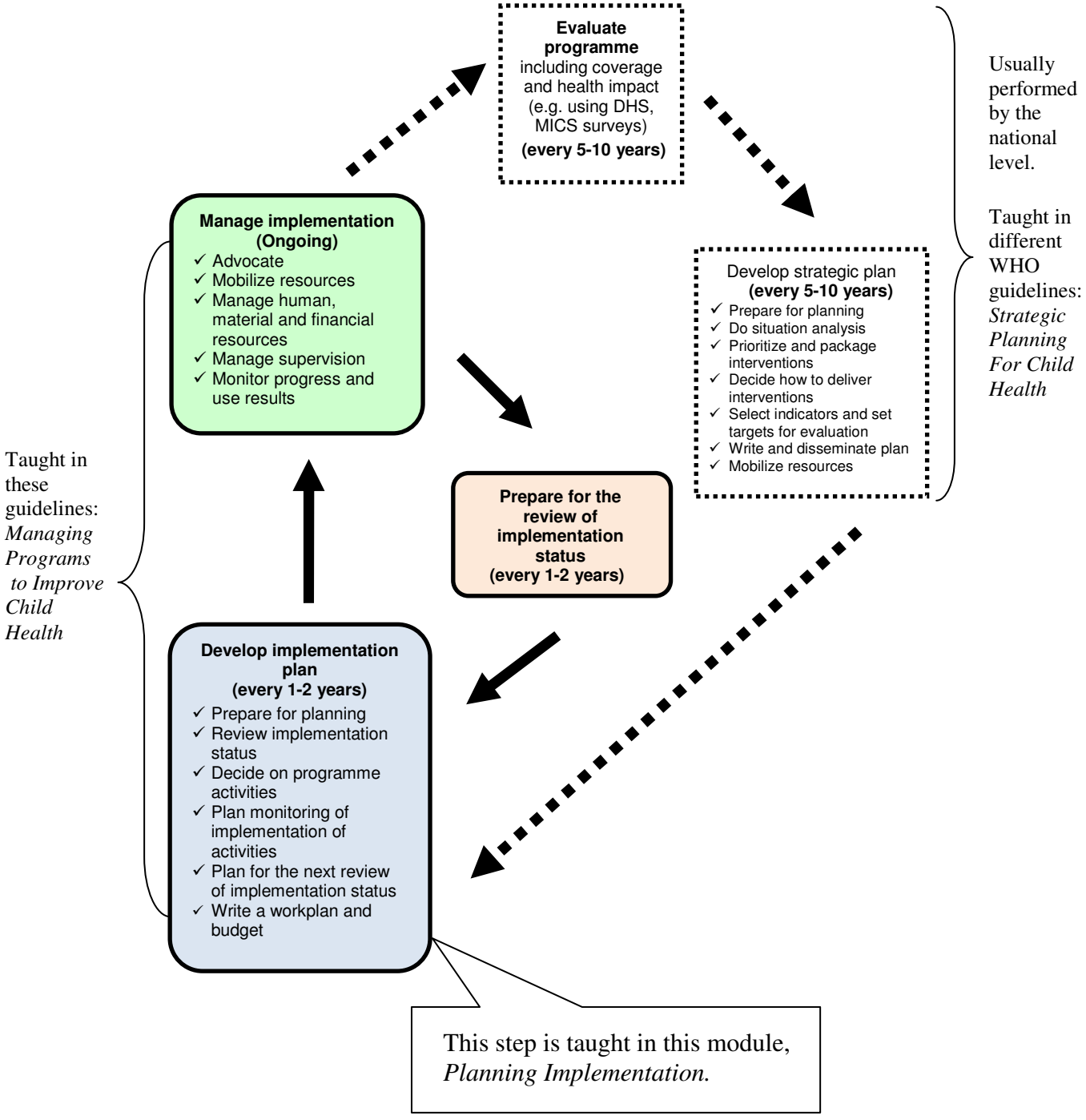
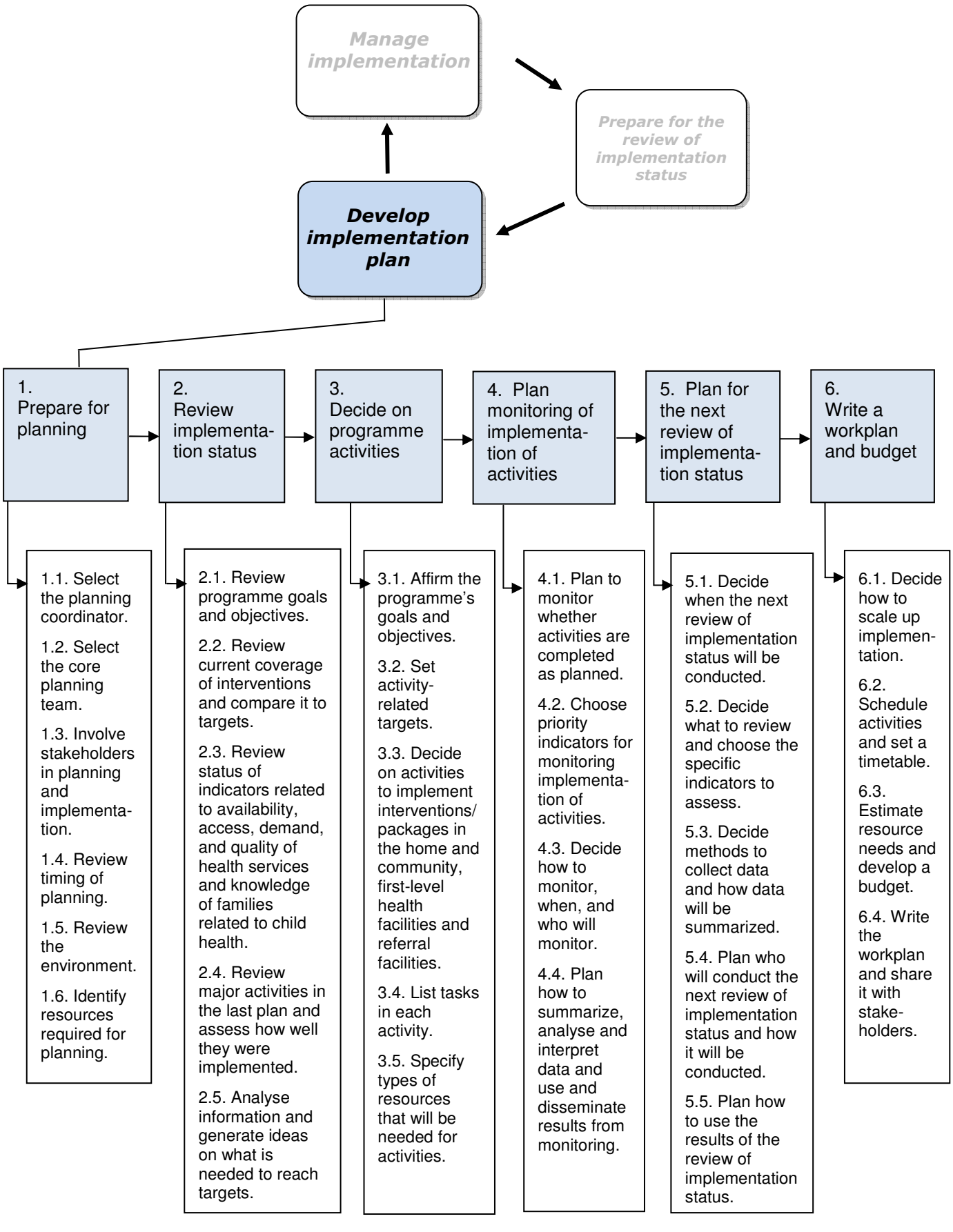


Figure 2

Planning Implementation

The steps to develop an implementation plan are described in this module



Planning Implementation

Introduction

An implementation plan guides the effective delivery of programme interventions by describing in detail how implementation will take place on the ground. The process of developing an implementation plan includes describing the activities for delivering each intervention or intervention package in the home and community, first-level health facilities and referral facilities.

Implementation plans:

- ✓ Are usually developed at each administrative level (national, sub-national and district). Plans at the lowest level (usually the district) are most directly related to field implementation in communities and at first-level health facilities.
- ✓ Are developed relatively frequently, usually every 1–2 years.
- ✓ Should focus on improving coverage with the priority interventions.

Interventions to include in the child health programmes are usually specified in the strategic plan

Decisions about which interventions to include in the child health programme are usually made during strategic planning which is done at the national level every 5–10 years. These decisions have implications for key policies, guidelines, and the provision of essential medicines, vaccines and supplies.

Thus, planning implementation does not usually involve deciding **which** interventions to include, but focuses on **improving coverage** with the priority interventions for the child health programme. However, in some local circumstances, programme managers may choose to implement some of the selected interventions, and not others.

For more information on selecting and prioritising child health interventions, see the WHO guidelines “Strategic Planning for Child Health” (in development).

Learning objectives

At the end of this module, you will understand:

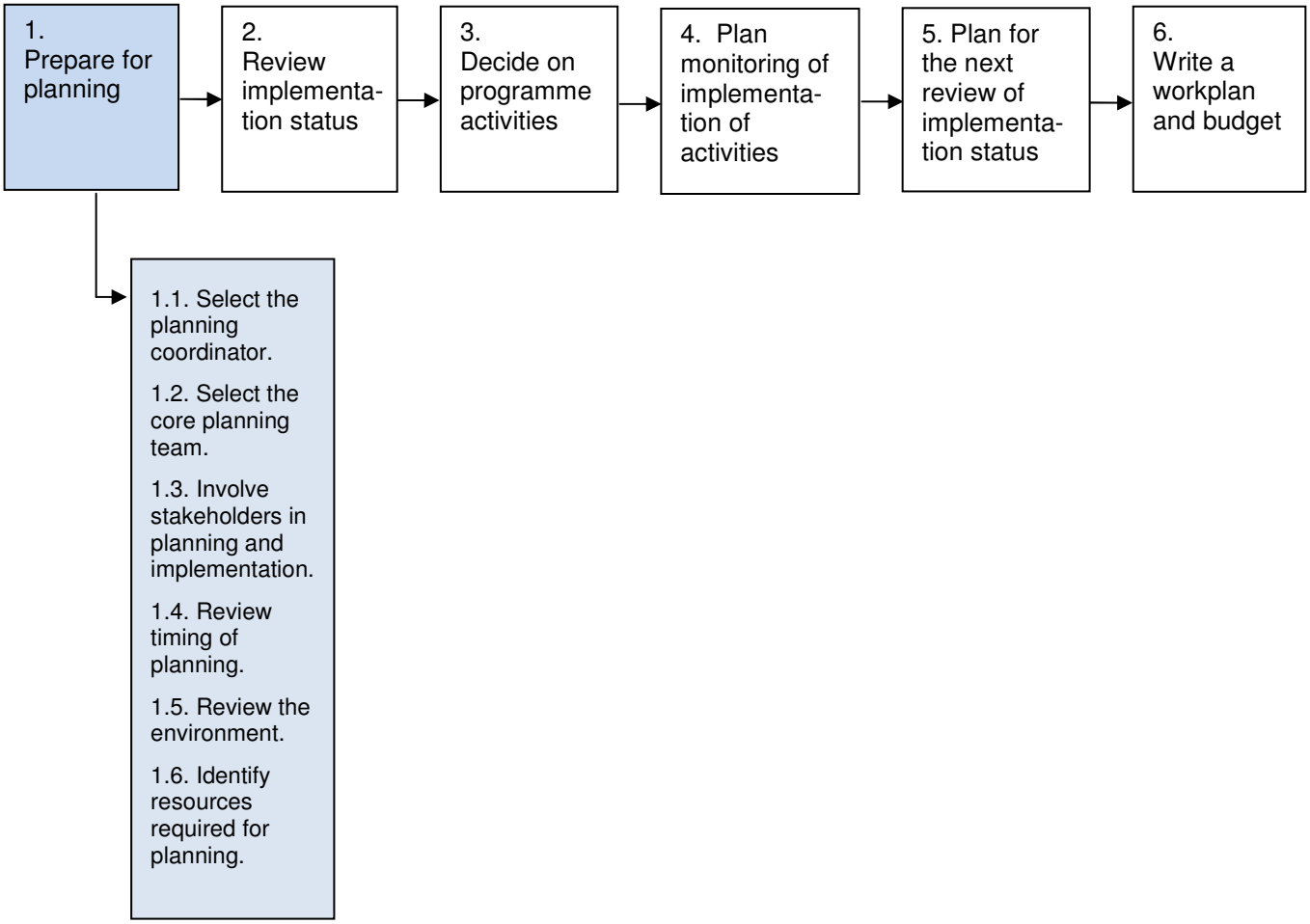
- The preparations needed for developing an implementation plan
- The steps to review implementation status
- Coverage targets and activity-related targets (Note that these were discussed in *Module 1. Introduction.*)
- How to plan to monitor activities
- Components of a workplan and budget
- Some methods for estimating needs and costs for human resources and medicines.

You will have practised the following skills:

- Assessing the current coverage of interventions in your programme, the status of some activity-related indicators, and how well activities were implemented.
- Analysing information and generating ideas on what is needed to meet targets.
- Calculating a target for improved quality of care.
- Selecting activities that will result in increased intervention coverage.
- Choosing priority indicators for monitoring activities and planning how to monitor them.
- Planning the next review of implementation status.
- Estimating human resource needs at a health facility and medicine needs for treatment of pneumonia.
- Reviewing a workplan for a child health programme.

Step 1
Prepare for Planning

Figure 3



Step 1. Prepare for planning

1.1. Identify the planning coordinator

The planning coordinator is responsible for ensuring that an implementation plan is developed. He or she should ideally be an expert in child health issues, with leadership and facilitation skills to ensure progress and to mobilize available technical resources. Coordinators can also play a role in ensuring that plans are used effectively and by the appropriate people. Programme managers often make ideal planning coordinators.

1.2. Select the core planning team

The core planning team is responsible for the work of planning. Therefore, it is important that members have the technical skills required. The planning coordinator is usually responsible for forming this team and organizing the work. To be most efficient, the team should consist of no more than 5-10 people and should be established at the level (national, regional, district) at which planning for implementation is being conducted. *It is important that this team has the support of senior managers and decision makers*–so that the team can get data and talk to staff. This support will also help ensure that the plan will be put into action.

Suggested criteria for selecting team members are listed below:

- ✓ Have necessary technical skills. Skills are needed in several areas, for example: epidemiology, quantitative and qualitative data collection and interpretation, community-based strategies, programme management and implementation, health systems, health policies. Sometimes one individual may have several of these skills.

- ✓ Represent experience at different levels of the health system.

- ✓ Represent programmes along the continuum of care for the mother and child to ensure that experiences from these programmes are considered during development of plans for implementation.

- ✓ Represent partners and stakeholders adequately (see step 1.3 below). It is important to involve partners and stakeholders in planning in order to secure their commitment to the planning process and their investment in implementing the plans.

- ✓ Are available to do the work. Since the work will include review of data, discussion, detailed planning, and writing, team members should be prepared to commit sufficient time.

1.3. Involve stakeholders in planning and implementation

Stakeholders are those who have a ‘stake’ or an interest in child health and child health programmes. They can be individuals, organizations, or informal groups. Stakeholders at the national level may include international groups (e.g. donors, cooperating partners) and national or political groups or figures (e.g. legislators, governors). At national and lower levels, stakeholders may include local governments (e.g. mayor, city council), local community and traditional leaders, medical/nursing associations, academic institutions,

commercial/private for-profit organization (e.g. pharmacies), nonprofit organizations (e.g. NGOs, foundations), community-based organizations (women's groups, mother's groups), faith-based organizations, schools and teachers, health-care workers, users of health services, and community members.

Why involve stakeholders?

Ownership and commitment by stakeholders is critical to ensuring that plans are implemented. It is important, therefore, that sufficient attention is given to the process of consulting with stakeholders during the development of implementation plans at both the central level and the implementation level.

The five main reasons for involving stakeholders in planning are to:

- develop broad ownership of the plan
- identify resources to support the plan
- motivate collective action based on the strengths of the various partners
- design interventions that reflect the local needs (i.e. respect of local culture and existing systems and approaches) to foster sustainability
- harmonize policies, practices, and messages.

How can stakeholders be involved?

Stakeholders can be involved by asking them to:

- participate in the planning team responsible for developing the implementation plan
- provide input on implementation plans
- participate in individual or group discussions to provide input or comments on plans
- participate in programme implementation in areas where they have expertise, or are already working.

Who are key stakeholders?

The key stakeholders will be different in different settings and sectors. Examples are shown in Figure 4. Informal sector stakeholders can be identified by talking to individuals or groups working in communities, for example, local programme managers, local health staff, NGOs, or community leaders.

Stakeholders should have relevant knowledge and skills to contribute to the planning process. Individuals should not be appointed to the planning team solely because of the position they hold in a community or stakeholder organization.

The selection of stakeholders to be involved reflects the purpose of planning and the underlying values and principles. When, for example, a sector-wide approach is to be used, international donor partners will be a key group to consult. Other likely groups could include communities, key ministries, health professionals, and private sector health-care providers. Planning for implementation needs to involve managers and implementers at the health facility and community levels. Planners must ensure that plans will respond to the needs of the community.

Figure 4
EXAMPLE: Key stakeholders by sector

	Informal/Community	Intersectoral	Formal
Who?	Village and religious leaders Women's group leaders Men's group leaders Health providers (traditional birth attendants, traditional healers, volunteer community health workers)	Local development boards Donors Other ministries - finance - agriculture - education, (teachers) - transportation - water and sanitation	Nurses and midwives Doctors in clinical service (including private practice) District/regional medical officers National MOH staff (e.g. Director of Pharmacy) Medical and nursing schools Teaching institutions Professional associations, NGOs and others active in health provision International health organizations
Why?	To include client viewpoints on the problem and the current performance of the child health system To promote ownership of the problem and the potential solutions within the community To mobilize community resources	To mobilize resources (i.e. transport, development funds, communications, education) Involvement may influence policy	To understand staff perceptions (positive and negative) To promote ownership of the problem and the potential solutions To access and improve the data available To harmonize policies, practices and messages
How?	Community-wide meetings Focus groups Community mapping Key informant interviews	Formal meetings Focus group discussions Meetings with intersectoral representatives	Collection and presentation of data Discussion meetings Participation in audits
Challenges?	May not perceive as a problem (lack of knowledge, gender differences in perception) Traditional practices Mistrust of formal health system Cost/lack of resources	Not traditionally included in these sectors Poor communication/ lack of established relationship Partners push their own priorities Some donors focused on certain geographic areas	Limited number of technical, competent staff Underpaid, poor motivation Negative attitudes Inadequate time Competing activities

1.4. Review timing of planning

Schedule planning so that implementation plans will be available when:

- Governments are allocating annual budgets or staff to particular areas.
- Donors are seeking proposals for funding.
- Local or international NGOs are beginning work in a particular district or group of districts.
- Non-health groups or organizations (community-based organizations, religious groups, teachers, etc.) are looking for ways of being involved with local health projects.

Annex A includes a sample schedule for planning tasks.

1.5. Review the environment

The *environment* or *context* in which health programmes operate influences what can be done. Failure to recognize and accommodate environmental factors can lead to an ineffective implementation plan.

Environmental factors that are important for planning include:

- **Local and national politics** – Politics may influence health policies, the budget allocated to health, and the types of activities that will be approved. Some types of international loans require that various health sector reforms, such as decentralization, are put in place. Some governments have a commitment to working toward the MDGs.

- **Health policies and regulations** – Policies may influence elements of a programme including what first-line treatments are available, and whether or not community health workers are allowed to give antibiotics.

- **The health budget** – The amount of money available will influence every aspect of planning including staffing, logistics, and the availability of essential medicines, vaccines and supplies. Donor pressures can be a significant influence.

- **The state of the economy** – Areas with high unemployment may need more attention; areas with a high prevalence of poverty may require feeding programmes and more attention to malnutrition and micronutrient deficiencies. A poor economy means fewer resources will be available for health and infrastructure development.

- **The socio-economic and cultural context** – Literacy and poverty are two factors with serious impact on what activities are needed and what activities are possible. Children in poorer areas or from less advantaged subgroups may have greater needs than those from more affluent areas**.**

- **The risk of natural or man-made disasters**, such as drought, famine, flooding, political conflict, war, and population displacements, may mean there is a need for different technical and logistical support and emergency plans. Areas with seasonal epidemics (cholera, malaria, dysentery, for example) will need to plan for them.

Figure 5

Impact of environment for planning

The environment (context) in which planning is done can affect the:

- ✓ priority given to planning
- ✓ principles and values expressed in the planning process
- ✓ method by which planning is done and time allocated for it
- ✓ resources available
- ✓ role of different stakeholders
- ✓ content and focus of the plan

1.6. Identify resources required for planning

The three main resources needed for planning are personnel, information and funds.

- **Personnel.** As described previously, members are needed for the planning team and to work directly on developing the plan. Stakeholders may be involved directly (as part of the planning team), or indirectly (by providing information or advice). Identify all team members early. Assess their availability and willingness to devote time to the process, and tailor their roles to both their skills and availability.

- **Information.** There are four types of information needed:

    1. Policies, strategies and guidelines relevant to child health

    2. Programme plans for child health, including the most recent implementation plan, strategic plan, proposals or other activity plans

    3. Programme guidelines and tools, including health education and counselling materials, and training materials

    4. Data on child health, related community practices, and health services. Five primary sources of data are listed below. Planning should use existing data as much as possible. A list of possible sources of data should be established, and each source examined for relevant data. Not all sources will have data applicable for district planning.

        - ✓ Routine data from health information systems. These are reported regularly from health facilities to districts and then up the system to the national level. The quality, completeness and timeliness of routine data are highly variable. In developing countries, these systems rarely collect complete data. Community-based health information systems exist in some areas and are often supported by NGOs.
        - ✓ Regular data on programme activities, from monitoring, supervisory visits, and other reports of activities, such as training and community-based activities. This data must be summarized so that the planning team can access and use the information.
        - ✓ Survey-based data. Surveys can be national in scope, or limited to smaller geographic areas. Large sample surveys are often the only valid and reliable method of obtaining good estimates of morbidity and mortality. They may also provide information on caregiver knowledge and practices for child health. Smaller surveys, such as health facility surveys and household surveys, are excellent data sources for the areas in which they are done.
        - ✓ Research data from local and international studies. It is important to carefully review the methods used in the study and the generalizability of the findings before using them.
        - ✓ Qualitative research studies (e.g. focus group discussions). Qualitative data might include information such as local beliefs and perceptions of disease,

local practices related to care of children, care-seeking practices, and barriers to referral.

A list of important information for planning implementation is in Annex A.

- **Funds.** The amount required will depend on a number of factors including:

  — whether planning team members are paid for their time
  — whether stakeholders are paid for their participation
  — whether or not additional data collection is needed
  — the costs of producing the final implementation plan, the number of copies needed, and how it is to be distributed.

  Costs can be kept to a minimum by establishing a small planning team.

EXERCISE A – Prepare for planning

In this exercise, you will review key questions about planning in your child health programme. To prepare for a group discussion, write answers to the questions below.

1. Who usually coordinates planning for implementation?

2. Is planning usually done by a planning team or by the manager alone?

3. Are stakeholders usually involved in the planning process? If yes, what stakeholders are usually involved?

4. What is the timing of planning for implementation?

5. Are the required resources available to support implementation planning?

6. Which of the following factors have significant influence on planning for implementation in your programme? (Circle all that you feel are very significant)

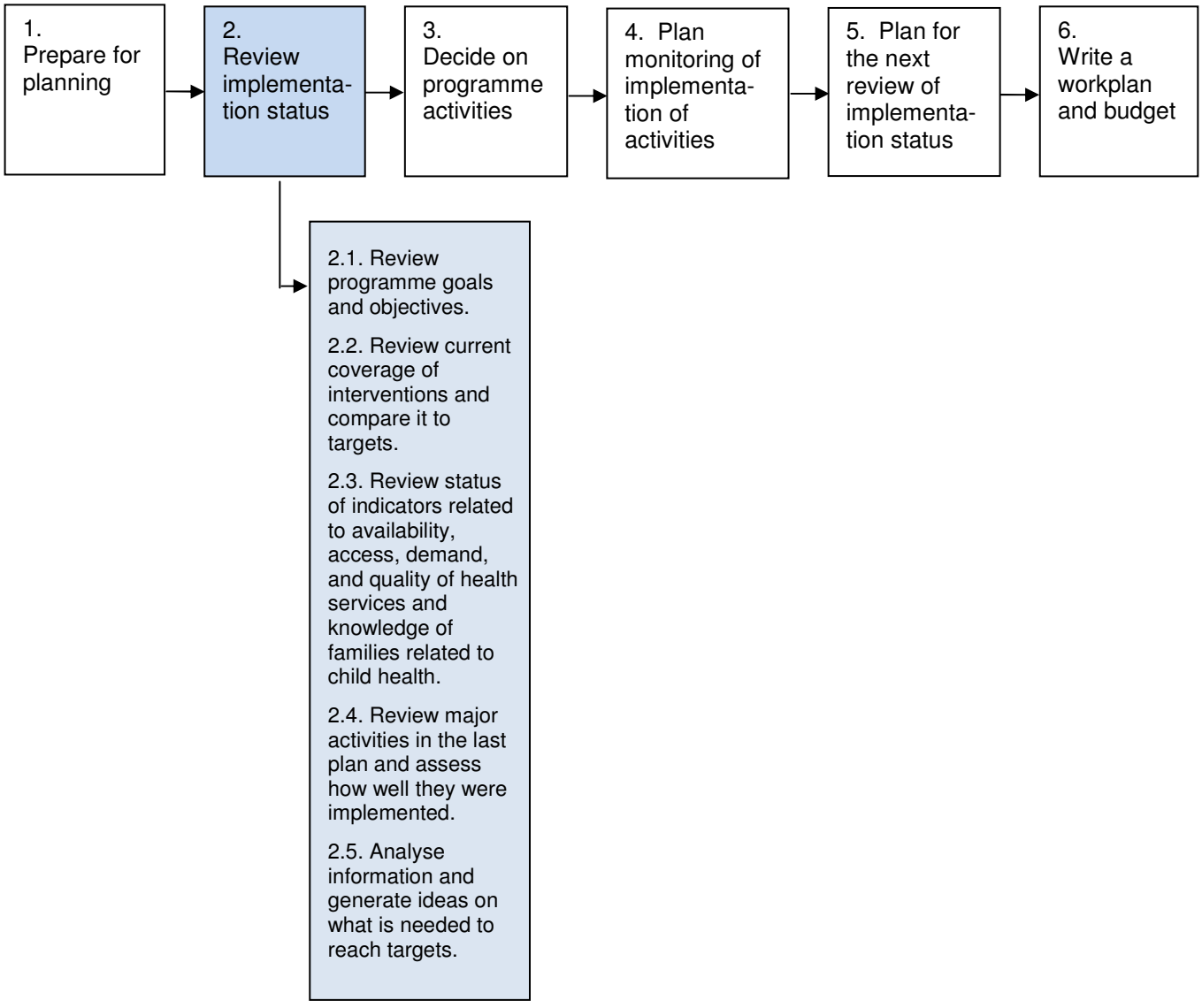
Local and national politics	Health policies	State of the economy
Health budget	Socio-economic context	Risk of natural disasters
Risk of man-made disasters	Other (specify) _____	

7. What problems are commonly encountered during planning? Do you think planning is done well? Do you think it can be improved?

When you have completed this exercise, tell your facilitator that you are ready for the group discussion.

Step 2
Review Implementation Status

Figure 6



Step 2. Review implementation status

The planning team starts by reviewing the status of implementation of the child health programme. An understanding of the current status is essential in order to plan how to implement the programme in the future. This review is an important step in planning at any level–the national, sub-national and district.

A review of implementation status examines a synthesis of monitoring data, supervisory reports and activity reports collected during the year, and may sometimes use survey data (when available) to assess changes in intervention coverage and some other activity-related indicators. It assesses progress in implementing activities and compares results against previously-set targets, such as targets for availability or access. It helps a programme manager determine what is working and not working and provides understanding that is used to make plans for the next implementation cycle. (Some may think of this review as an evaluation; these materials call it a "review" to indicate that it need not consume a lot of resources, does not necessarily require outside evaluators, does not require special data collection, assesses the progress of implementation rather than its impact, and is done annually if possible.)

At the national level, the review may take the form of a short programme review[1] or a situation analysis. At sub-national levels, the review should follow the steps described in this section. These steps apply the same principles but could be less extensive and involve fewer reviewers, depending on resources available, the extent of programme implementation and the amount and types of data available to be reviewed. At the district level, the review might be done on a more limited scale by the planning team or the district health management team.

The planning team will assess implementation status using data that was collected during the previous year and then was compiled and summarized for the review. Data may have come from a variety of sources such as a monitoring data, reports of supervisory visits, administrative reports, previous plans, and maybe health facility surveys, household surveys, special studies, discussions with staff at different levels of the programme, and visits to communities.

2.1 Review programme goals and objectives

Goals and objectives provide the overall direction for child health programmes. Look in current strategic and implementation plans for the child health programme to find statements of the goals and objectives that were established at the national level.

Remember that goals are desired changes in childhood nutritional status, morbidity or mortality.

A key objective of any child health programme is to increase coverage, that is, the proportion of the target population who receives an intervention. For example:

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[1] A rigorous process is described in *Using Data for Reviewing Child Health Programme (Guidelines for conducting short programme reviews)*. Geneva, World Health Organization, 2009. See Annex G for a description of a short programme review.

- ***To increase the proportion of infants under 6 months who are exclusively breastfed***
- ***To increase the proportion of children with diarrhoea who receive ORT***

A programme may have other objectives such as to improve equity in coverage or improve quality of health care. Keep the programme goals and objectives in mind during all assessment and planning for the programme.

2.2 Review current coverage of interventions and compare it to targets

Effective child health interventions and intervention packages were described in *Module 1: Introduction*. The lists are repeated in Annex B in this module. Turn to Annex B now and review the interventions and packages. Some are currently delivered in your programme.

Population-based coverage indicators provide the best measure of how well interventions are reaching the target population. They must be measured in a household survey. Household surveys on the national level, for example a national Demographic and Health Survey (DHS), are usually conducted only every few years because of the resources involved. For routine review of implementation status each year, current data on coverage may not be available, but it is still useful to review the most recent data available. At the district level, coverage data for the district is only available if specific surveys were planned and carried out.

For each stage of the continuum of care, Figure 7 lists interventions, possible population-based coverage indicators, and possible sources of data to measure the indicators. The far right column suggests other data that can help to explain reasons for the current coverage.

Record the current coverage for interventions delivered by your programme (if possible). Also specify any targets that were set for coverage, so that these can be compared to the actual coverage achieved.

Figure 7
Coverage indicators for key child health interventions and possible sources of data to assess them

Period	Intervention	Population-based coverage indicator	Data source[2]	Supporting data
PREGNANCY	Antenatal care (ANC)	% of pregnant women who receive at least 2 ANC visits	DHS MNCH-HHS	Qualitative data for ANC quality
	Tetanus toxoid to all pregnant women	% of newborns protected against tetanus at birth	DHS and MICS MNCH-HHS	
	Intermittent preventive therapy with antimalarials	% of pregnant women who received at least 1 dose of IPT (in endemic areas)	DHS and MICS MNCH-HHS	
	Voluntary counselling and testing for HIV and PMTCT	% of HIV+ women attending ANC who receive ARV prophylaxis		

[2] **DHS** is Demographic and Health Survey. Commonly conducted large-scale surveys include the DHS survey (http://www.measuredhs.com) and UNICEF **MICS**3 survey. (http://www.childinfo.org/ mics/mics3)
MNCH-HHS is the WHO *Maternal, Newborn, and Child Health Household Survey, final draft 2009.* Geneva, World Health Organization, 2009.
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Figure 7 (continued)

Coverage indicators for key child health interventions and possible sources of data to assess them

Period	Intervention	Population-based coverage indicator	Data source	Supporting data
LABOUR AND DELIVERY	Skilled care at birth	% of births attended by skilled birth attendants	DHS and MICS MNCH-HHS	
		% of births that occurred at health facility	DHS and MICS MNCH-HHS	
	Emergency obstetric and newborn care	% of expected obstetric emergencies who receive treatment (met need)	DHS	
		% of pregnant women having a caesarean section	MNCH-HHS	
POSTNATAL/ NEWBORN PERIOD	Postnatal care visit	% of mothers/newborns who had a postnatal check-up in the first two days after birth	DHS and MICS	
	Immediate initiation of breastfeeding	% of newborns put to the breast within 1 hour of birth	DHS and MICS and MNCH-HHS	
INFANTS AND CHILDREN	Exclusive breastfeeding (EBF)	% of infants less than 6 months of age who are exclusively breastfed	DHS and MICS and MNCH-HHS	Qualitative data on barriers to EBF
	Safe and appropriate complementary feeding	% of infants aged 6-9 months who receive breastfeeding and appropriate complementary feeding	DHS and MICS and MNCH-HHS	Qualitative data on local feeding practices
	Vitamin A supplementation	% of children aged 6-59 months who have received a dose of vitamin A in the previous 6 months	DHS and MICS MNCH-HHS for vitamin A	
INFANTS AND CHILDREN	Immunizations against vaccine preventable diseases	% of children aged 12-23 months who are fully vaccinated (national EPI schedule)	DHS and MICS and MNCH-HHS Immunization coverage surveys Facility-based coverage data if reliable	Proportion of children 12-23 months: completely vaccinated; vaccinated with OPV, DPT, HepB
	Sleeping under an insecticide-treated bednet (ITN)	% of children under 5 years sleeping under ITN the previous night (in malaria risk areas)	DHS and MICS and MNCH-HHS Special studies	Qualitative data on net pricing, distribution and re-impregnation
	Treatment of common childhood illness	% of children under 5 years with fast/difficult breathing who received an antibiotic	DHS and MICS and MNCH-HHS Community-based surveillance data	Qualitative data on barriers to recognition of illness, home care, and care-seeking
		% of children under 5 years with fast/difficult breathing taken to a health provider for care		
		% of children under 5 years with fever who received an antimalarial		
		% of children under 5 years with diarrhoea who received ORT		

2.3 Review status of indicators related to availability, access, demand and quality of health services and knowledge of families related to child health

Programme activities are the work that is done to implement interventions effectively. Activities are planned and conducted for a reason, such as to increase the availability of services to the target population and their access to the services, to improve the demand for the services, and to improve the quality of the services provided for the target population. Most activities will affect one or more of these aspects.

For example, training first-level health workers in IMCI in additional facilities would increase quality of services and will also have a role in increasing availability and access to IMCI case management. Providing essential medicines at those facilities would also increase access and quality. Training community health workers (CHWs) to promote and counsel about key family and community practices would increase the availability of counselling, should make it more accessible, and should also increase demand for case management services.

Figure 8

Availability, access, demand, quality, knowledge

Availability means that the health services (preventive and treatment) are available to those who need them. For example, the availability of counselling on breastfeeding (preventive service) can be improved by training health workers on breastfeeding counselling. The availability of treatment services can be improved by increasing the opening hours of the clinic, by increasing the number of health workers available to run the clinic, and by ensuring regular supplies of necessary medicines.

Access means that caregivers are able to reach the health services, when they are available. Possible barriers to access include geographic distance, financial barriers (unable to afford costs of transport, goods or services), cultural barriers (husband or other family members may not agree for women to take their sick children to a health facility on their own), or time limitations.

Demand means that clients are motivated to seek and make use of the health services. Improved demand indicates that clients have knowledge of the availability and benefits of the services and are motivated to use them.

Quality means that the health services are provided according to technical standards, and in a way that is appropriate for the target population. Increasing the quality of a service often increases demand for it.

Knowledge of families and communities means that the caregivers know about the appropriate home care practices during health and illness, as well as when and where to seek care outside the home.

Figure 9 (page 20) lists major intervention packages for child health and some activity-related indicators. Data on availability, access, demand and quality of health services, and knowledge of families are usually difficult to find but are very useful in planning implementation. Appropriate sources of these data are monitoring reports, activity reports, and, when they are available, health facility surveys and small-sample household surveys. If supervision is done and reported well, many of these indicators can also be calculated from supervisory visit data.

Data are collected over time to track whether activities were **implemented** in the past year and to what extent, for example:

- 6 of the 10 planned IMCI training courses for first-level health facility workers were conducted
- CHWs in 32 of the planned 40 villages were recruited and trained to promote key family and community practices
- All of the planned 2000 c-IMCI counselling cards were printed and distributed to CHWs
- 48% of planned supervisory visits were completed last year

Then the data are used to calculate the **results** of activities, that is, improvements (or declines) in availability, access, demand, quality and knowledge. For example:

- 40% of health facilities have at least 60% of health workers caring for children trained in IMCI
- 35% of health facilities had no stock-outs of essential medicines and supplies for managing common childhood illnesses in the past 3 months
- 53% of villages in the district have a CHW trained to provide education on key family and community practices
- 85% of newly trained CHWs conducted 10 or more household visits to promote family and community practices in the previous month
- 66% of first-level health facilities received a supervisory visit in the previous 6 months
- 80% of sick children attending health facilities who need an antibiotic and/or an antimalarial were prescribed the medicine correctly

Use the best data available to assess each indicator and complete the worksheet (as in Figure 9) to describe the current achievements. If any activity-related target was specified in previous implementation plans, it should be written down also, so that it can be compared to the actual level of achievement.

Figure 9
EXAMPLE

COASTAL REGION, INTEGRATIA

WORKSHEET: Status of Indicators Related to Increasing Availability, Access, Demand, and Quality of Services, and Knowledge of Families Relevant to Child Health

Intervention Package	Indicator	Target Year: 2007	Current level Year: 2007
ANC	% of pregnant women attending ANC who receive all interventions listed in the national ANC package	70%	40%
Skilled care at birth, emergency obstetric and newborn care	% of skilled birth attendants trained in newborn care at birth	80%	60%
	% of first-level health facilities providing basic emergency obstetric and newborn care (24 hours/day, 7 days/week)	70%	55%
	% of hospitals providing comprehensive emergency obstetric and newborn care (24 hours/day, 7 days/week)	20%	5%
Postnatal care	% of villages with trained health worker or CHW to make postnatal home visits	30%	10%
IMCI (Integrated management of newborn and child illness)	% of health facilities with at least 60% of health workers caring for children trained in IMCI	40%	46%
	% of health facilities with no stock-outs of essential medicines and supplies for managing common childhood illnesses in the previous 6 months	80%	60%
	% of health facilities receiving at least one supervisory visit with observation of case management in the previous 6 months	80%	60%
	% of sick children attending health facilities assessed correctly	60%	62%
	% of children attending health facilities who need an antibiotic and/or an antimalarial who are prescribed the medicine correctly	80%	65%
	% of referral facilities that manage severely ill children with oxygen and paediatric delivery systems available in the paediatric ward	45%	25%
Community IMCI	% of villages with a trained CHW or volunteer for promoting key family and community practices	30%	10%
	% of caregivers who know 2 danger signs for seeking care	70%	50%
EPI	% of health facilities with immunization services available daily	90%	90%

2.4 Review major activities in the last plan and assess how well they were implemented

2.4.1 List the major activities in your last implementation plan

Planned activities are usually summarized in the most recent implementation plan or workplan. Sometimes child health plans for different technical areas (for example, newborn health, maternal health, immunization, nutrition) are written by different divisions or departments. In this case, all of these plans will need to be reviewed to get information on planned child health activities.

The main categories of activities for implementing child health interventions are in Figure 10 (next page). It is helpful to review activities for each of the three levels of the health system, that is, home and community, first-level health facilities, and referral facilities. Examine workplans, proposals, or other planning documents to find the activities that were planned for the previous year. List them on a worksheet such as in Figure 11, page 23–24.

2.4.2 Assess how well activities were implemented

Look for information on whether the planned activities were completed and the results of those activities. Assess each activity as follows:

- **Status of implementation:** Determine whether planned activities were implemented fully, partly or not at all.

  Information on the status of implementation can be obtained from the most recent programme reports such as routine monitoring or supervision reports, and discussions with staff.

- **Geographic scope:** Note the number (and percentage) of districts or health facilities in which the activities were implemented, and where these are. This will help to determine whether there is some characteristic common to the districts that are implementing activities.

- **How well the activity was conducted:**

  Information on how well activities were implemented may be obtained from programme documents and discussions with staff. Examples of questions and criteria for assessing activities are provided in Annex C.

- **Reasons for observed implementation performance:**

  Write down reasons contributing to the extent of implementation of the activity (fully, partly, not at all), or to how well the activity was done. Programme documents may state reasons, or you may have knowledge of some reasons.

Figure 10

Activity areas for implementing child health interventions

1. ***Advocacy/Resource mobilization***
   - Advocating for effective policies and appropriate norms and standards
   - Preparing project proposals for potential donors
2. ***Training/Human resource development***
   - Adaptation of training materials and supportive tools
   - Conducting pre- and in-service training for health personnel
   - Ensuring adequate staffing
   - Limiting staff turnover
3. ***Strengthening supplies of medicines and equipment***
   - Procurement and distribution of essential medicines and vaccines
   - Procurement and distribution of essential equipment and supplies (weighing scales, syringes and needles, etc.)
4. ***Strengthening referral pathways***
   - Development of locally-supported referral schemes
   - Introduction of and adherence to standards for referral care
   - Development of hospital capacity (staff and equipment) to provide comprehensive emergency obstetric and newborn care
5. ***Communication/Development of community supports***
   - Improvement in knowledge and practices, through communication with individuals and groups, mass media, health workers and CHWs
   - Developing community supports (such as health volunteers, groups, essential infrastructure, supervision or oversight of activities)
6. ***Supervision***
   - Development of integrated supervisory checklists
   - Conducting supervisory visits to health personnel
   - Supervision of CHWs, community volunteers
7. ***Monitoring progress***
   - Regularly collecting data on activities conducted, resources used, results of activities
   - Analysing data and identifying problems (so they can be solved)

EXAMPLE

COASTAL REGION, INTEGRATIA

On the next page is a worksheet completed by the manager of a region that has 5 districts, 13 primary health facilities, 3 hospitals, 4 towns, and about 120 villages. The implementation plan for the region specified the following priority interventions and related activities:

- in the home and community, c-IMCI (specifically promotion of breastfeeding and complementary feeding, insecticide-treated bednets, immunization, care-seeking for illness)
- in first-level health facilities, IMCI, breastfeeding promotion, ANC, and skilled care at birth
- in referral facilities, management of severe childhood and newborn illnesses, emergency triage, assessment and treatment (ETAT), and emergency obstetric care.

Figure 11
EXAMPLE

Part 4 (Step 2.4): Review the major activities <u>in the last plan</u> and assess how well they were implemented

Complete the following worksheets. These categories can be used to classify the activities:

1. Advocacy/Resource mobilization	**5**. Communication/Developing community supports
2. Training/Human resource development	**6**. Supervision
3. Strengthening supplies of medicines and equipment	**7**. Monitoring
4. Strengthening referral pathways	**8**. Other (specify):_____

WORKSHEET: Assess How Well the Planned Activities were Implemented

*FOR IMPLEMENTING INTERVENTIONS **IN THE HOME AND COMMUNITY:***

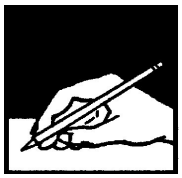
Planned activity (Number indicates category of activity)	**Status of implementation**	**Geographic scope** (implemented in _ % of districts/HF)	**How well activity was conducted**	**Reasons for observed implementation performance**
***1**-District-level meeting with stakeholders to share plans about c-IMCI*	*Completed*	*Stakeholders from 4 of 5 districts*	*Good attendance* *IEC materials provided for stakeholders*	*Invitations sent out well in advance* *Donor funding enabled printing of materials*
***2**-Train CHWs from 40 (of a total 120) villages in promotion of key messages*	*Completed*			
***3**- Procure and distribute 30,000 ITNs*	*Only partially implemented*	*Only 1 district*		*Inadequate (only 10% of requested ITNs were received)*
***4**-Develop referral transport scheme for mothers and sick children in 10 villages*	*Not done*	*0*		*Community leaders not available for discussion and planning*
***5**-Community IEC activities on timely care-seeking for illness*	*Completed*	*100% (5 districts)*	*Health facilities hung new posters* *Community dramas well done*	*Donor funding for posters* *CHWs enthusiastic about organizing dramas*
***5**-Daily radio messages on use of ITNs and immunization*	*Only partially implemented*			
***5**-Reactivate 6 dormant mothers' groups and form 4 new groups to promote infant and young child feeding*	*Completed*	*3 districts ,as planned (60% of districts)*		*CHWs enthusiastic about meeting with mothers groups*
***6**-Develop CHW supervisory checklist*	*Completed, but not yet printed*	*NA*	*Checklist includes counselling on feeding, ITNs, immunization*	
***7-**Monitor monthly the activities of the 42 mothers' groups and the activities of stakeholders*	*Mostly completed*	*3 districts*	*CHWs completed simple forms on dates and activities of groups*	*Simple forms for CHW*

*FOR IMPLEMENTING INTERVENTIONS AT **FIRST-LEVEL HEALTH FACILITIES***

Planned activity	Status of implementation	Geographic scope (implemented in __ % of districts/HF)	How well activity was conducted	Reasons for observed implementation performance
***2**-Appoint and train the breastfeeding coordinator*	*Completed*			*Donor support has brought new interest*
***2**-Conduct half-day sensitising training on breastfeeding for health staff at 13 facilities*	*Completed*	*12 of 13 facilities attended*	*IEC materials provided* *Speakers very good*	
***2**-Organise 2-day retraining workshop for 19 practicing skilled birth attendants*	*Completed*	*21 birth attendants re-trained (4 districts)*		
***2**-Organise 2-day training for 9 health facility in-charges on management of medicines*	*Completed*	*9 health facilities as planned (3 districts)*	*Practice included; Drug Supply Manual provided*	*Appropriate materials available; Trainer provided by partner*
***2**-Organise 3-day refresher course for 30 health staff in IMCI*	*Completed*	*4 districts represented (10 facilities)*	*Practice included; staff took IMCI charts back with them*	*Trainer provided by regional child health*
***3**-Provide all 13 facilities with updated IMCI and other charts, protocols*	*Completed*	*5 districts* *13 of 13 health facilities*		*IMCI materials reprinted late last year*
***3**-Set up ORT corners in 10 health facilities*	*Completed*	*10 out of 13 health facilities*	*Good*	*Dr Lhab facilitated process*
***3**-Procure 5 new refrigerators*	*Ordered but not received*			
***5-**Provide posters for 13 health facilities on exclusive breastfeeding*	*Completed*	*100% of health facilities*		*Donor funding enabled printing of materials*
***6**-Conduct monthly supportive supervision visits to 11 facilities doing ANC*	*Partial*	*5 facilities out of 11 doing ANC*	*Included observation*	
***7**-Monitor quarterly proper medicine management practices*	*Completed*			

*FOR IMPLEMENTING INTERVENTIONS AT **REFERRAL FACILITIES***

Planned activity	Status of implementation	Geographic scope (implemented in _ % of districts/HF)	How well activity was conducted	Reasons for implementation performance
***2**-Provide 3 hospitals with IMCI charts and other protocols*	*Completed*	*3 districts*	*Good*	*IMCI materials reprinted late last year*
***2**-Introduce ETAT in 3 hospitals*	*Partially*	*1 hospital*	*Good*	*International and national experts from MOH and WHO available* *Hands-on practice* *Too few trainers*
***4**-Establish a blood bank at the district hospital*	*Not completed*			*Funding not released; Technical assistance not scheduled*
***7**-Monitor monthly the use of standard protocol for Emergency obstetric care*	*Partially*	*1 hospital*	*Good*	*Dr Lhab introduced and monitored use at his hospital*



EXERCISE B – Review implementation status

In this exercise you will practise the steps to review the implementation status of your child health programme. This exercise has several parts which match the sub-steps as described in section 2.0 of this module.

By following the instructions and using the worksheets in the **Workbook**, you will:

Part 1. Review the current goals and objectives of your child health programme.

Part 2. Review current coverage of interventions and compare it to targets.

Part 3. Review status of indicators related to availability, access, demand and quality of health services, and knowledge of families and communities relevant to child health.

Part 4. Review major activities in the last plan and assess how well they were implemented.

When you return home and have more time, you can use the process that you practise here and copies of the worksheets provided to assess your programme's status, including ALL the interventions implemented by your programme.

To be done in Exercise C:

Part 5. Analyse information and generate ideas on what is needed to reach targets.

This exercise will require data from as many of the following sources as are available: strategic plan, most recent implementation plan, situation analysis, short programme review, most recent Demographic and Health Surveys (DHS) or MICS surveys, any recent small-sample household surveys or health facility surveys, and programme reports such as supervisory and monitoring reports.

It is important to use your own knowledge and experience when assessing implementation status. If a colleague from your child health programme is present at this training, it is helpful to work together to study the data from your country's programme and complete this exercise.

Locate your **Workbook**. It contains all the worksheets, with instructions, that you will need to complete this exercise. Find the pages for Exercise B—Review implementation status. Then follow the instructions to complete each of the parts.

What to do:

Part 1. Review programme goals and objectives (**Workbook**, page 3).

Part 2. Review current coverage of interventions and compare it to targets (**Workbook**, page 5).

Part 3: Review status of indicators related to availability, access, demand and quality of health services, and knowledge of families relevant to child health (**Workbook**, page 7).

If you are not sure about what to do at any time, ask your facilitator for help.

When you have completed Parts 1, 2 and 3, discuss your work with a facilitator.

Then do:

Part 4: Review major activities in the last plan and assess how well they were implemented (**Workbook**, page 9–10).

When you have completed Part 4, discuss your work with a facilitator.

2.5 Analyse information and generate ideas on what is needed to reach targets

Review your assessment of implementation status so far (all the worksheets you have completed). Also keep in mind any additional information gained from reports of supervision or monitoring, information on training, discussions with health staff, and your own experience.

Indicators measure coverage and other results along the continuum of care for the mother and child–between pregnancy, delivery, the newborn period, infancy and childhood–and the continuum of care across the health system–in the home and community, first-level health facilities, and referral facilities. Having information all along this pathway can give a more complete picture of implementation status.

To analyse all the information and look ahead, answer the questions below. This analysis is best done by the planning team as a group so that as many ideas as possible are included. It is often useful to have a facilitator who can lead and direct the discussion.

- **What are the main STRENGTHS and WEAKNESSES of the child health programme in your area?**

  To answer these questions, consider:

  - *Are the interventions reaching the target population?*
    - *Is intervention coverage high or low?*
    - *Were the targets met?*
    - *Are interventions delivered at each level of the health system?*
    - *Is the geographic scope of implementation sufficient?*
    - *Are vulnerable groups being reached?*

  - *What are the strengths and weaknesses of the activities?*
    - *Which activities were most successful? Why were they successful?*
    - *Why were some activities not implemented?*
    - *Are there reasons why some activities may not have been effective?*
    - *Is the intervention being delivered by the most appropriate staff?*
    - *Was planned support received?*
    - *How can quality be improved?*
    - *How can equity be improved?*

- **Are there any issues related to POLICY, STRATEGY, or REGULATORY FRAMEWORK that need to be tackled to address the weaknesses?**
- **Are you on course to meeting your targets with the current activities? If no, what CHANGES or what ADDITIONAL ACTIVITIES would be needed in the next plan to meet targets?**
- **What RESOURCES would be needed to conduct the ADDITIONAL ACTIVITIES?**
- **What OPPORTUNITIES can be used for obtaining these resources?**

Figure 12

EXAMPLE WORKSHEET: Analyse Information and Generate Ideas on What is Needed to Reach Targets

What are the main STRENGTHS of the child health programme in your area?

1. *Interventions are planned across all three levels of the health system.*
2. *There is a sub-section of the national strategy that aims at reaching vulnerable populations.*
3. *Overall funding is adequate for implementing planned activities.*
4. *Interventions are delivered by nurses, with a designated a focal person for child health at district level.*
5. *Most health facilities have at least one person managing sick children trained in IMCI.*

What are the main WEAKNESSES of the child health programme in your area?

1. *Supervision is not done adequately due to lack of personnel and transport.*
2. *Although district focal persons for child health are in place, they have many other competing tasks.*
3. *Long-term planning is difficult due to funding cycle of the government and the main donors.*
4. *Most activities are done where access is the easiest, leaving the most vulnerable and hard-to-reach populations unserved.*
5. *Community health workers are not allowed to prescribe medicines.*

Are there any issues related to POLICY, STRATEGY, or REGULATORY FRAMEWORK that need to be tackled to address the weaknesses?

1. *The formulation of a long-term human resources development plan*
2. *The formulation of clear job descriptions for staff*
3. *Discussion on the role of CHWs in treating common conditions such as pneumonia and malaria*
4. *Development of a national strategy for child health*
5. *Standards of hospital care*

Are you on course to meeting your targets with the current activities? If no, what CHANGES or what ADDITIONAL ACTIVITIES would be needed in the next plan to meet targets?

1. *Development of an integrated supervisory checklist for child health-related programmes*
2. *Integrated plan, including the use of transport for monitoring and supervision*

3. *Improved donor coordination*
4. *Formulation of a long-term training plan*
5. *Improved coordination with the community groups and community leaders*

What RESOURCES would be needed to conduct the ADDITIONAL ACTIVITIES?

1. Change in policies or regulations:

   MOH directives for conducting integrated supervision

2. Human resources:

   A consultant to work on the adaptation of an integrated supervisory checklist

   Trained health staff to conduct monthly meetings with the community groups and community leaders

3. Financial resources:

   Increased financial resources for transportation for monitoring and supervision

   Funds for having quarterly donor meetings in the district

4. Material resources:

   Guidelines on roles and responsibilities of donors and other stakeholders

   Computers and appropriate software at district health office

5. Community support:

   Resource mobilization for recruitment of community health workers

What OPPORTUNITIES can be used for obtaining these resources?

1. *Health Sector Reform*
2. *Global initiatives such as Health Systems Strengthening Initiatives, Global Fund for Malaria, Tuberculosis, and HIV/AIDS may provide some funding.*
3. *PMNCH (Partnership for Maternal, Newborn and Child Health). It offers an opportunity for mobilizing resources as well as global and national commitments for maternal, newborn and child health.*

EXERCISE C – Review implementation status: Analyse information

Part 5: Analyse information and generate ideas on what is needed to reach targets

In this exercise, you will analyse information from the review of your programme's implementation status (Parts 1 through 4). If possible, work with one or more colleagues from your programme to complete this exercise.

Turn in your **Workbook** to the *WORKSHEET: Analyse Information and Generate Ideas on What is Needed to Reach Targets* (page 11–12). You will find questions listed there in a worksheet with space to write your answers.

When you have completed the worksheet, tell your facilitator that you are ready for the group discussion.