MANAGING PROGRAMMES
TO IMPROVE CHILD HEALTH

MODULE 3

Managing Implementation

World Health Organization

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Managing Programmes to Improve Child Health

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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
CHW	Community health worker
CRC	Convention on the Rights of the Child
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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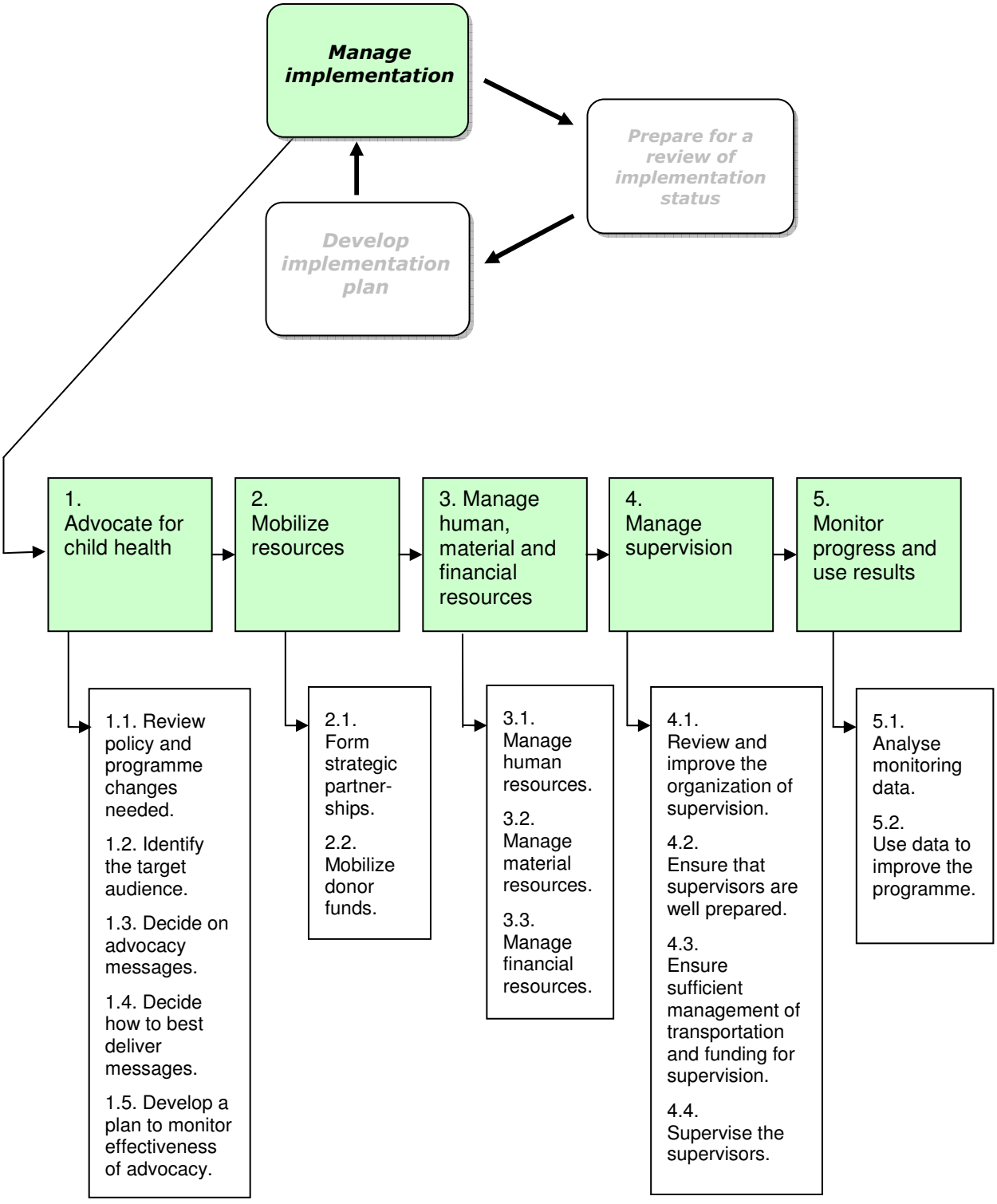
Interim versions of the training course were field-tested at intercountry workshops in the Western Pacific Region (Cambodia and Philippines), the African Region (Ghana), and at WHO/HQ. The comments and suggestions provided by participants at these workshops have been used to refine and improve the materials.

Figure 1

Managing Implementation

The steps to manage implementation are described in this module



Managing Implementation

Introduction

Managing implementation is the process of getting activities and tasks done according to the implementation plan. A number of different skills are important for this to take place, and this module outlines some that are required to successfully implement child health programmes. Management skills are often general skills that cut across technical areas.

To ensure that activities can be carried out according to the implementation plan and programmes are implemented effectively, managers should be able to:

- Advocate for child health to secure commitment from policy-makers, donors, staff and communities.
- Mobilize resources, including human, material and financial resources, so that activities can be implemented as planned.
- Manage human, material and financial resources to ensure that resources are used effectively.
- Manage supervision to ensure that health staff receive routine supportive supervision in order to motivate them, ensure quality, and solve problems.
- Monitor progress in implementing activities by analysing data that are collected regularly.

Learning objectives

At the end of this module, you will understand the principles of:

- Advocacy for child health
- Mobilizing resources to help with implementation
- Supportive versus punitive supervision
- Monitoring progress of programme activities

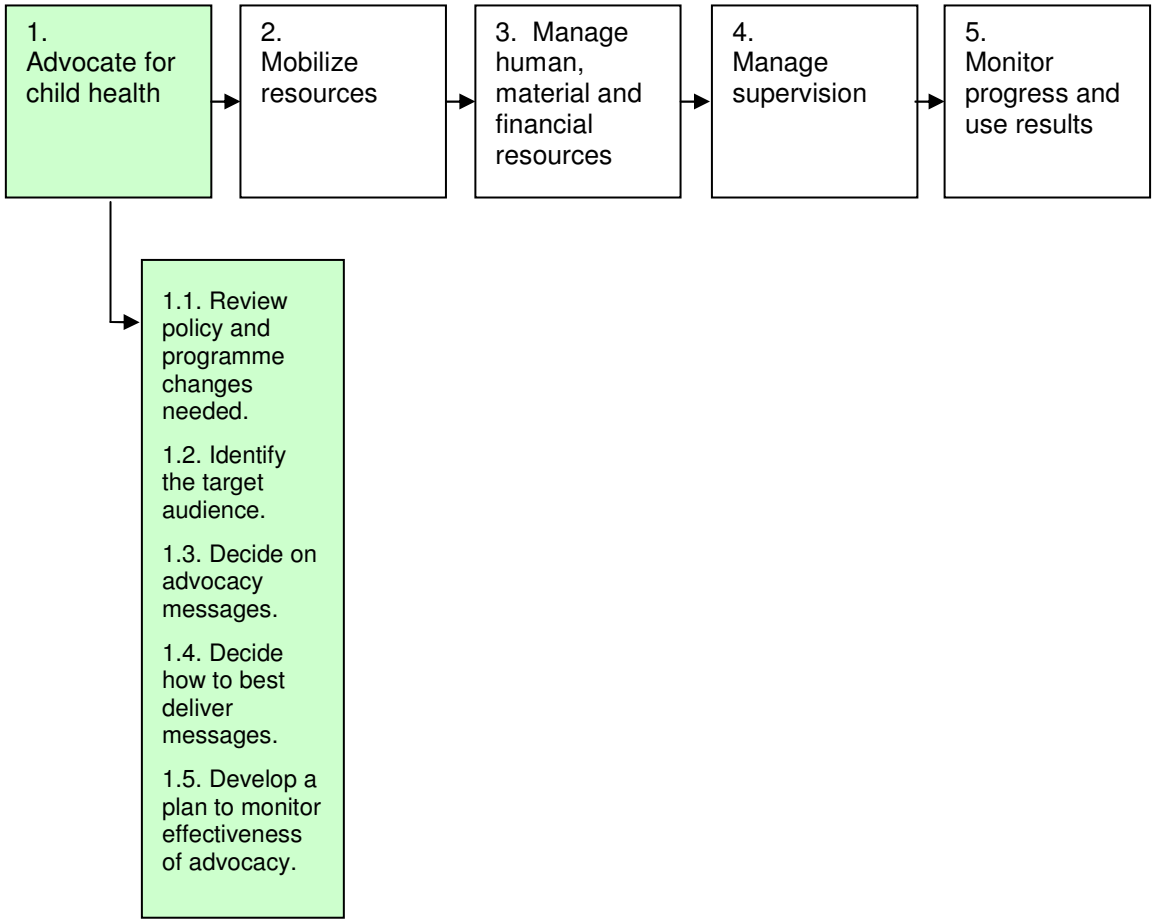
You will have practised:

- Preparing and giving an advocacy presentation
- Preparing a presentation to ask for support from a strategic partner
- Preparing a letter of intent to a donor
- Calculating quantities of medicines needed
- Monitoring expenditures
- Analysing common problems found during supervision
- Giving feedback during supervision
- Analysing monitoring indicators to identify successes and problem areas

Skill 1

Advocate for Child Health

Figure 2



1. Advocate for child health

Advocacy is essential for securing support–political, financial and material–for child health programmes. Support at all levels, from policy-makers, managers, health staff, and communities, is required in order to implement programmes effectively. Advocacy includes all communication activities directed at generating this support.

> **Advocacy** is the act of putting your case persuasively before a target audience.
>
> **Advocacy** is a set of targeted actions, which aim to ensure support for programme implementation at all levels.

Advocacy aims to ensure:

- Political will for allocation of budgets and other resources towards child health
- Sharing of resources between ministries to assist child health programmes
- Communities' support for child health initiatives
- More involvement of non-governmental organizations
- More support from donors for child health activities.

Politicians and policy-makers respond to pressure from the public. Accordingly, a part of advocacy is to raise the profile of child health activities among the general public.

Advocacy activities may include:

- meetings with individuals and groups
- mass and print media
- organizing workshops on particular issues
- distribution of technical reports and data relevant to child health, including situation analysis reports.

Figure 3

Examples of advocacy objectives

- ✓ Highlight the disproportionate burden of infant and neonatal mortality among the poor or marginalized sections of the population.
- ✓ Promote better linkages between neonatal, maternal and child health services.
- ✓ Emphasise the importance of IMCI as an integrated approach to child health.
- ✓ Argue for action to strengthen existing health services and to improve access.
- ✓ Raise the profile of neglected aspects of neonatal and maternal health, such as postnatal care.
- ✓ Encourage the participation of community groups in health education.
- ✓ Highlight the importance of a human rights approach to child health.

1.1 Review policy and programme changes needed

Advocacy can be directed at any area of policy or programming where changes are needed. Decide on specific objectives for your advocacy. Consider:

- What child health problem or issue is advocacy aiming to address?
- What policy or programme changes will most effectively address the problem?
- What action should be taken, by whom and when?

Advocacy can aim for:

- general public support for child health
- more financial resources for child health
- allocation of more staff for child health, or training of new categories of staff
- more community involvement with primary health care activities
- promotion of new areas of child health that have not received much attention, such as newborn care
- promotion of technical policies in particular areas such as breastfeeding or complementary feeding
- promotion of key family practices such as sleeping under an insecticide-treated bednet (ITN) or care-seeking for illness

1.2 Identify the target audience

When identifying a target audience, consider what group or groups are in a position to change current policies or practices, or to provide support. Decision makers and the general public are important target audiences. Advocating to the general public can create a favourable climate for child health policies and activities. Target audiences for advocacy can include:

- policy-makers at international, national and sub-national levels
- health workers
- professional associations
- NGOs, civil society and private sector organizations
- media and other opinion leaders
- religious and community leaders
- communities and families

To better understand the target audience, find out:

- What does the target audience know about child health?
- What does the target audience need to know?
- What can the target audience do to influence the objective?

Strategies to find out about current knowledge and attitudes include:

- talking to members of the target audience or those familiar with the target audience
- reviewing speeches and attending meetings with the target audience present
- reviewing reports
- talking to health staff
- talking with village leaders and community groups

1.3 Decide on advocacy messages

Advocacy messages should provide a clear **statement of the problem** and **recommendations for action**. They should also be easy to understand. Different target groups will have different priorities and will respond to different messages. Consider:

- What will motivate the target group to change views or take action?
- What messages will convince different audiences to take action?

Local data is particularly important. The audience is more likely to be interested by information about their own situation.

Arguments to obtain more support for child health could include:

- Burden of disease – National data on neonatal, infant and child mortality, and causes of death
- Effects on families – Child mortality has serious emotional, social and economic impact on families.
- Millennium Development Goals – Achievement of the MDG for reduction in child mortality
- Other global commitments – A guiding principle of the Convention on the Rights of the Child is the right to life, survival and development and, in Article 24, governments made a commitment to reduce infant and child mortality; this was reinforced at the World Summit for Children in 1990. In 2000, building upon a decade of major United Nations conferences and summits, world leaders came together at the Millennium Summit in New York and adopted the United Nations Millennium Declaration, committing all nations to achieve reduction of under-five mortality by two-thirds between 1990 and 2015.
- Economic burden on the country of a high level of disease and child mortality and implications for economic development
- Implications for population growth – Improved child survival is important for transition from high to low fertility and stabilization of population growth.

Design advocacy messages for a specific target audience and provide:

- a clear statement of the problem and
- recommendations for action.

Examples of key messages on neonatal health targeted to policy-makers and different messages targeted to communities are shown in Figure 4.

Figure 4

Example advocacy messages on newborn health

Key messages for policy-makers

- Neonatal mortality is everyone's problem. Newborn health is essential for future improvements in child health as well as development of the country.
- Reducing neonatal mortality is essential if the MDG target of reducing under-five mortality by two-thirds between 1990 and 2015 is to be reached.
- Reducing neonatal mortality is not totally dependent on socio-economic development. Most newborn deaths can be prevented with cost-effective solutions that do not require sophisticated equipment or highly trained specialists and can be implemented even where health services have limited capacity and resources.
- The additional per capita annual cost of implementing child health interventions is estimated between $0.50 and $1.50. Investment in newborn interventions can save the lives of newborns, older children and women, as well as reduce the incidence of disabilities.
- Many interventions can be effectively implemented through strengthening or expanding existing maternal and child health services and programmes such as Safe Motherhood, Community-based Integrated Management of Childhood Illness and Home-based Newborn Care.

Key messages for communities

- Communities can help improve the survival and health of mothers and newborns by doing a few simple things during pregnancy, birth and after birth.
- During pregnancy: All pregnant women should attend at least four antenatal care visits.
- During birth: There should be a skilled attendant at birth.
- After birth: Start breastfeeding early, breastfeed exclusively, and keep the baby warm at all times.
- Families should seek timely care from an appropriate health provider for mothers and newborns with danger signs. This is critical for preventing maternal and newborn deaths.

Figure 5

Using success stories: Bangladesh–reducing neonatal tetanus deaths

In Bangladesh, deaths from neonatal tetanus were reduced by over 90% in just over a decade. With government commitment and support from a range of partners, a massive immunization campaign was launched in the mid-1980s, increasing coverage with tetanus toxoid vaccine from 5% in 1986 to 86% in 1998. As a result, neonatal tetanus death rates fell from 41 to 4 per 1000 live births.

Figure 6

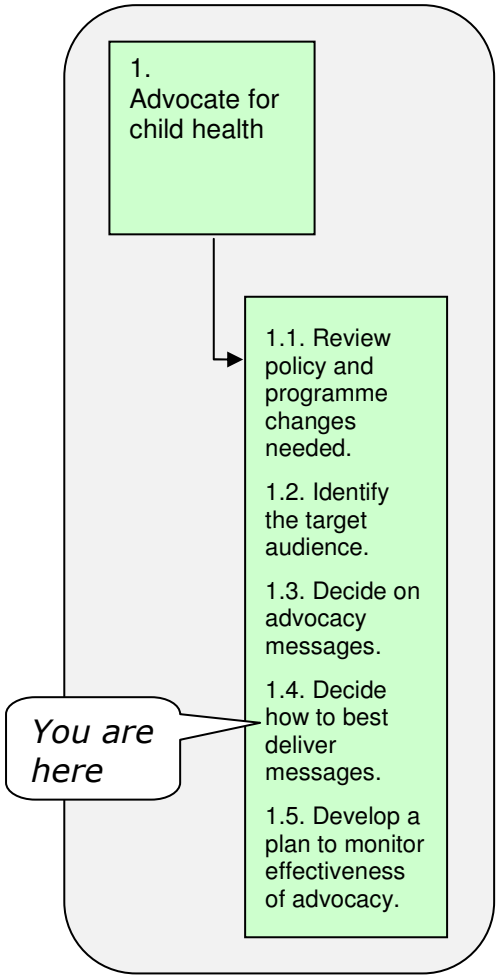
Using success stories: Sri Lanka–a comprehensive approach in a low income country

Despite being a resource-poor country, Sri Lanka has succeeded in reducing neonatal mortality to 12.9 per 1000 live births (less than a third of the rate of many other countries in the region) and maternal mortality to 58 per 100 000 through the development of high quality, comprehensive health care for mothers and babies delivered through strong health systems.

1.4 Decide how best to deliver messages

Consider what channels and methods will most effectively reach and deliver messages to different audiences. Channels and methods can include:

- Mass media. Assess the potential of TV, radio, and press to reach different audiences. Target influential and opinion-leading journalists and provide regular briefings, articles, and press releases to highlight issues. Work to gain the support of journalists through effective advocacy.
- Supportive individuals. Identify 'champions' who can advocate with their peers and develop strategic collaborations with professional and other groups.
- Meetings with groups and individuals. Bring together policy-makers and opinion leaders, including politicians, programme managers, health profession leaders, researchers, media professionals, NGO leaders, donor representatives and others who could influence policy.
- Conferences. Highlight the issue at national and sub-national events and forums attended by policy-makers.
- Presentations. Ensure presentations are adapted to the audience, are clear and easy to understand, credible and appealing. Presentations need to highlight the problem, what can be done and the action needed.



Advocating to decision-makers

Decision-makers (at all levels) influence decisions on policies that affect child health. When approaching decision makers, it is important to:

- ✓ Keep the message simple. Include only one or two messages; too many messages are confusing.
- ✓ Target what is said to the skills/responsibilities of the decision maker.
- ✓ Ensure that there is enough time for them to focus on the issue – and be brief.
- ✓ Think strategically. For example, advocate before the budget is decided for next year, not afterwards.
- ✓ Remember that information from a number of different channels can be useful in changing attitudes and opinions of decision makers. For example, follow a key newspaper article or public event that highlighted the problem with a face-to-face meeting.
- ✓ Consider involving key partners in meetings. For example, if a significant local donor is committed to child health, ask them to contribute to a meeting with decision makers.

Advocating to the general public

There are multiple ways the public can be informed about health issues such as child health. Possible channels include:

- Mass media: newspapers, radio, television
- Community meetings and groups (mothers' groups, village committees, health committees) and community theatre
- Health facilities and health workers who can provide counselling, health education meetings, posters and information hand-outs
- Religious leaders and groups who can distribute information, or present information at group gatherings
- Teachers who can be given information for children to take home
- National groups such as Rotary and Lions Club

Communication methods for advocacy

The two main methods are **face-to-face** contact with individuals or groups to obtain support for child health programmes and **mass media** to create awareness of the importance of child health issues and the need for action.

Advocacy – face-to-face with individuals

When arranging meetings to advocate for child health, consider the following:

- Is the meeting with the right person? Are they likely to be interested in child health? Do they have the power to take the needed action?

- Think about the person who is being approached. What is the benefit to them of supporting child health activities? People are more likely to give support if their own organization will benefit in some way, for example, through attainment of their own organization's goals, enhanced respect by senior policy-makers and increased support from the community.
- Who is the best person to make the approach? Are they senior enough? Do they have the right technical skills?

Advocacy – face-to-face with groups

This generally means making a public presentation. The following principles are important:

- ✓ Design the presentation to be appropriate for the educational background, interests and roles of your target audience.
- ✓ Time presentations strategically, for example, soon after the release of key survey data, at the beginning of a new donor-funded project on child health, at the publication of a key newspaper article, or soon after the death of a child.
- ✓ Prepare high-quality material to hand out at the meeting that summarizes the key points.
- ✓ Make it clear how the target audience can be involved and what they can do. Be specific.
- ✓ Do follow-up. The type of follow-up will depend on the target audience. For a group involved with policy decisions, it may be important to follow up key individuals with concrete proposals for policy revisions or additions. For those involved with funding, it may be appropriate to follow up with funding proposals.

Advocacy – using the mass media

The mass media (TV, radio, newspapers, text messages to mobile phones) are skilled at creating awareness. There are two main approaches to using the mass media:

- *Buying time* to promote messages. This can be through advertising, public service announcements, TV soap operas, radio programmes, etc. The advantage of this approach is that messages can be carefully developed, tested and controlled for maximum impact. The disadvantage of this approach is that it is often expensive. However, note that messages from "paid media" and messages in the "news" can be interpreted differently by audiences (i.e. one has more legitimacy and perceived independence than the other as a source of information).

- *Encouraging the media to cover activities and promote causes*. Journalists are encouraged to write articles about key child health issues, or to report on significant events, such as workshops and meetings, new projects, public meetings or rallies, the release of new child health data, and so on. Programme managers should note the names of journalists and media presenters who cover health topics and consider meeting with them to discuss key issues. This approach is cheaper than buying media time although there is much less control over the messages that are broadcast. Sometimes journalists get their facts wrong. Incorrect coverage of health topics can undermine programme efforts. Misinformation or false rumours should be quickly corrected.

Become familiar with the media that are popular in the local community. A useful starting point is to buy copies of newspapers and magazines, and to listen to radio and television to get a feel for how health topics are covered. Choose media that will reach the target audience. If television ownership and use is low, then this will not be a useful medium for reaching a wide population. Print media are not useful for a largely illiterate audience; radio may be more effective. Where increasing numbers of people have mobile phones, SMS or text messages are able to reach many members of the community. Household survey data are often available to help determine the local availability of media channels in communities.

Planning a media event

The media will only cover a topic if it is newsworthy and makes a good story. Journalists may have a long list of possible topics to cover and will choose ones that are new, interesting or unusual. One way of getting coverage is to plan a "media event" that will attract journalists, film crews and photographers. Principles of a good media event include:

- Timing the activity so that journalists can meet any deadlines
- Making the event interesting–not just speeches–by including dancing, music, children, processions, street marches, etc.
- Involving well known personalities such as politicians or local personalities
- Giving the activity visual appeal so that it will provide good photographs
- Sending a media advisory in advance of the event, to entice journalists to attend the event to get the whole story
- Providing a "press packet" of basic information and key points about the issue

An example of press information about an important event is in Annex A.

Preparing a press release

A press release is usually a one-page typed document which is used to inform the media of a forthcoming event or to update them on new information. It should provide the following information:

- *WHAT will be happening*? Describe the event. Give names of important participants and details of activities that might make a good photograph.
- *WHY will it take place*? Give background details. Supply some facts and figures that can be quoted in a story. For example, when describing the importance of pneumonia, give the number of children who died of pneumonia last year in that community.
- *WHERE will it take place*? Give precise details of how to get there.
- *WHEN will it take place?* Give the date and time of day.
- *CONTACT DETAILS* for more information.

Giving an interview

Sometimes programme managers are asked for interviews about a topic or activity. It is very important to do this well as thousands and even millions of people may be influenced positively or negatively by what is said and how it is said. Ideally, only people who have had media training should talk directly to the media. Figure 7 provides some guidelines for making an interview interesting and effective.

Figure 7

Tips for being interviewed on radio and television

- Be prepared. Know facts and figures or have details handy, and prepare answers for anticipated questions.
- Before the interview, if possible, discuss with the interviewer the questions and issues.
- Be clear and concise. Keep to the point. Plan three or four key points and make sure that these are mentioned.
- Make it interesting! Sound enthusiastic. Have notes to refer to but avoid reading them. Build in personal examples or stories (but be careful about giving names and breaching confidentiality).
- Keep the language simple and avoid technical words. Give statistics in ways people will find easy to grasp (rather than saying 15% of children die in the first year, try saying 'one in six children die' or 'every hour a baby dies of malnutrition').
- Keep calm! If a question is difficult, do not refuse to answer but take a lesson from politicians by changing the subject or asking a question back!
- If the interview is being broadcast `live,' choose words carefully. If it is being recorded, don't be afraid to ask to repeat part of the interview.

Adapted from Hubley J. *Communicating Health! An action guide to health education and health promotion*, 2nd edition. Oxford, Macmillan, 2004.

Presentation skills

The performance of managers is often judged most critically when they are making a presentation in front of others. So it is particularly important that presentations meet a high standard. Practise and refine your presentation beforehand!

A good presentation does not simply depend on preparing a number of interesting slides (although this can help).

Figure 8

Principles for developing a presentation

Give it a structure, including a beginning, a middle and an end:

- An introduction – what will be covered and why
- Clear overall messages – no more than a few
- A final summary – to review the points that have been made
- Limits on the amount of data or information – too much is confusing
- An end-point – "My conclusion is that we need three more health clinics built in Kunduz District."

Keep it short

- Attention spans vary. Very busy people like Ministers may only have five minutes to give you. Students may be able to focus for thirty minutes. Don't expect *anyone* to listen for more than thirty minutes.
- As a general rule plan to **talk on one slide per minute**. A five-minute presentation needs no more than five slides. Make each one count!

Keep it simple

- Complicated graphs do not impress audiences. It is difficult to study a graph and listen at the same time. Give the title of a graph and what it demonstrates. Explain anything that is not immediately obvious: "This slide shows the increasing cost of providing the service over the past five years."
- Limit the amount of information on any one slide. Use no more than five bullet points on any one slide. Do not over-fill the page or screen.
- It is easier to read simple fonts such as Arial that have no serifs (extra lines at the tips of the letters). Use large letters such as **28 or 32** font size that can be seen from the back of the room. Make fonts consistent throughout the presentation. Changing fonts are difficult to read.

Make it interesting

- Try to tell a story with your slides – with a beginning, a middle and an end.
- Keep the visual message interesting. Illustrations or pictures can be more powerful than words. But choose them carefully because they may distract from your message. Using a digital camera, it is now possible to take your own photographs and incorporate them easily into a presentation.
- Share something new. Describe new developments such as new outbreaks, research, newly released data or new initiatives to control a disease.
- Use powerful language. Personalize statistics and give the problem a human face.
- Vary your voice. Monotonous presentations send everyone to sleep.
- S*low down!* Until you are experienced, everyone tends to talk too fast in a presentation. You do not transmit more information by talking faster, even if you only have five minutes to get your message across!

1.5 Develop a plan to monitor effectiveness of advocacy

What can be measured to assess the effectiveness of advocacy? Approaches to assessing effectiveness can include:

- Measuring **activities successfully completed**, such as meetings held and materials produced.

- Measuring **results of activities**, such as changes in budget, expenditure, personnel availability or effort; changes in use of health services (demand); changes in the availability of community-level resources or community-based activities; or knowledge or attitudes before and after advocacy (such as proportion of mothers who say breast milk is the best food for an infant).

Plan how the effectiveness of advocacy will be monitored, who will collect the information, and a schedule for monitoring. Also plan for the materials, skills and financial resources needed to monitor the effectiveness of advocacy. Examples of some items to monitor appear in the far-right column of Figure 9.

Figure 9

EXAMPLE: Summary of approach to child health advocacy

Intervention: Improve exclusive breastfeeding of children under 6 months of age

1. Advocacy objective (desired changes)	2. Target audience	3. Advocacy message	4. Methods for delivering message	5. Resources required for advocacy (human, material, financial)	6. Measures of effectiveness of advocacy
Change national policy from 4 to 6 months	*Decision-makers*	*Increasing duration of exclusive breastfeeding will save more lives*	*One-on-one meetings* *Small group meetings*	*Low* *(time to write presentation and to have meetings)*	*Policy changed*
Increase awareness of the importance of exclusive breastfeeding and encourage families to support women with young babies	*General public, health workers, decision makers*	*Exclusive breastfeeding is a simple way to reduce deaths, improve health and improve bonding with mother* *Breastfeeding is all a baby needs*	*Mass media: radio and TV* *Group presentations*	*High* *(costs of developing and broadcasting mass media; group presentations require time and venue)*	*Number of sessions/ broadcasts* *Proportion caregivers/ families hearing broadcasts or attending meetings* *Correct knowledge in target groups*
Implement the baby-friendly hospital initiative	*Decision-makers, programme managers*	*Can be an effective way of educating and encouraging exclusive breastfeeding*	*Small group meetings*	*Low* *(time for small meetings)*	*Baby-friendly hospital initiative adopted by the MOH and budgeted*
Decrease the use of formula	*General public, health workers, pharmacists, medicine vendors*	*Formula should not be given in the first 6 months*	*Mass media* *Technical training or updates*	*High (mass media costs; costs of training)*	*Broadcasts conducted* *Training conducted* *Proportion hearing messages* *Proportion of staff trained* *Correct knowledge in target groups*

EXERCISE A – Advocate for child health

In this exercise, you will develop an approach to advocacy for an intervention that will be implemented in your area. You will then develop a short advocacy presentation and present it to the group. Your facilitator will divide you into pairs or small groups for this exercise.

Part 1: Plan an approach for advocacy of an intervention

Locate in your **Workbook** the *Worksheet: Summary of Approach to Child Health Advocacy* (page 37). Follow the instructions on page 36 to complete the worksheet.

Part 2: Prepare an advocacy presentation

1. Prepare a **5-minute** advocacy presentation for **one** of the selected target audiences. The message should include:
    - a statement of the problem
    - what you would like from the target audience (the action).

2. One person will make your presentation to the group. After each presentation, the entire group will then discuss the following questions, so that you can learn ways to make a better advocacy presentation:

    - Did the presentation convince you, as a member of the audience?

    - Was the action desired of the audience clear?

    - What was done well? What was not done as well? (Consider content, format, timing, simplicity, overall message, organization, body language and style of the presenter.)

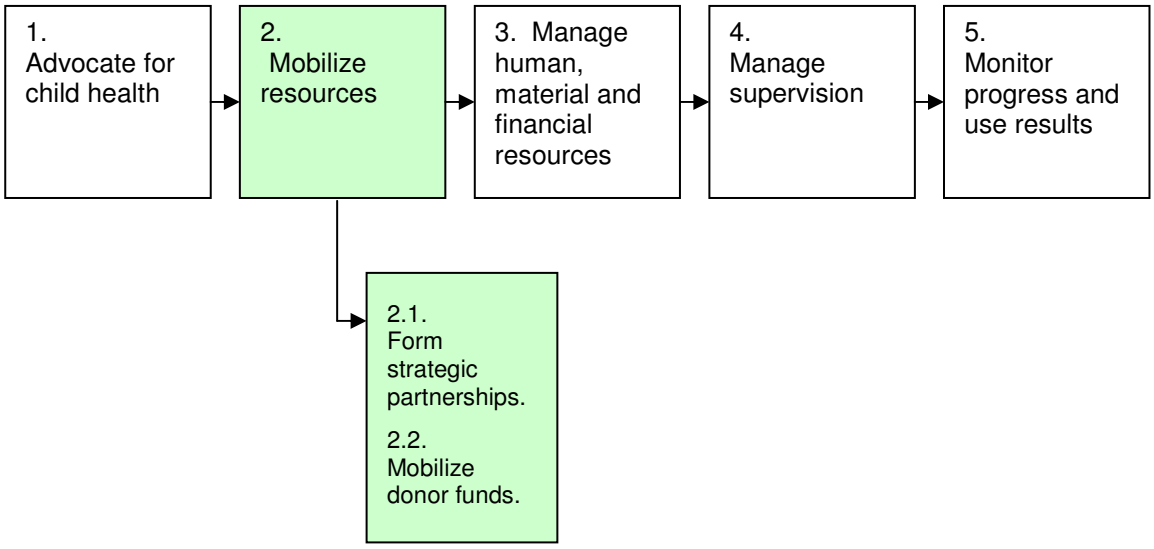
    - What could have been done to improve the presentation?

When you are ready for the presentations, tell your facilitator.

Skill 2

Mobilize Resources

Figure 10



2. Mobilize resources

Resource mobilisation is the process of obtaining the resources needed to implement planned activities. Resources are the elements needed in order to carry out your work and can include:

- Human resources
  - — people who can help in the planning and management of activities
  - — people who can help with the implementation of activities
  - — full-time staff, volunteers, consultants

- Material resources
  - — equipment for short or long-term use
  - — supplies of consumables, e.g. vaccines, medicines, injection supplies, training materials, cards, logbooks, recording and reporting forms
  - — offices or buildings
  - — vehicles or other forms of transportation

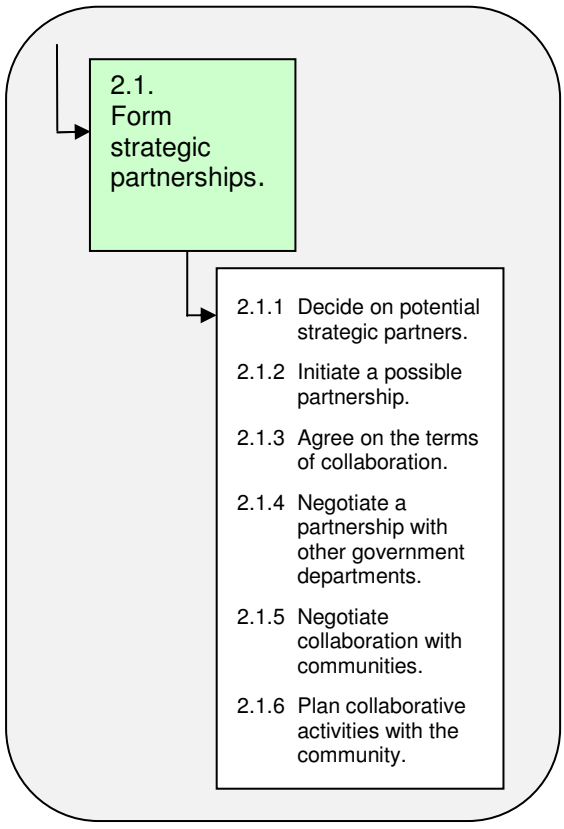
- Financial resources
  - — funds for programme activities
  - — funds for essential system supports
  - — funds for staff

2.1 Form strategic partnerships

Strategic partners are groups, organizations or individuals who share in the implementation of activities through the contribution of human and material resources and in some cases funding. Some of these may be stakeholders who were involved in planning. (Donors are a particular type of strategic partner, one that provides only financial resources.)

The sub-steps of this step are shown in Figure 11. Strategic partners can include any groups or individuals active in communities, districts or nationally. Potential partners must be convinced that supporting the effort will directly benefit their own constituencies. Partnerships are not built overnight.

Figure 11



2.1.1 Decide on potential strategic partners

Possible partners could include:

- other government departments/ministries
- NGOs, both local and international
- international donors or relief organizations
- UN agencies
- community groups, such as Lions, Rotary, etc.
- advocacy groups on breastfeeding, family planning, etc.
- professional groups or societies of people such as physicians, nurses, pediatricians, midwives
- universities, research institutions
- school teachers
- religious groups or organizations, including local churches or mosques
- traditional healers
- pharmacists
- local medicine sellers or medicine vendors
- media
- private sector/corporate/business sector

Factors for assessing suitability of possible strategic partners include:

- Human, material and technical resources that they can contribute. These should complement the resources that already exist, either in size, geographical focus, flexibility or skill.
- Their personal interests and objectives. Examine a potential partner's history of involvement in health. Are they likely to support child health?
- Their potential for long-term involvement. The leaders of religious organizations may be asked to participate in a single activity, in the hope that they will see child health as an important area to continue.

2.1.2 Initiate a possible partnership

a) Clarify your goals for the partnership

Determine the desired outcome. What will you ask for from **this** partner? Can your goals be modified if possible partners have slightly different goals?

b) Prepare to clearly state the case for collaboration

Gather the relevant facts and information. Determine the most persuasive way to present this information. Clearly articulate the *medical* effectiveness of child health programme activities. Provide economic data supporting the *cost*-effectiveness of such programmes. Mention the potential political benefits of showing leadership on an issue and the potential political consequences of failing to take action. Give concrete examples of what the potential partner could do to support implementation.

c) Arrange a first meeting with the potential partner

Make contact. Introduce your organization by phone and letter. Do not focus on gaining support at this stage. Listen carefully to the interests of possible partners. You should state your case and if necessary provide short summary documents. Identify a "first step" activity for their participation. In most cases, the first step should be an activity that is easy to undertake. At the end of the meeting, the next steps should be clear.

A useful first step is to invite potential partners to meet together for a proposal development workshop. This might last one or two days depending on the nature of the activity that is being planned. A workshop allows each partner to understand each other's perspectives, build trust and develop a shared understanding of the problem and possible solutions.

d) Maintain the relationship through regular communication

Make follow-up visits. Find legitimate ways to follow up on the original conversation and keep the partner informed. Be generous with thanks and ask for further involvement. Help the partner achieve their particular self-interest.

2.1.3 Agree on the terms of collaboration

Once partners have agreed to be involved, the terms of collaboration need to be negotiated. Examples include:

- The partner provides staff or other resources using their own funds in order to support programme activities. The partner may ask "What benefits are there for our organization?" They will need to be convinced that the best way for that organization to achieve its own objectives is to work collaboratively. Offer something in return for their collaboration. If collaboration is seen to be providing mutual benefits, the organization will be more willing to collaborate.

- The partner is included on a joint funding bid to another donor. In this situation, the partner organization needs to be involved closely in the development of the proposal so that it can identify what its role will be, and what resources will be required.

- The partner provides a specific service that is paid for by the child health programme. Usually a formal request for services is required, agreeing on costs and the scope of the activity. Then a letter of agreement (or contract, or memorandum of understanding) is developed spelling out the details of the agreement.

Remember that some donor agencies have very precise definitions of partnership as well as defined criteria for the type of organizations that are eligible for funding. This needs to be taken into account when selecting strategic partners.

2.1.4 Negotiate a partnership with other government departments

Sometimes resources for child health can be released from other government departments, especially when there is overlap between different ministries who may be working with the

same target groups in the field. For example, the following departments might be willing to provide support for special activities:

- Ministry of Education may provide support for child health promotion activities in schools and pre-school facilities and also adult education programmes.
- Ministry of Youth may provide support for activities targeted at youth, such as education on HIV and reproductive health.
- Ministry of Women may include child health when working with women's groups.
- Ministry of Agriculture may provide access to their extension officers who work with rural men on developing kitchen gardens.
- Ministry of Rural Development may provide field staff and community groups to carry out health education activities.

There are many possibilities to explore with other departments when looking for ways to collaborate. For example:

- Consider offering something to collaborating departments such as health education and counselling materials, or links with health facilities.
- Use existing structures for intersectoral coordination such as district management committees. Sometimes it can be easier to obtain support by approaching community and district-based field staff and working through existing committees or groups. In other cases some clearance at a national level is needed to obtain support.
- Consider collaboration on short-term activities such as immunization campaigns. These may be more feasible for departments that cannot commit resources on an ongoing basis, and can provide an opportunity to build a working relationship that can be used in the future.

2.1.5 Negotiate collaboration with communities

Mobilizing resources from the community is particularly important because it:

- Draws upon expertise and talents that exist within communities (such as traditional birth attendants, traditional healers, artists, musicians, actors) and is therefore more likely to be accepted and appropriate for the local social and cultural norms.
- Results in a greater sense of ownership of the programme by the community and greater participation in activities because they have contributed to implementation.
- Leads to programmes which are less dependent on external inputs and have long-term sustainability.

Programme managers can work with community leaders and community groups to help them understand child health problems, the types of activities that may be useful, and how these can be implemented with local support. An inventory of resources available in the community is useful. For example, the inventory could include rooms for meetings or for health education, a community health worker with some training in child health, nutrition groups or mothers' groups, and traditional healers who are willing to collaborate.

Individuals and groups that are often involved in health include:

- ✓ community health workers
- ✓ village health committees
- ✓ village management committees
- ✓ village elders or leaders
- ✓ women's groups
- ✓ school teachers
- ✓ religious leaders
- ✓ faith-based groups
- ✓ community-based NGOs

2.1.6 Plan collaborative activities with the community

A group of community leaders such as a village health committee should work with health staff to plan the collaborative child health activities. This group can help develop simple action plans that specify what will be done, when, and by whom, and then discuss the plans further with the community. Community planning needs to describe how the community will benefit from participation in child health programmes and how responsibilities will be shared between the community and the programme staff.

There are a number of ways that communities can contribute to programme activities. Some options that are described below include:

a) self-help
b) use of volunteers
c) financial contributions by the community
d) commercial sponsorship

a) Self-help

Communities help themselves by contributing time and skills to make changes or improvements that have a health impact. Self-help approaches mobilize the energy and enthusiasm in a community. Experience has shown that communities are willing to contribute time and effort to activities if they believe that real benefits will result. It is often useful if some of the costs or expertise is provided by the health programme so that the effort is collaborative.

Examples of projects for which a community has contributed labour include:

- construction of a health post
- preparation of a school garden
- cleaning of a communal area
- maintenance of a public latrine
- digging and protection of wells
- construction of latrines for individual households.

b) Use of Volunteers

Many communities have traditions of volunteering. One valuable source of volunteers is schools; children and teachers can be involved in community projects that provide

opportunities to learn about health and make a direct contribution to health in their community. Youth organizations are sometimes used as a focus for educational activities such as community drama on health topics. Nutrition support groups use women with well-nourished children to teach those with undernourished children how to feed correctly.

Volunteers must be trained and organized, and a key group or individual in the community should assume the role of coordinator. Programme managers or others with technical expertise need to ensure that volunteers use information and methods that are technically sound and should provide materials and supplies when needed.

Examples of ways that community volunteers have been used include:

- health education on particular topics
- nutrition support groups
- case-finding and follow-up
- community-based distribution activities (for example, distributing bednets, vitamin A, iron)
- managing the logistics of re-impregnating bednets
- mobilizing the community for immunization days.

c) Financial contributions by the community

Financial contributions by the community can help sustain child health programme activities in the longer term and help build local commitment to the programme. Local funds have been provided for a variety of purposes including:

- building health posts, latrines, wells
- medicines that are distributed by community health workers
- salaries of community health workers
- costs of transporting sick children and mothers to referral centres.

Fundraising and cost-recovery are two mechanisms of local funding. **Fundraising** means that a community raises money for health activities. The funds need to be collected, stored and managed by a coordinating committee who is accountable for the money. Fundraising may include activities such as fairs or community gatherings that sell donated food or goods; selling donated produce; or community theatre for which contributions are collected.

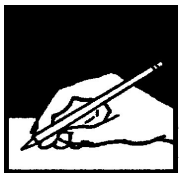
Cost-recovery systems charge for goods and services such as medicines, insecticide-impregnated mosquito nets, soap, chlorine for disinfection of water, services of community health workers, and services of facility-based health workers. The challenge is to find a price that will cover enough of the real cost of the good or service, while not deterring people from spending the money.

d) Commercial sponsorship

Commercial companies, businesses and shops in the community may be willing to sponsor child health activities. Sponsors have often contributed to health education activities (such as production of posters, community drama, video equipment), and directly contributed supplies such as birth kits or weighing scales. Sometimes this is done without conditions. Usually, however, sponsorship is in exchange for increased visibility for their business or for the products they sell. It is important to ensure that businesses offering sponsorship do not produce products that are unhealthy or inappropriate.

Examples of non-desirable corporate sponsorship include:

- sponsorship by tobacco or cigarette companies
- sponsorship by companies producing breast milk substitutes, breast milk supplements and other related products
- sponsorship by companies promoting inappropriate medicines for children such as antidiarrhoeals or some traditional remedies.



EXERCISE B – Assess potential strategic partnerships and ask for support

In Part 1 of this exercise you will review potential strategic partners for implementation of the intervention package that you planned in *Module 2: Planning Implementation.* You will assess their interests and objectives and the resources they can offer. In Part 2, your small group will prepare a presentation to one of the potential partners. Finally, in a role play, one person will make the presentation to the rest of the group.

Part 1. Review potential strategic partners who could help with implementation of the intervention package in your programme.

A. Answer key questions for potential strategic partners.

Complete the *WORKSHEET: Key Questions for Potential Strategic Partners* in your **Workbook** (page 39).

B. List resources offered by potential strategic partners.

Complete the *WORKSHEET: Resources Inventory for Strategic Partners* (**Workbook**, page 40).

C. Decide whether or not each of the potential partners is likely to be useful to help with implementing your intervention package.

When you have completed this part of the exercise, discuss your work with a facilitator.

(Exercise continues on next page)

Part 2. Develop a presentation to a potential partner.

Work in small groups. Each group will prepare for a meeting with **one** selected partner to ask for their support for a selected intervention package and to identify ways that they can help. Prepare **5 slides** for your presentation. Refer to page 13 in this module to remind you of the principles for developing a presentation, including developing effective slides.

> Tell your facilitator when your small group is ready to make a presentation.

Part 3. Presentations to potential partners

One person from each small group will make the presentation to the large group. Before you begin the presentation, describe to the group the target audience (the potential partner) to whom the presentation is directed. After each presentation, the entire group will then discuss the questions below.

While other participants are making presentations, think about the following questions and make notes. Then there will be a brief discussion.

A. Was it clear what the partner was being asked to do?

B. Was a good reason for the activity presented? Were you convinced?

C. Was it clear how the partner could benefit from the collaboration?

D. Was the presentation appropriate for the target audience?

E. Were the slides interesting? Were they clear?

F. What was done well in the presentation? Consider content, timing, simplicity, overall message, organization, body language, and style of the presenter.

G. What could have been done to improve the presentation?

2.2 Mobilize donor funds

Figure 12

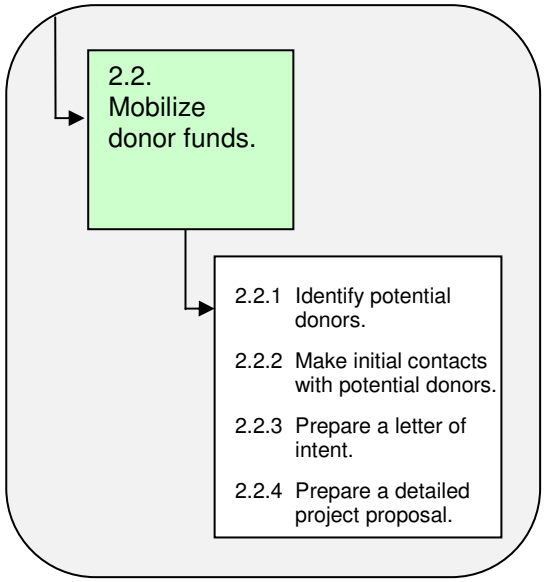


Figure 12 shows the sub-steps to mobilize funds for a child health programme's activities.

2.2.1 Identify potential donors

A donor is any organization or individual who can provide financial resources. Donors all have different interests, funding procedures and methods. It is useful to prepare an **inventory** of possible donors which includes their interest in child health and the programmes and projects they have funded in the past. Examples of different kinds of donors are presented in the figure below.

One must be very careful when involving private companies as donors as there may be a conflict of interest (for example, a tobacco company or a company that produces breast milk substitutes).

Figure 13

Types of potential donors

Type of organization	General information on the type of resource provider	Specific examples
NGOs/ International NGOs (INGOs)	International NGOs operate in more than one country. In some cases they have funds from fundraising in their own countries but also submit proposals to donors. Local NGOs are active in implementation of programmes.	International NGOs: Action aid, CARE, Medicines Sans Frontiers, Oxfam, Red Cross, Save the Children, World Vision National NGOs
Civil society organizations	These include women's organizations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions, advocacy groups	They vary from country to country
Community-based Organizations	Community-based organizations, local NGOs	They vary from country to country and between regions in the same country
Religious groups/ Institutions	Churches and religious institutions, mission societies	They vary from country to country and between regions in the same country
UN agencies	UN organizations are sources of technical expertise and funds	WHO, UNDP, UNFPA, UNAIDS, UNICEF, UNHCR
Government donors	Provide funds and technical support to MOH, NGOs and other groups	Australia, Canada, Germany, Holland, UK, Scandanavian countries, USA, etc.
Multi-lateral donors	Donors representing regional groups	Asia Development Bank, European Community, SADEC, World Bank
International foundations	These foundations are primarily sources of funding. The largest are based in the United States.	Bill and Melinda Gates Foundation, Carter Foundation, European Foundation Centre, Ford Foundation
Private companies	Are sometimes interested in sponsoring specific events, activities or developments. The largest often have their own charities.	Welcome Trust, Novartis Foundation for Sustainable Development

2.2.2 Make initial contacts with potential donors

Initial contacts (meetings or telephone calls) are important to inform the donor organization about your organization and programme(s) and to find out more about the donor organization, including its funding interests and requirements. After the initial contacts, summarize the findings and decide which donors to pursue further.

Figure 14

Preparing for an initial meeting with a donor

The purpose of the initial contact with the potential donor is to establish the interest of the donor and the likelihood of funding. Important preparatory steps include:

- Prepare a one-page summary of the proposed project.
- Anticipate difficult questions and think of how you would answer them.
- Make sure you can describe your organization well. Bring along materials about your organization to give to the donor.
- Carefully research the donor organization to know why it provides resources and its programmatic priorities.
- Prepare a list of questions to ask the donor.
- Prepare to be asked about previous problems in your organization. Prepare honest answers that explain how problems in the past have been addressed.
- Dress appropriately for the meeting.

Adapted from *Raising funds and mobilising resources for HIV/AIDS work.* International HIV/AIDS Alliance, 2002.

Key questions to ask the donor about funding include:

- What technical areas are of most interest to the donor? Many donors identify areas of particular focus such as AIDS, nutrition, or micronutrients, and areas of interest can change.
- Are there preferred target groups or beneficiaries for the funding? Sometimes donors are interested in working with particular groups such as women, urban populations, remote populations, or refugees.
- Do matching funds need to be provided by your organization or from others?
- Are there limits to the amount of funds that will be provided?
- When are funding requests accepted? Some donors are willing to receive funding requests throughout the year. Others have specific deadlines.

- What is the required format for proposals? What indicators should be used for monitoring and evaluating progress?

- Are local partners needed on the funding application, in addition to your organization? For example, are funds sometimes specifically allocated to local NGOs?

Figure 15

EXAMPLE: Donor inventory

Category of organization	Example of organization	Likelihood of interest in child health activities
NGOs/INGOs	Save the Children Fund	Highly interested–has district level projects in child health
Civil society organizations	Women United	Mainly involved with advancement of women but might be prepared to make a small donation and involve its members, particularly in pregnancy care and newborn health.
Community-based organizations	Chikoka District Dairy Cooperative	Might be prepared to provide funds for a short-term education campaign but unlikely to provide long-term support. Interested in nutrition, particularly around weaning when milk is a part of the diet.
Religious groups/institutions	Mothers Union	Highly likely to provide education and advocacy through involvement of members but unlikely to provide financial support.
UN agencies	UNICEF	Highly likely to provide technical support and may provide some funding for certain types of activity, particularly community programmes.
Bilateral donors	USAID	Is interested in providing child health funds, particularly if activities are collaborative with local NGOs.
Multi-lateral donors	European Commission	Will be prepared to consider providing funds if it fulfilled the terms of reference of its most recent call for funding proposals. Last year the European Commission supported a national immunization programme.
International foundations	Bill and Melinda Gates Foundation	Provides support for several child health related activities. Newborn health activities are being implemented in collaboration with Save the Children US.
Private companies	Novartis Foundation for Sustainable Development	Provides funding for the development of an IMCI Computerized Adaptation and Training Tool (ICATT).

2.2.3 Prepare a letter of intent

An early step in obtaining funding is usually to submit a letter of intent. If the donor is interested, they will request a detailed funding proposal.

Donors often ask for a **letter of intent**. This is a 1–2 page summary of proposed programme activities with 2–3 pages attachment (e.g. timetable, budget). It is used for initial negotiations with the donor. The document needs to be clear and concise. It should allow an external reviewer, who is not necessarily knowledgeable about the subject, to get a clear idea of what the project is about. Based on the letter of intent, donors will make a decision as to whether they would like to see an expanded project document.

A suggested list of headings for a letter of intent is as follows:

1. Title
2. Summary of the problem and public health need
3. Goal and objectives
4. Estimated population of beneficiaries of programme activities
5. Desired outcomes
6. Summary of main activities and timetable
7. Monitoring and evaluation
8. Budget
9. (Annex: list of abbreviations)

Figure 16
EXAMPLE: Letter of intent

MINISTRY OF HEALTH – INTEGRATIA
GOING FORWARD IN HEALTH

Letter of Intent submitted to International Coalition for Children

Problem: Child deaths from pneumonia

Summary of problem and need: The number of deaths of children under age five in Metropolis region is persistently higher than other regions in the country and is not declining. The worst affected districts are Bihari, Muta and Zimba. DHS data suggest that at least 30% of deaths are due to pneumonia. In neighbouring Mountani region, the level was similar five years ago but was reduced by half after an intensive programme of training of health workers and educating families. At the meeting of the Regional Development Council last year, community leaders expressed concern about the high level of child deaths and called for action. A recent survey in the three districts found that families had heard of pneumonia but were not able to recognize it, so children were brought to the clinic at a late stage.

Goal: Reduce child deaths from pneumonia by 50% over 3 years in 3 districts.

Objective: Increase proportion of children with pneumonia who receive appropriate treatment from a trained provider from the current 30% to 74%.

The main beneficiaries: 123 000 children under five in Bihari, Muta and Zimba districts of Metropolis Region.

The desired outcomes are:

- Improved recognition by caregivers of signs of pneumonia and timely care-seeking for pneumonia (improved demand for care)
- Improved availability and quality of facility-based case management of pneumonia

The main activities will be:

- Community education on recognition of pneumonia and early care-seeking using village health committees, and community drama.
- Training of health workers in case management of pneumonia.

The methods of implementation will include:

- Development of set of simple counselling cards, showing key messages visually, based on materials used in other districts.
- Training of health workers in case management of pneumonia.
- Adaptation of National IMCI case management materials
- Supply health workers with timers, job aids and other supplies

Activities, timetable and budget: Please find attached. The budget includes capital and recurrent costs. It also includes resources from the government and other partners to ensure sustainability.

Monitoring and evaluation: A list of indicators for monitoring training for health workers and community education is attached. Results will be measured using baseline and end-line household and health facility surveys.

Figure 17
EXAMPLE: Reviewers' comments

INTERNATIONAL COALITION FOR CHILDREN

Review of letter of Intent for Project in Metropolis Region

Relevance

Data provided shows that the programme meets a real need. The target group is well defined. Pneumonia is one of the priorities in the Regional 5-Year Health Plan and child deaths were identified as an issue of concern by community leaders. Pneumonia fits well into our organization's terms of reference.

Added Value

The programme is committed to scaling-up initial activities using IMCI materials. In the long term, training will enhance capacity to respond to other child health problems. Contacts with the community could be built upon for future health education activities. The counselling materials used will be those already developed for a neighbouring region, so this saves on development costs. These materials can be used to expand the programme to other districts of the region. A weakness is that there is mention but no discussion of problems with access to services; this may still be an issue, even when knowledge of danger signs is improved.

Likely Impact

Some initial research into the causes of the problem has been carried out. The region appears highly committed to tackling the problem. The target is ambitious but in line with impact achieved in neighbouring region. It is therefore possible that a well planned programme could achieve its planned impact. Issues that will need to be considered when planning implementation include: supervision of staff to maintain quality, supplies of antibiotics, access to care, and access to referral facilities for severely ill children.

Recommendation: Ask for a full project proposal to be considered for funding.

2.2.4 Prepare a detailed project proposal

A project proposal is an expanded version of the letter of intent. This is submitted to donors for a more detailed review and consideration for funding. Donors usually ask for a project proposal after they have considered the initial letter of intent and decided that they are interested in providing support. If a project proposal is approved it will act as part of the contract. Therefore, it needs to clearly specify activities, timeline, and roles and responsibilities.

A donor may have very specific requirements for a project proposal, such as:

- language
- section headings
- targets and indicators to be used
- specific project management tools
- the budget layout
- accompanying documents such as annual reports, audited accounts, legal documents on the status of partners
- number of copies needed
- signed statements of commitment from partners.

Be sure that you are aware of these requirements and follow them closely. A previous successful proposal may help. Sometimes proposal requirements are posted on web sites. For example, the European Union has posted guidelines on project cycle management and logical frameworks that they expect to be used for all project proposals to the European Union.

Technical officers in donor organizations can be helpful in explaining regulations and advising on proposals. In some cases they might return an application that has been incorrectly completed and ask you to improve and resubmit the proposal. There may be limits on the amount of help they can provide to funding applicants, however. In situations where more than one funding request is being made to a donor, there will be strict regulations to ensure that everyone is treated fairly and that none of the applications receives extra help.

Figure 18

Key elements of a project proposal

Element	Content
1. Organizational information and proposal summary	• What is the name and address of your organization? • Who is the main contact person and what are their contact details? • In what region(s)/district(s) will the work take place? • What are the impact and coverage targets? • What is the total budget; what fraction is provided by other donors? • What is the timeframe for the work, including start and end dates?
2. Rationale for the proposed work	• What problem is the work expected to solve? • How does the work relate to this problem? • What experience do you have of working on these issues? • Have you used past experience/evaluations to inform the proposal?
3. Project design	• What interventions, packages and delivery approaches have been chosen? • Who are the direct and indirect beneficiaries? • Are the beneficiaries involved in project design or implementation? • What is the coverage of the project (area, number of people, etc.)? • How sustainable will project strategies be in the long term?
4. Management and implementation	• How will the work be implemented and managed, and by whom? • What human and material resources are required? • How will you collaborate with other organizations? • What is the timetable of activities?
5. Monitoring, evaluation and dissemination of findings	• How will activities be monitored and evaluated? • How and when will progress be reported? • How will conclusions and lessons be shared?
6. Risks/assumptions considered in the design	• What are the main risks that could affect implementation? • What measures have been taken to minimize potential risks?
7. Budgetary information and explanation	• What is the total cost? • How do the costs break down? • What other sources of funds and resources are available?

Discussing a project proposal within the MOH and with strategic partners

Follow local guidelines and procedures for the approval of project documents. This might include internal review within the Ministry of Health or other government departments, as well as review by strategic partners. If the submission must happen quickly to meet a tight deadline, alert staff who will review the proposal about the deadline. Strategic partners also might require internal clearance from senior officials in their own organizations, and sufficient time should be allocated for this.

Involve key staff as early as possible in the development and review process. This will minimize changes needed near the time of submission.

Submitting the project proposal

Submission may be to an in-country office or the international headquarters. This will determine how to submit the proposal, for example, by personal delivery, courier, or e-mail attachment.

Late receipt of a funding proposal can lead to rejection or postponement of consideration until the next round of funding. If unforeseen circumstances delay submitting the proposal, notify the donor and ask whether they will still accept it.

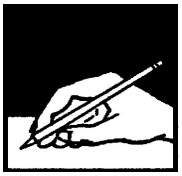
Once the proposal is submitted, there may still be a need for follow-up. Donors may fail to respond to your proposal for a number of reasons:

- They may be too busy.
- They may have forgotten about the proposal.
- The proposal may have been submitted to the wrong person and gotten lost in the system.
- The deadline had passed and it will be considered in the next funding round.
- The contact details were incorrect.
- The resource provider needs additional information.
- The donor's decision committee has not met yet.
- The donor may be checking information provided, e.g. references of partners.
- The application may have been unsuccessful.

If a significant time has passed and nothing has been heard from the donor, the proposal should be followed-up by:

- ✓ telephoning, writing or e-mailing the contact person
- ✓ asking to meet with the contact person
- ✓ asking anyone with contacts in the organization to enquire about it.

If the proposal is rejected, arrange a meeting with the contact person to identify how to improve it for the next funding cycle.



EXERCISE C – Mobilize funds from a donor

In this exercise you will analyse possible donors on a worksheet, analyse your past experience with donors, and write a letter of intent to a potential donor to request funds.

1. Prepare an inventory of possible child health donors who might be able to provide financial support for child health activities. Complete the *WORKSHEET: Donor Inventory* in your **Workbook** (page 41).

2. Describe your experience with donors in the past (in the space below). Have you had problems working with donors? If so, what problems have you had? What could you do to prevent these problems?

(Exercise continues on next page)

3. Write a letter of intent for a period of 1–3 years focusing on your selected intervention package (on a separate sheet of paper or your computer). At the top of the sheet, indicate the organization that is writing the letter and to whom (the individual or agency) it will be submitted.

   Follow the format of the example letter of intent on page 31–32. Make it no longer than one page. (You do not need to prepare the attachments.)

4. Exchange your letter of intent with another participant. Assume the role of donor and consider:

   - How well does the writer fulfil the requirements for a letter of intent?
   - What are the strengths and weaknesses of the letter of intent?

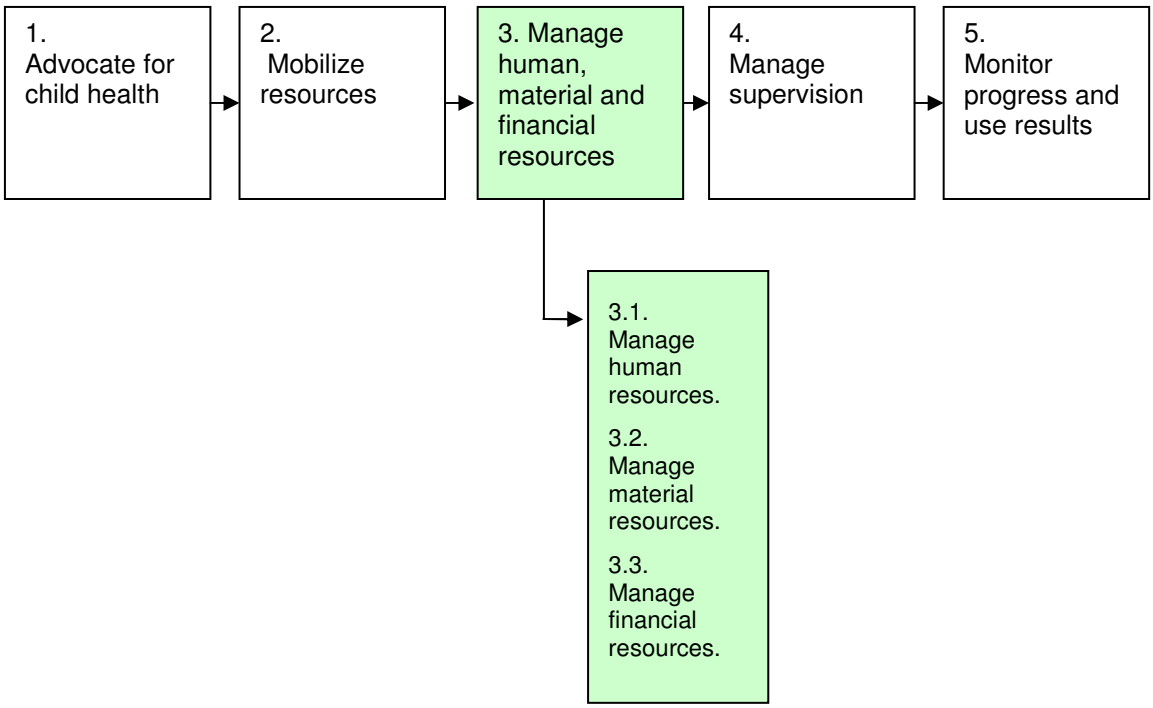
Give feedback to the other participant and receive feedback on your letter of intent.

When you have completed this exercise, discuss your work with a facilitator.

Skill 3

Manage Human, Material and Financial Resources

Figure 19



3. Manage human, material and financial resources

3.1 Manage human resources

Health workers are the single most important resource required for delivery of child health interventions. Without well-trained, well-organized and motivated health staff, effective child health programmes will not be possible. That is why management of human resources is such an important skill.

Human resource management is often shared by different levels of the health system. For example, the central or regional government, often through the MOH, may select and recruit all health personnel and assign them to jobs throughout the country. Regional health authorities may be responsible for training new staff members at health facilities. District health authorities may provide supplies and equipment and supervise health facility staff, while the health facility manager provides day-to-day management. The increasing trend towards decentralization in many countries means that local-level managers are becoming increasingly responsible for elements of human resources management.

It is important that processes and procedures are in place to provide training for health staff and to plan, supervise, support, and monitor their work to ensure that they provide quality health services.

Important elements of managing human resources include:

- Estimating human resource needs (described in *Module 2: Planning Implementation*)
- Estimating the cost of human resources (described in *Module 2: Planning Implementation*)
- Organizing work in facilities and communities (described below)
- Training
- Managing supervision including preparing supervisors (described in Skill 4 in this module)

Health workers are the single most important resource required for the delivery of child health interventions.

3.1.1 Organize work at health facilities

When work is divided among different categories of technically skilled people, and the work is directed and coordinated, the group becomes a team, with each member applying his or her own skills toward achieving the common objective. This is the principle of **division of labour.** This and the **skill mix** of health staff can have a major impact on the effectiveness and efficiency of services. When labour is divided appropriately, work is easier and more effective, and satisfaction for both health staff and clients is improved. Information on the current organization of work at a health facility can be obtained by:

1) observing daily practices at the health facility
2) interviewing health workers and the facility manager
3) talking with supervisors who visit the facility regularly
4) talking with clients (caregivers) who may have opinions on what worked or did not work, and what can be done better
5) assessing and analysing how time is allocated and used, and how staff and clients move through the facility.

Key questions include:

- What services do clients need? How many children/people consult on an average each day?

  The reason for a child's visit to the health facility will determine what skills are required by the health worker, and how much time the interaction will take. IMCI-trained staff will need to see sick children. Other staff may be assigned to do basic screening or immunizations, or conduct postnatal clinics.

- What categories of staff are currently available? What pre- and in-service training have they received?

  Skills of health workers will help determine their role in the facility. Ensuring that health workers are adequately trained and supported can allow them to assume roles with additional responsibilities.

- Can tasks be divided or reorganized for better efficiency?

  For example, at one health facility, the IMCI-trained nurse managed all sick children while her assistant only weighed and measured children and gave immunizations. The queue of children was usually long, and the assistant was not busy much of the time. After giving her some training, the nurse assigned the assistant the task of counselling the caregiver after she has seen the child and given treatment. As a result, the queue moves much more quickly.

- Can scheduling for non-urgent cases be changed so that staff can be used more efficiently?

  For example, follow-up visits could be scheduled on certain days and at certain times of the day.

Figures 20 and 21 describe two situations in which work was reorganized to improve services.

Figure 20

EXAMPLE: Investigating problems and managing human resources

A district implemented a new programme that quickly trained all nurses who care for children and pregnant women to apply IMCI, antenatal care and postnatal care. The number of these nurses in first-level health facilities has not changed. Most first-level health facilities have 2 nurses and 2 health assistants.

The supervisor who visits 6 of the facilities soon realized that the nurses are not happy. They are having difficulty making time for the new services that they are required to provide. They take a lot of time with sick children. Children are not always managed correctly. Women wait a very long time for ANC. Most clients complain they have to wait longer.

The district manager visited two facilities to interview the nurses and met with several supervisors to get their input on why the nurses are dissatisfied. He investigated the following questions:

- *How long does it take you to provide service to your clients now? Is this longer than it used to take? Why does it take longer, do you think?*
- *What part of the new services (IMCI, ANC or postnatal care) is more difficult for you to do? Why is it difficult?*
- *How do mothers react when you provide care to their children according to IMCI procedures?*
- *What is the case-load and what services do clients need?*

Based on the interviews, he identified some possible causes of the problem and the possible solutions shown below.

Possible causes	Possible solutions
Training was brief. There has been no follow-up after training. Staff are not sure how to do new tasks and are slow to perform them.	*Give additional practice with feedback, to help staff develop skill, speed and confidence.*
Some staff do not want to do ANC and postnatal care; they say they do not know how to do it; do not feel comfortable doing it.	*Divide assignments so that one nurse does ANC and postnatal care so other staff can concentrate on children.*
Mothers do not like it when they are not given the medicines they think their children need (antibiotics for colds or diarrhoea) and are hostile to health staff, which makes health staff unhappy.	*Teach health workers some information and skills to better discuss with mothers why children do not need antibiotics for colds or diarrhoea.* *Teach staff how to explain the benefit of a full assessment of the child to the mother (won't miss any problems).*
Assistants are not being utilized to do some tasks that they used to do. The nurses do it all now.	*Reassign some tasks to assistants to save the nurses some time.*

The supervisor has not yet provided additional clinical practice, but has implemented the other solutions. After a few weeks, the supervisor finds that the nurses are coping better and motivation has improved. He has asked the district trainer to do follow-up visits to refresh the nurses' skills in IMCI, and these visits are scheduled next month.

Figure 21

Emergency Triage Assessment and Treatment (ETAT)–
The importance of organization of work

Triage is the process of rapidly screening sick children when they first arrive at a health facility in order to identify children who need emergency treatment, children who should be given a high priority, and children who can wait in the queue and be seen in the regular way. Triage should be carried out in the place where sick children arrive at a health facility and before any administrative procedures.

This may require **reorganizing** the sequence usually followed by patients arriving at a clinic. A trained worker is given the responsibility for doing a rapid assessment of each child **before** weighing and registration, and then ensuring that those who need emergency care are taken to the emergency area immediately; others wait in the outpatient area.

All clinical staff involved with the initial assessment and care of sick children should be trained to carry out triage and, if possible, to give initial emergency treatment. The treatment is based on the use of a limited number of medicines and procedures that can safely be given by nurses and medical assistants after training.

The most experienced doctor or other health worker should direct the emergency department, or be responsible for providing emergency care. As the top priority is to give emergency treatment without delay, any trained member of the staff may have to start treatment while the most experienced person is called.

For more information on Emergency Triage Assessment and Treatment, see the WHO documents on ETAT and the WHO pocketbook, *Hospital Care for Children: guidelines for the management of common illnesses with limited resources*.

3.1.2 Establish regular clinic hours and schedule health staff

The regular clinic hours of the health facility should be posted in a visible place, and health workers should always be available during this time. Limited clinic hours can be a barrier to use of health services. If the health facility is not open 24 hours, arrange the opening hours so that they are convenient for the population. For example, it may be possible to increase use by opening early in the morning and/or by extending clinic hours into the early evening on some days. Also ensure that some kind of "on-call" system for emergencies is in place.

Key considerations when scheduling health workers include:

- presence of enough staff during peak hours
- presence of staff with the appropriate skills
- labour regulations (overtime, night shifts, seniority, etc.)
- nighttime coverage.

For more information on organization of work see the WHO publications: "On being in Charge: a guide to management in primary health care" and "Determining skill mix in the health workforce: guidelines for managers and health professionals."

3.2. Manage material resources

In addition to human resources, material resources are important for the delivery of child health interventions. Material resources include supplies used when providing health services, such as medicines, vaccines and medical equipment, and supporting items, such as communication materials, training materials, vehicles, infrastructure and administrative supplies. To enable health workers to deliver child health interventions, effective management of material resources is critical and requires the following skills:

- estimating needs
- estimating costs
- procuring and purchasing medicines and other supplies
- monitoring and ordering stock
- receiving, storing and distributing materials
- maintaining vehicles and buildings.

Estimating material needs and costs is discussed in *Module 2: Planning Implementation.*

Procuring and purchasing medicines and other supplies

If the manager has the authority to purchase goods independently, the following issues are important:

- Get estimates from at least three suppliers to ensure that the best price is obtained. This is particularly relevant for expensive items such as capital goods (i.e. goods that are purchased less often and last for over one year).
- Review quality and reliability, in addition to the price of an item. Cheaper items that are lower quality or have a short life-expectancy may not be cost-effective in the long term.
- Ensure that the date of expected supply is specified so the supplier takes on any risk of price increases.
- Ensure that the supplies are insured during transport in case of loss or damage.

If the manager does not have authority to purchase goods independently, then goods must be ordered from a central agency or supplier. Prices are fixed and often there is limited choice. In this case, managers need to ensure that requests to the central store are made on schedule to allow plenty of time for the goods to be released. Regular follow-up with store managers may be required.

Monitoring and ordering

Clear policies and procedures are needed for monitoring and ordering stock. If the programme or facility is large, staff are allocated full-time to this task. In a district hospital or health centre, the pharmacist is normally responsible for stock-keeping and monitoring. Reordering must be done on schedule so that materials can be delivered in sufficient time to avoid stock-outs. Sometimes the stock manager is responsible for reordering; sometimes reordering is done by a programme manager.

The **stock card** is an important tool for management of medicines and other supplies at a health facility, hospital, or storage facility. Accurate records allow managers to track what has been used, when, and for what purpose. This information allows managers to know how much of each item is available at any time, how much to order, and when to reorder. It is also important for ensuring accountability. An example of a stock card is shown below.

Figure 22

EXAMPLE: Stock Card

Item:					Code number:		
Unit + size:			Price:		Reorder level:		
Date	Received from	Quantity received	Issued to	Quantity issued	Balance in stock	Remarks	Signature

Principles for keeping stock records include:

- Make a stock card for each item in the store.
- Keep the stock card with the item on the shelf.
- Keep the record up-to-date. Make an entry every time an item is received or issued. Do not wait until the end of the clinic session, day, week or month; otherwise there is a risk that the details will be forgotten. Keep an accurate running balance of the number of items available.
- Count the stock at regular intervals, for example once a month, and record the actual physical count on the stock card. Compare with the balance on the stock card. If there are significant discrepancies, investigate what may have happened.

Where computers are available, managers may use them for keeping track of stocks. In such situations, it is still recommended to keep a physical stock card so that staff who do not use the computer can record use of stock. The stock card is also a backup record in case of loss of computer data.

Also keep a record of equipment and other assets (sometimes referred to as an asset register). The records should contain a description of the asset, manufacturer, serial number, date of purchase, supplier, purchase reference, and cost.

Stock outside of the health facility may also need to be monitored. For example, health workers in a community-outreach programme or community health workers may be allocated materials and will need to have a system for reordering their stock.

Re-ordering medicines and supplies

Medicines and other supplies are reordered based on their rate of consumption to ensure that stock-outs are avoided. The **reorder factor** can be used for calculating the reorder level and the quantity to reorder each time. The reorder factor, shown in the box below, takes into account an additional safety stock to allow for unexpected demands, delays in transport and receiving the order, or other unexpected events. (The reorder factor is equivalent to the number of months in the order period times 2, plus 1.)

The **reorder level** is the threshold below which an order should be placed and is also the quantity to reorder at that time. Determine the reorder level by multiplying the average monthly consumption of the medicine by the appropriate reorder factor.

Figure 23

Reorder factors and reorder levels

The reorder factor is based on doubling the number of months in the order period and adding an extra month. It is used to calculate the reorder level and the quantity to reorder each time.

If supplies are delivered once a month, the reorder factor is 3
If every 2 months = 5
If every 3 months = 7
If every 4 months = 9

The reorder level is the stock threshold below which an order should be placed and is also the quantity to reorder at that time.

Reorder level is calculated as follows:

average monthly consumption (AMC) x reorder factor = reorder level

Figure 24

EXAMPLE:
Reordering medicines for the Pax District

Item: Paracetamol tablets (100 mg)

AMC = 10 bottles

Delivery frequency = every 3 months

Reorder factor = 7

Reorder level = 10 x 7 = 70 bottles

On 1 March, balance in stock is 83. Order no paracetamol.

On 1 April, balance in stock is 68. Order 70 bottles of paracetamol.

The steps below (demonstrated in Figure 24) are commonly used to order stock based on past consumption:[1]

1. Using stock cards, calculate the average monthly consumption (AMC) of each item in the store.
2. Determine how often the facility receives deliveries.
3. Determine the **reorder factor** of each item in your store based on the information in the box (above).
4. Calculate the **reorder level** by multiplying the average monthly consumption by the reorder factor.
5. Determine when and how much to order by comparing the reorder level with the balance in stock. If the balance in stock is **more than or equal to** the reorder level, it is not time to reorder. If the balance is **less** than the reorder level, it is time to reorder. Order the reorder level of the item.
6. Place the order in writing to the medical supplier.

Procedures are different when ordering medicines and supplies to manage seasonal diseases, epidemics or other emergencies. Instead, consider the following:

- Based on local experience of the onset of seasonal diseases in your area, order enough supplies well in advance. Do not order the reorder level; instead base estimates on the quantity ordered last season, adjusting for last season's experience and any possible population changes.

- For an epidemic or emergency, estimate the number of cases expected from past experience or experience in other settings. This might require estimating the total number of children under 5 years of age and the proportion of these who are expected to get sick, based on the expected attack rate for an infection or public health problem. Ordering in this situation is usually done as an emergency order, outside of normal channels.

Receiving and storing materials

File notes on the delivery and the invoice for payment.

Procedures to receive supplies properly include:

- Receiving the supplies in person.
- Checking the outside of the box for damage or theft.
- Keeping a record of deliveries (date, amount, from whom).
- Checking the supplies received against the items on the requisition form (item and quantity), and asking the delivery person to sign the form to verify the delivery (and to note and sign for any discrepancies).

[1] Different countries, facilities or programmes may use different systems. The method used does not matter provided it is systematic, easy to follow, and used consistently.

- Checking the expiry dates of all items.
- Checking the basic quality of the delivered items.
- Documenting all problems.
- Sending a note to the supplier that the materials have arrived and describing any problems.

After goods have been received and checked, they need to be stored. Supplies should be organized so that the storekeeper (or other people with access to the store) can easily find what they are looking for.

Key principles of storage include:

- Choose a secure room that can be locked.
- Double-lock the store and keep it locked at all times when not in use.
- Inspect the physical structure regularly.
- Control the temperature, light and humidity.
- Prevent water damage.
- Keep free from pests (e.g. rats, roaches, ants, wasps).
- Store similar items in the same area.
- Arrange and label the supplies on the shelves, with a stock card for each item.
- Arrange medicines by expiry date if known, and remove expired and poor quality medicines.

When arranging medicines with an expiry date, apply the principle: "first expiry, first out." This means that medicines due to expire first should be placed in front of medicines that will expire later. Apply the principle "first in, first out" for items without an expiry date; newly received items should be put behind items already on the shelves.

Ensure that there is enough storage space for materials and supplies. If space is not available, it is necessary to:

1) negotiate more frequent (smaller) deliveries, and
2) build more storage space.

Distributing materials

Regional child health managers may have to work with the supply agency, the suppliers and the receivers to ensure a smooth distribution of needed materials. If they are not directly responsible for ordering and distribution, then they need to liaise with the department that is responsible to ensure that adequate supply levels are maintained.

District child health managers need to work with facility-based staff to ensure that supplies get out to where they are needed. Often this means using all available opportunities for delivery, including supervisory visits, trips to the district office by facility staff, or linking with trips to facilities by staff in other programmes.

For community outreach, materials need to be taken from facilities to community service delivery points or to CHWs. Distribution systems will often be different, depending on the distances involved, the available transportation, and the possibilities for collaborating with local partners for distribution. Do not send more materials than the receiving facility or staff can safely receive and store.

Health staff who receive material resources are **accountable** for them, just as they are held accountable for financial resources spent. Regular physical counts of materials and supplies allow a review of what is actually in stock. If discrepancies are discovered between what should be in stock and what is actually in stock, then the cause needs to be identified and appropriate action taken.

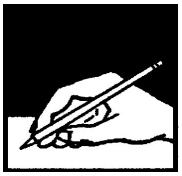
Figure 25

EXAMPLE: Managing the problem of stock-outs

A newly-assigned district health manager learned that several facilities in the district report stock-outs of essential medicines almost every month. Medicine supplies from the regional level are normally reliable. The district manager analysed the problem as shown below.

Possible causes of stock-outs	Possible solutions
Facilities or district store do not calculate needs correctly or order too late	*Train responsible people how to calculate needs and when to reorder*
Transportation to facilities has been unreliable so deliveries of medicines are often late or are completely missed (because of lack of fuel, impassable roads, security issues such as theft of medicines from trucks)	*Try to solve problems of fuel shortage.* *Increase size of shipments to carry facilities through periods of time when roads or other conditions limit deliveries.*
Needs in this district have been unexpectedly high. Perhaps because more patients are attending facilities (e.g. influx of refugees) or more sickness is occurring than usual (e.g. seasonal increases, or outbreaks after flooding)	*Find out whether needs were unusually high and if so, why.* *Teach responsible people to adjust estimates of medicines needed for seasonal changes; teach how to order additional supplies in an emergency.*
Medicines are not well accounted for. Stock cards are not kept up to date. Thefts or wastage of medicines from stocks are not detected.	*Train and supervise responsible people to: keep stock cards up to date, keep the stockroom locked except when medicines are taken out or in, record any wastage, do a physical count of stock monthly, and justify discrepancies on stock cards.*

After doing this analysis, she decided that she must investigate further to determine which of the possible causes were indeed true, before choosing a solution.



EXERCISE D – Manage medicines and supplies

In this exercise you will answer questions related to managing medicines and supplies.

Part 1: Reordering medicines

You are responsible for ordering medicines and supplies at a first-level health facility. Answer the questions relating to scenario A and B. The item to be ordered is co-trimoxazole paediatric tablets (bottles).

Scenario A

Average monthly consumption: 3 bottles
Frequency of delivery: once per month
Stock card balance: 12 bottles

What reorder factor should be used? _____

What is the reorder level? _____

Is it time to order? _____

If yes, how many items should be ordered? _____

Scenario B

Average monthly consumption: 8 bottles
Frequency of delivery: every 2 months
Stock card balance: 32 bottles

What reorder factor should be used? _____

What is the reorder level? _____

Is it time to order? _____

If yes, how many items should be ordered? _____

Part 2: Discrepancies between issued and actual materials

You are the manager of a district health facility and are responsible for issuing materials to a mobile community outreach programme. Two months ago you issued 5 weighing scales to the mobile clinic, but during stock monitoring this month, you learn that only 2 remain.

1. What are the possible causes of this discrepancy?

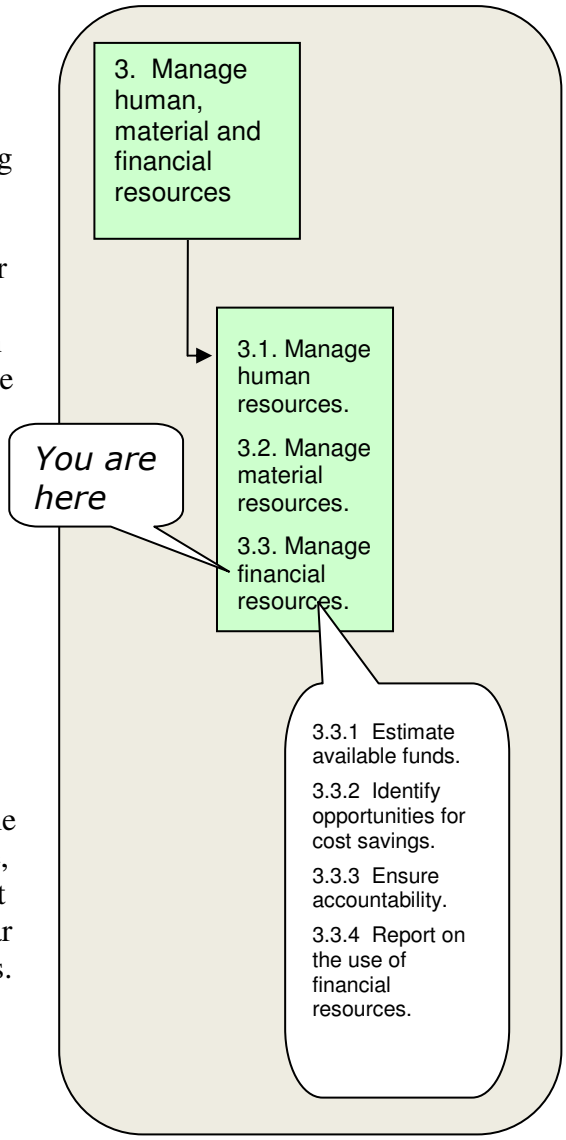
2. How can you address this problem?

3. What can you do to prevent this situation from happening again?

When you have completed this exercise, discuss your work with a facilitator.

3.3. Manage financial resources

Figure 26



Management of financial resources is an important function of a child health manager. Financial management includes developing accurate budgets, establishing safe systems for handling funds, monitoring spending, minimizing waste, and reporting on the use of the funds. While good financial management is essential in any setting, it is particularly important when resources are limited. For more information on management of financial resources see the WHO publication: "Cost analysis in primary health care. A training manual for programme managers."

Budgeting, including estimating human and material resource costs, was summarized in section 6.3 of *Module 2: Planning Implementation*.

3.3.1. Estimate available funds

A proportion of the total estimated budget will come from the government. Determine the proportion to be funded by the government by close communication with the ministry of finance or other key staff. In some cases, the annual funding is fixed and will not change, regardless of requirements. In other cases, the amount allocated to child health may change from year to year because of shifting priorities among programme areas. Once the funding available for child health for the budget period is known, managers can compare the total budget to this amount. If the funding will be sufficient, all activities can be implemented as planned. If there is insufficient funding, then alternative sources of funds must be mobilized or plans for activities must be modified.

Mobilizing resources for child health is described in section 2 in this module.

3.3.2 Identify opportunities for cost savings

Given that financial resources are limited, managers should try to save on costs whenever possible, **without compromising on the quality** of material resources. Cost savings can be made in a number of ways including:

- Implementing strategies such as IMCI that have proven to be cost-effective. (IMCI has been demonstrated to reduce unnecessary medicine use, and therefore to reduce medicine costs.)

- Removing activities that are not essential, for example, by prioritising some activities and delaying others until the next phase.

- Better packaging of interventions with existing child health activities. Examples include: combining new training with another planned training course; training existing staff to perform new duties. For example, immunization staff may distribute vitamin A, or outreach workers can have ANC counselling added to their current tasks.

- Improving access to equipment, supplies and staff from other sections of the ministry of health, for example:

  — health education/communication staff, equipment and materials
  — technicians for operating and maintaining equipment
  — vehicles and fuel
  — medicines and supply logistics
  — press officers who can help work with the media

- Ensuring that medicines and supplies are good quality and well-priced. Order medicines and supplies from well-known and trusted international and national suppliers, for example, UNIPAC (United Nations Packing and Assembling Centre in Copenhagen), IDA (International Dispensary Association), or National Medical Stores. Buy non-brand name and generic medicines to lower costs of implementation.

- Monitoring medicines in the pharmacy or storage room to ensure that they are stored correctly and managed in a way that avoids unnecessary waste. Monitor to ensure that medicines are used before their expiry dates so that they do not have to be discarded. This requires good stock management procedures such as the use of stock cards.

- Using new technology to improve communications. Use mobile phones for better and rapid communication. For example, mobile phones may be used to rapidly report adverse events, or to report immunization coverage, or to assist with referral of severe illness or obstetric complications. The mobile phone number of a skilled birth attendant may be posted in the home of a pregnant woman to facilitate rapid contact.

- Linking activities. This is often possible in the area of transportation. For example, the regular delivery of medicines and vaccines by government or NGOs can be linked with the delivery of other supplies or materials or with transportation for supervisory visits.

- Monitoring the ordering system to ensure that adequate but not excessive amounts of materials are ordered.

- Ensuring that staff are ***accountable*** for handling of funds and materials to minimize wastage and inappropriate use of resources.

Even when a manager does not have control over a certain area, such as procurement of medicines, it is often possible to influence the decisions and plans made by others. Provide recommendations to them that are supported by correct and persuasive information.

3.3.3 Ensure accountability

Managers and employees of the government are accountable for how financial resources are used. The government is in turn accountable to the general public. To ensure accountability at all levels of a programme, managers should:

- Ensure that there are sound procedures for requesting, handling and distributing funds.
- Know how money has been spent at any given moment in the implementation cycle.
- Ensure that money is spent as intended.

These steps are part of what is referred to as "internal control." Procedures that are important for internal control include:

- Approval is required for all purchasing.
- Payments due to creditors are settled within a specified period of time (but not earlier than necessary).
- Revenue is collected when it is due.
- Records of all transactions are kept so that they can be followed-up (audit trail).

Requesting funds

Transfer of funds from the government or donors may be done automatically, on an agreed time schedule. However, sometimes funds for child health activities need to be requested directly. Requests should be made in a timely manner, and managers should have a system in place for alerting themselves (or other staff if responsibility has been delegated) when funds will be needed. This requires monitoring bank accounts and cash reserves continuously. It is time to request more funds when the balance reaches an amount that is insufficient to cover possible contingencies. Different sources of funding (MOH and donors, for example) may need different amounts of time to process requests and transfer funds; know the time required to process transfers.

Handling funds

Keep records of all payments received from the MOH and donors, as well as from patients (as user fees, for example). Two types of funds need to be tracked and recorded:

1) cash used for day-to-day programme expenses
2) credit systems.

Government money is often allocated for specific needs such as medicines or other materials. These funds are transferred but do not involve cash transaction; movement of the funds still needs to be tracked and recorded.

Cash needs to be handled carefully. The following principles are important.

- In institutions charging fees for services, account daily for payments received.
- Check the payment received against the receipt.
- Keep money in a secure place.

- Do regular checks to verify that the actual balances of bank accounts and cash on hand correspond with records.
- Deposit all money regularly into bank accounts. (The person transporting and depositing money into bank must be protected.)
- Ensure that a system is in place for staff to account for money (or material resources) that they have been given. This is generally called the acquittal process. For example, if an individual was given money for fuel, he or she will have to keep receipts from the fuel station to confirm that the money was spent for fuel.

Keeping accounts

Managers at all levels need to know about keeping accounts and account books. Simple systems for collecting, compiling, and analysing financial data are needed. In many countries these are now computer-based software programmes. It is important to enter data on transactions regularly. This helps to identify potential problems early, such as overspending, and allows timely action to correct a problem. An accounting system also assists with the preparation of financial reports (see section 3.3.4 below).

Monitoring expenditures

The most important tool for monitoring expenditures is the budget. The budget shows how much should be spent on different activities and tasks over a given time, usually one year.

Allocate one day each month (or more often, especially at the end of the financial year) for reviewing expenditures. All health staff who have a role in spending should be present. Review expenditures line by line to ensure that they are within the budget. If the budget is being used too quickly or too slowly, identify the reasons. Expenditures should be reviewed in the following areas:

- ***By item***. Expenditures for some items may be higher than budgeted and some may be lower. For example, salary expenditures are often higher than budgeted, due to unexpected increases. Similarly, it is common to spend more on fuel than planned. Sometimes money has not been spent as planned. Identify areas where spending can be improved since unspent money may need to be returned at the end of the fiscal year. Where possible, spend as soon as possible; this is particularly important for materials and supplies that can be ordered in advance.

- ***By function***. Particular activities may be delayed. Others may have happened sooner than expected. For example, the implementation of training activities may be slower than expected, leading to underspending.

- ***By level.*** Different levels can have different rates of expenditure and different costs. For example, you may find that you are overspending at the facility level, but that you are underspending on community outreach activities.

Once the sources of discrepancies between the budget and actual expenditures have been identified, address the problems by increasing or decreasing the rate of spending. Examples include:

- Reducing spending by looking for alternative ways to meet costs. For example, fuel costs can be decreased by ensuring that vehicles are only used when absolutely necessary.
- Increasing spending in key areas by improving the availability of certain resources. For example, if training has not occurred because trained facilitators are not available, funds could be made available to train additional facilitators, and then planned training courses can be conducted.

If it is not possible to influence the expenditure pattern, which is sometimes the case, then it may be necessary to move money between budget lines. This approach re-allocates funds, while maintaining the same overall spending levels. Sometimes clearance from the funding organization is required before it is allowable (legal) to transfer funds from one activity to another.

3.3.4 Report on the use of financial resources

Providing end-of-period reports on the use of financial resources is an important part of financial management. Financial reports need to be tailored to the target audience for whom they are intended; different organizations require different formats. In addition, reports from different levels of the health system will have different content. Different levels of financial reporting include:

- ***Community***. Local managers of community activities will usually report to district-level managers. Financial details will relate to human and material costs of community activities.

- ***Districts.*** District managers can report to the national level or sometimes to the sub-national level in decentralized programmes. Financial reports will cover the entire district budget, which will include all recurrent and non-recurrent human and material expenses. In some cases, district managers receive funding directly from international donors or NGOs and must tailor financial reports on the use of these funds for these organizations.

- ***National***. National managers often have to report to the government and to international donors. When some elements of the programme are funded by the government and others by donors, reports must be tailored accordingly, and indicate how specific funds are contributing to the entire programme.

Figure 27

Policy and socio-economic factors important for financial management

Government policy

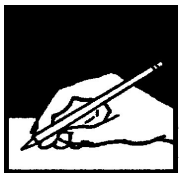
- Increase in salaries of public employees
- Decision to give more autonomy to districts/facilities in purchasing materials
- Decision to allow community health workers to give antibiotics for pneumonia

Donor policy

- Decision not to fund specific initiatives, such as IMCI, but sector-wide approaches (SWAPs)
- Increase/decrease in funding for child health

Socioeconomic context

- Admittance to the World Trade Organization (impact on medicine and vaccine prices)
- Increased competition for human resources in the private sector
- Increased out-migration of health workers to Europe or USA for work




EXERCISE E – Manage financial resources

In this exercise you will analyse some ways to improve financial management in a child health programme. Write answers to Part 1, 2 and 3 below. Then there will be a group discussion.

Part 1: Cost saving

You are the manager of the regional child health programme in your country. List some different ways you can save on costs in the programme without compromising on quality.

Area	Strategies for reducing costs
Selection and procurement of medicines	
Supply logistics	
Supervision	
Clinical skills for service delivery	
Communications	

Part 2: Monitoring expenditures in a district

Cost	Budget	Expenditure at mid-year	Expenditure as % of budget
Capital costs			
Infrastructure	*14 000*	*6 000*	
Vehicles	*16 500*	*11 250*	
Equipment	*10 000*	*5 500*	
Training (non-recurrent)	*1 000*	*0*	
Communication/IEC (non-recurrent)	*0*	*0*	
Sub-total capital			
Recurrent Costs			
Personnel	*68 000*	*31 750*	
Medicines	*20 000*	*12 500*	
Other supplies	*3 000*	*1400*	
Maintenance and operations – infrastructure	*2 000*	*900*	
Maintenance and operations – vehicles	*8 000*	*4 750*	
Maintenance and operations – equipment	*1 700*	*625*	
Training (recurrent)	*1 250*	*0*	
Communication/IEC (recurrent)	*0*	*0*	
Administrative expenses	*1 000*	*425*	
Utilities (electricity, water, etc.)	*7 800*	*4 675*	
Sub-total recurrent			
Total			

a) Complete the sub-totals, totals, and the last column in the table. (Round decimals to the nearest whole percent (e.g. 0.625 = 0.63).)

b) Then answer the following questions:

1) Did the district's total expenditure by mid-year keep within the budget? If yes, by how many percent was the budget underspent? If no, by how many percent was the budget overspent?

2) Which budget lines are overspent at mid-year and which are underspent?

3) What percentage of the total expenditure so far was spent on vehicles?

4) What percentage of recurrent expenditure at mid-year was spent on medicines?

5) What percentage of the total expenditure at mid-year was spent on personnel?

6) What is your conclusion regarding this programme's spending as compared to its budget?

Part 3: What are the most common problems with budgeting for your programme?

To prepare for a group discussion, make notes below on the most common problems with budgeting for your programme.

Consider:

- How budgets are developed by staff

- How budgets are allocated from the national, provincial or district level

- How budgets are routinely spent

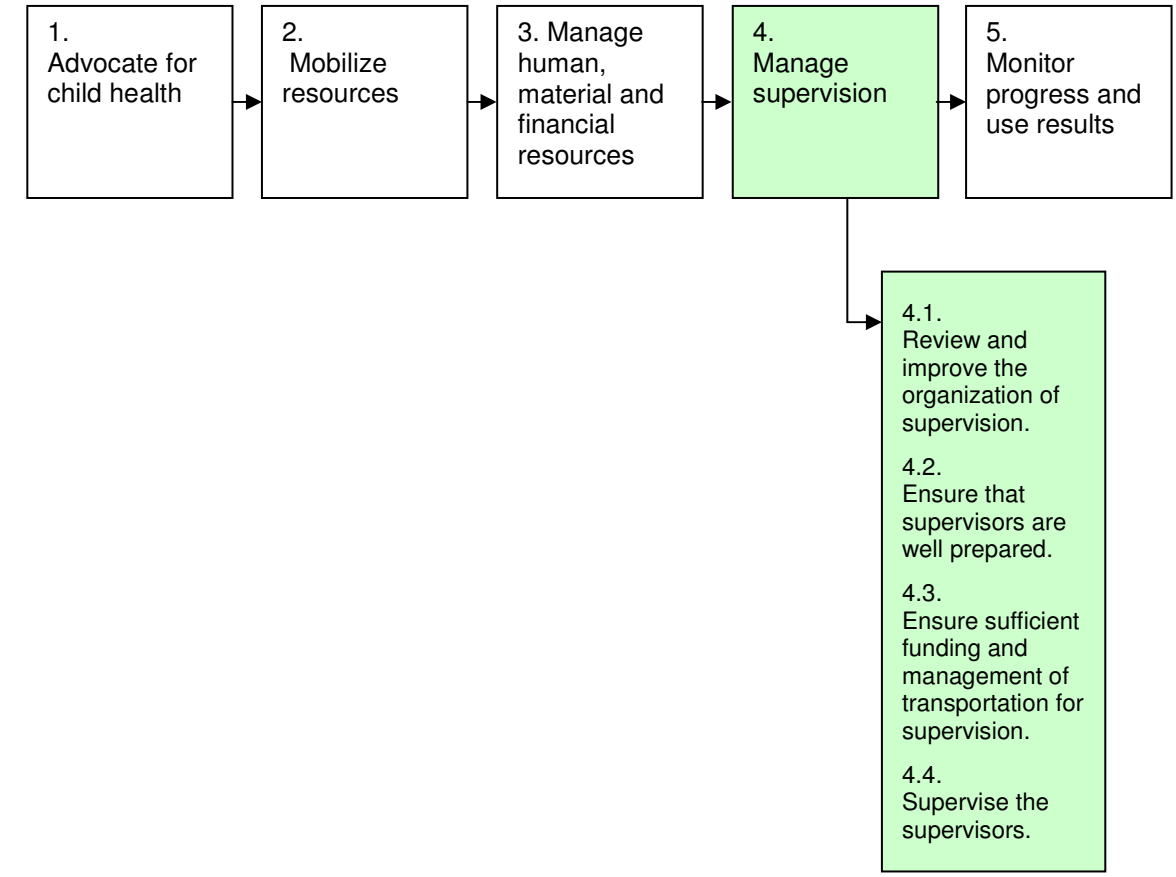
- How expenditures are monitored

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

Skill 4

Manage Supervision

Figure 28



4. Manage supervision

Supervision is a way of ensuring staff competence, effectiveness and efficiency, through observation, discussion, support and guidance.

The purpose of a supervisory visit to a health facility is to assess performance of health workers, give them support, give them guidance as needed, and assess how the health facility is functioning. If any problems are identified, the supervisor takes action to help the staff and solve the problems. Good supervision is a supportive, not punitive, interaction.

> **Supervision** is a support system aimed at improving the knowledge, attitudes and skills of health staff, and the quality of health programmes. Supervisors provide feedback and support, give training and help solve problems.

Figure 29

The Difference between Supervision and Monitoring

Supervision is overseeing or watching over an activity or task being done **by someone** and ensuring that it is performed correctly. A supervisor will, by watching, posing questions, giving guidance, and/or taking actions, all in consultation with the staff concerned, make sure that the important activities are being performed and are performed correctly.

For example, a supervisor will observe whether a trained health worker manages a sick child according to standard IMCI case management protocols and, if not, will find out the reasons and try to remedy them.

Monitoring is the continuous review of programme implementation to identify and solve problems so that activities can be implemented correctly and effectively. Monitoring involves regular collection and analysis of information/data on aspects of the programme‘s activities.

The difference between monitoring and supervision is that monitoring is usually concerned with aspects of the programme that can be **counted**, whereas supervision deals with the performance of the people working within the programme including giving them support and assessing conditions in the health facility.

Some aspects of monitoring are closely connected to supervision. During the supervisory visit, the supervisor can monitor by taking notes and recording data, such as how many trained health workers at the facility are managing sick children according to the protocols, and the medicines and supplies available. However, a person who monitors does not always come in contact with the staff, for example, when reviewing reports to count the number of health workers who attended training.

Thus, supervision must involve interaction with staff, and usually also has an element of monitoring. Monitoring does not often or automatically have a supervisory element.

4.1 Review and improve the organization of supervision

Supervision is important for maintaining the correct performance and motivation of health staff and, thereby, the quality of health services. The organization of supervision in the programme includes what and who is supervised, how, when, and by whom.

4.1.1 What is examined during supervisory visits?

Supervision seeks to improve the quality of:

- clinical care, including case management practices and counselling
- programme activities including routine reporting, medicine/vaccine ordering, health education, supply management, training
- work by facility staff in the community, such as doing outreach sessions, supervising community health workers, supporting mothers' groups

When deciding what will be supervised, a manager should consider beyond the supervision of health staff at health centres, clinics, dispensaries, etc. Other types of staff and their work require supervision as well, such as trainers, supply officers, health educators, and community health workers. Plan for a supervisor to visit all the different types of workers who perform activities for the programme. Also plan so that each of the types of activities listed above are supervised.

It would be ideal for supervisors to check whether each type of worker performs all their assigned activities well. However, it is nearly impossible to review all activities in one visit. Everyone involved with supervision is limited by the available resources–people, time and funding. Therefore it is important to prioritize and focus on supervising those activities and tasks that are the most important for a programme's success. The tasks or items that need to be supervised may change over time. When deciding what to supervise, consider the questions in Figure 30.

Figure 30

What to supervise?
Questions to consider

- What are the key tasks of clinical practice or case management performed by health staff that should be checked against the technical standards?
- In what activities is there a failure to perform adequately? What specific failures would seriously interfere with the success of the programme?
- What tasks and activities are the most difficult or challenging for health workers?
- What tasks and activities are new to health workers?
- What do the clients complain about?

The IMCI case management approach provides a technical basis for managing sick children at first-level health facilities and in some cases for community health workers. It also forms the basis for what data to collect during supervisory visits to facilities. Other standards are required to review antenatal, postnatal and newborn care.

When deciding what will be supervised, try to combine intervention packages or programmes. Joint supervision has a number of benefits including:

1) saving resources such as vehicles and travel time
2) avoiding duplication of work of supervisors
3) reducing disruption to routine facility services
4) promoting stronger/closer collaboration among programmes.

A supervisor should check that health workers have the health system supports they need to perform their work. When visiting a health facility, a supervisor would check for:

- adequate supplies of medicines and vaccines, with proper storage conditions and good record keeping
- adequate supplies of essential equipment, and materials
- adequate potable water and latrines, hand washing facilities
- adequate waste disposal (e.g. of needles and syringes)
- supplies of record books, mother's cards, growth records, forms.

The supervisor should also assess whether the health system at higher levels is providing these basic requirements:

- adequate staffing of facilities
- adequate conditions including accommodation, regular payment, career advancement
- a functional system for distributing medicines, vaccines, materials and supplies
- adequate budget for routine activities
- clear guidelines on routine reporting requirements
- resources for regular supervision.

If not, the supervisor should inform management at higher levels, and provide details of the problem and its impact.

All supervisory visits should give staff an opportunity to express problems they have encountered.

4.1.2 What methods are used during supervisory visits?

There is no single best method of supervising. Several methods exist, all of which have advantages and disadvantages.

- *Observation of health worker practice*. This method is the only way supervisors can see what a health worker is actually doing and at the same time appreciate the environment in which he/she works. Observation is also key to assessing supply management and organization of the health facility.

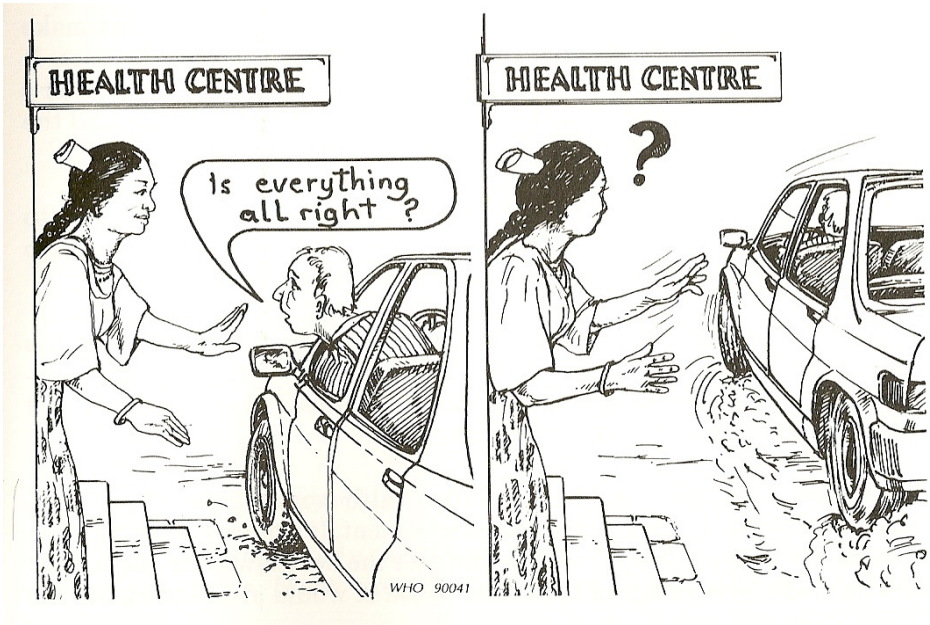
- *Talking with health workers.* This may help assess knowledge on different topics. It also allows supervisors to understand what health workers see as problems and what they see as possible solutions.
- *Review of records*. This is a quick way to review some of the activities of health workers since the last supervisory visit. Keep in mind that record review is only useful for activities for which records are complete and well kept.
- *Exit interviews with the child's caregiver.* After the consultation, supervisors can check the caregiver's general knowledge and specifically review how much he/she remembers of the advice given during the consultation.
- *Community interviews*. Interviews with caregivers and other community members one-on-one or in small focus groups can ask how they perceive the quality of services provided by the health facility.

On any supervisory visit, it is recommended to use a combination of several of these methods.

4.1.3 When are supervisory visits conducted?

When developing a schedule for supervisory visits, decide how frequently and when visits will be conducted. Supervisory visits should occur **regularly** (that is, recur at fixed intervals) such as monthly or quarterly. Health staff should be able to count on the supervisor coming on a regular schedule.

Visits should be scheduled when supervisors are available and able to devote sufficient time, such as in the middle of the month, rather than at the end of the month when there may be many competing tasks to be completed, such reporting and ordering. If a supervisor is rushed, he or she will have limited time to assess all areas and to give feedback and solve problems. ("Drive-by" supervision as shown in the pictures below provides little help and may damage trust in the supervisor.) Visits should be scheduled when health workers are likely to be available also. For example, outreach days, holidays, festivals, or national immunization days are poor times for visiting facilities.



From *On Being in Charge,* WHO Geneva 1992.

Supervisory visits should occur **frequently** enough to provide needed support, and to identify and solve problems before they have significant impact. Monthly visits to health facilities are recommended, if feasible. Staff or facilities that have been identified as having problems should be visited often, so that the supervisor can provide guidance to make improvements and support to maintain them. Staff who have recently been trained often need more frequent visits until they have gained experience applying their new skills.

However, seasons may necessitate changes in the schedule of visits. The season will influence the number and types of cases of diarrhoea, ARI or malaria that will be seen and the support needed. Seasons may also influence the accessibility of many facilities; during wet seasons, roads may be impassable. Remote facilities must be visited as well as those that are easily accessible, so ensure that they are given priority during seasons when it is possible to reach these facilities.

4.1.4 Who will conduct supervision?

Select staff to conduct supervisory visits keeping in mind:

- *Geographic proximity* to the staff to be visited (to minimize distances and expense for travel, to the extent possible)
- *Activities or tasks to be supervised* (for example, clinical practice versus administrative tasks)
- *Previous training/experience*. For example, IMCI supervisors should have basic IMCI training, preferably IMCI facilitator training, and experience with follow-up after training. Supervisors who visit supply officers need to be experienced in supply management. All supervisors should receive training in how to conduct supervisory visits, including use of supportive techniques. If supervisors are not trained in certain technical skills or supervisory skills, this should be remedied.
- *Who will be supervised*. Can nurses be supervised by medical assistants? Can health workers be supervised by non-medically trained staff? Ideally supervisors will be of similar or higher qualification or rank as the staff they supervise.
- *Availability for regular supervisory visits* (that is, availability for the number of days per month that supervisors will need to devote to making visits).

Figure 31

Summary of options for who conducts supervision

Regional or national staff visit districts

1. Supportive supervision to help district managers and supervisors
2. Technical supervision at referral facilities is done by national staff

District staff visit health facilities

1. Visit by a trained clinical supervisor – Supervisory visits by a trained clinical supervisor allow observation and validation of case-management, assessment of facility supports, immediate feedback and problem solving.
2. Visits by a non-clinical supervisor – In many districts, visits are already being carried out for many reasons, often by staff who are not trained to assess the clinical practice of health workers. Non-clinical staff can, however, assess administrative tasks and essential supports.

Supervision within a facility

1. By a trained senior health worker: A senior worker can be trained to provide skill reinforcement, solve problems, and record monitoring information.
2. Within-facility peer review: Two or more trained staff in the same facility or nearby facilities could assess and give feedback on one another's performance during clinical rounds, case conferences, or morbidity/mortality audits.

Health workers visit district office or hospital for supervision

Visits to collect pay or supplies can be used as an opportunity to discuss problems, get information on availability of essential medicines and supplies, and/or observe case-management.

Other contacts between health workers and district managers

Use of telephones, radios, e-mail and other forms of communication may allow reporting on the availability of equipment and supplies, and discussion of problems.

Self-assessment and reporting

It may be possible to teach health workers to review and document their own performance and the problems they encounter with child health programme activities.

To summarize, the organization of supervision in the programme includes what and who is supervised, how, when, and by whom. Figure 32 shows an example worksheet that specifies these aspects in a district in Integratia.

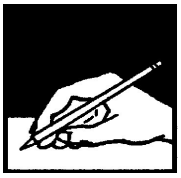
Figure 32

EXAMPLE WORKSHEET: Organization of Supervision

INTERVENTION/PACKAGE: *c-IMCI, skilled care at birth, IMCI*

Where	What and who to supervise	Supervisory methods	When: Frequency	Who will conduct supervisory visits	Interventions that could be supervised at same time
Community	*CHWs counsel on key practices (messages, methods, schedule of visits)*	*Observation* *Discussion with CHW* *Interview with community members*	*After training* *Quarterly thereafter*	*Health facility staff*	
	Skilled birth attendants (SBA) providing care at birth	*Talk with SBA when she comes to facility* *Visit to SBA to interview, check supplies, kits* *If possible, observe delivery* *Interview postpartum mother*	*When SBA comes to facility for resupply of kits* *Quarterly* *When mother comes to facility*	*Facility staff* *MCH staff from facility/hospital* *Facility staff*	*Promotion of ANC care-seeking* *Promotion of exclusive breastfeeding*
First-level health facilities	*Health workers doing IMCI case management* *Medicines & supplies*	*Observation of case management, record review, exit interview with caregivers, assessment of supplies*	*Quarterly*	*District supervisor*	
Training courses	*Trainers providing IMCI training* *Trainers of CHWs*	*Observation of IMCI courses* *Observation of CHW training sessions*	*When trainer is new; semi-annually thereafter* *Quarterly*	*District trainer*	

Note: Areas for supervision could include:
a) medicines, equipment, supplies
b) case management practices
c) administrative tasks such as reporting and medicine ordering
d) knowledge and practices of caregivers



EXERCISE F – Improve the organization of supervision

In this exercise, you will answer questions about supervision, and also plan how you will improve the organization of supervision in your programme.

1. What problems do you commonly have getting supervisors to conduct supervision in your own programme? What could you do to manage these problems?

Problems	How to manage

2. Outline an improved organization of supervision for the intervention package you have planned. Use the worksheet on page 43 in your **Workbook.**

When you have completed this exercise, discuss your work with a facilitator.

4.2 Ensure that supervisors are well prepared

4.2.1 Provide good supervisory checklists and recording forms and train supervisors to use them

Supervisory checklists are a good tool to state clearly what supervisors should check on a supervisory visit. They also remind the supervisor of what to check and record.

Periodically review supervisory checklists that are being used to find ways to improve them and improve supervisory visits. For example, you may find a section that supervisors rarely or never complete; this may indicate that supervisors do not know how to complete it, or that supervisors do not perceive that the information is important. Find out from supervisors why they do not use the section. Make improvements in the checklist, or in training in how to use the checklist, so that supervisory checklists are helpful guides to supervision and will provide the needed information about the facility visited.

Supervisory checklists:

- Should follow clear technical standards. For child health, IMCI is the best standard for outpatient services; other standards exist for antenatal care, skilled care at birth, newborn care, and referral-level care.
- Should remind the supervisor of items to check, for example:
  a) review health worker performance including
     — observation of clinical practice
     — review of records and other administrative tasks
     — review of the organization of case management tasks
  b) review health system supports such as availability of medicines, vaccines, equipment and supplies; infrastructure
  c) interview caregivers and communities to determine satisfaction with services and local perceptions of quality of care.
- Should be as concise as possible since there is limited time.
- Will differ depending on the type of health worker being supervised. Checklists for supervising community health workers, for example, need to be based on the clinical standards that are used to train community-based staff. Community staff use supplies–counselling materials and birth kits, for example–that may be different from facility-based staff. There will be different checklists for supervisory visits to health facility staff, community health workers, and trainers.

An example of an integrated supervisory checklist is in Annex B.

Supervisory recording forms are used to record the findings of each supervisory visit and the resulting recommendations. The recording form may be the same as the checklist or it may be separate from a supervisory checklist that is used as a reference, but is not written on. A copy of the recording form is usually left at the health facility or with the health worker, and another copy is taken by the supervisor to the district level or higher.

Supervisory recording forms should:

- ✓ be simple to use
- ✓ document the date and site of the visit, items checked, strengths observed, problems identified, actions taken at the facility, actions planned, and who will be responsible
- ✓ be integrated (i.e. include several technical areas, so that different forms are not required for different areas)
- ✓ produce data that can be abstracted at district level or higher and used to monitor progress at facilities (if supervisory visits are used to collect monitoring data).

Train supervisors to use the checklists

A simple but effective training session starts by giving information about what each item on the checklist means and how entries should be made for each item. Demonstrate filling in or show a completed checklist. Have supervisors practise filling in a checklist during training. (For example, read a step-by-step description of a supervisory visit, and ask supervisors to mark a checklist. When everyone is finished, compare and discuss checklists.) Also have supervisors complete a checklist when accompanying an experienced supervisor and receive feedback.

If the checklist is designed to be the report (that is, entries and comments are entered on the checklist itself), describe when the checklists should be completed, copied, and who should be given copies. If the checklist is not the report of the visit, describe what should be included in the report that is sent to others.

Also describe how the checklists or reports of visits will be reviewed and used.

4.2.2 Train supervisors in technical skills that they will supervise

Supervision of IMCI case management practice requires that the supervisor re-examine sick children to determine whether or not each child was managed correctly by the health worker. Supervising ANC, delivery, and postnatal care requires clinical skills in those practices. Supervisors who will visit health facilities to assess clinical practices must have all of the relevant clinical training.

Similarly, supervisors of supply management must understand the procedures of good supply management and must be able to identify problems by reviewing supply records.

> ***Never train health workers without training their supervisors!***

4.2.3 Train in supervisory skills and techniques

Find out about the steps that the supervisors in your programme currently accomplish during supervisory visits and the manner that they use. Supervisors who view their function as one of exerting power, finding mistakes, or reprimanding staff must be **retrained and re-educated about effective supervision methods**. Just as supervisors assess health workers by observing them at work, managers should assess how supervisors conduct supervisory visits by observing them during some of those visits. If their techniques are not adequate, feedback and training or refresher training may be needed.

It is recommended that all supervisors receive training or refresher training to help them improve their supervisory procedures and techniques. This might be accomplished in a training course, tutorials or in briefings. Any training should include role plays to practise giving feedback using good communication skills. The following topics and techniques apply for all levels of supervisors:

a) Supportive supervision
b) Steps to prepare for a supervisory visit
c) Steps to conduct a supervisory visit
d) Techniques for giving feedback during a supervisory visit
e) How to conduct a problem-solving discussion

a) Supportive supervision

An important aspect of supervision is the **manner** of interacting with the health workers that are supervised. There is a difference in the results achieved by supportive versus punitive supervision. Better compliance with performance standards, long-term behaviour change, and improved quality of care can best be achieved through a supervisory system that is welcomed rather than feared by health workers.

Figure 33

Principles of supportive supervision

Supportive supervision should:

- ✓ Use guidelines and standards that are technically sound.
- ✓ Have a friendly face, not mysterious.
- ✓ Reward positive behaviours and help solve the negative.
- ✓ Give concrete and immediate follow-up.
- ✓ Motivate health workers to perform better.
- ✓ Be flexible.
- ✓ Teach by example.

Figure 34

Comparison of supportive versus punitive supervision approaches		
Characteristic	**Supportive**	**Punitive**
Objectives	To identify problems and help health workers to solve them. To recognize good performance. To show health workers that their performance matters.	To identify flaws and reprimand those responsible
Technical basis	Behavioural science, communication skills and programme planning are all important technical skills.	No technical basis used in interpersonal contact, other than expertise in solving problems
Tools and methods	Diverse strategies to assess and understand the situation Observation of practices and environment Listening to concerns and offering help Sharing information Good communication skills	Inflexible use of checklists Judging based on assumptions, impressions or hearsay Intimidation Withholding information Poor communication skills
Feedback	Recognizes achievements. Focuses on problems that are solvable. Offers training and support.	Very little positive feedback. Feedback is usually unstructured and critical.

b) Steps to prepare for a supervisory visit

Prior to a supervisory visit to a facility, a supervisor should make preparations that will enable him or her to be thorough and helpful.

- **Review past performance at the facility.** Read reports from previous supervisory visits to the facility including problems identified and actions planned; the workplan for the facility (if available); health statistics of the facility (to look for changes in the number of sick children or child deaths).
- **Find out about follow-up actions** that have been taken in response to previous visits, or actions still needed, so that you can update the staff at the facility.
- **Collect appropriate checklists and recording forms** that you will use during the visit, and the report from the previous visit.
- **Prepare to inform staff at the facility of any updates, plans** (such as for upcoming immunization days), **changes in procedures, or feedback from higher levels.**
- **Collect supplies, equipment, and/or materials that can be delivered**.
- **Collect materials to take so that you will be prepared for problem solving**, such as training materials, counselling cards.
- **Confirm logistic arrangements,** such as transportation to the facility, any staff who will accompany you, funds for fuel and other expenses. Contact the facility to confirm the date of the visit; if the date has changed call to announce the new date, so the staff will expect you on that day.

c) Steps to conduct a supervisory visit

Important steps in a supervisory visit to a health facility are outlined below. At each step, the supervisor will note strengths and weaknesses. However, the purpose is **not** to catch staff doing something wrong, but to find ways to help them improve. The order of the steps may vary, and some steps are not always required.

1. **Private interview with the person in-charge.** Discussion of progress, actions taken and problems since the last visit. (Refer to the report from the last visit.)

2. **A review and assessment of current practices, procedures, logistics**, and the general appearance of the facility (walk about).

3. **A technical assessment of the performance of the health workers and the health services**, using a checklist and including observations of clinical practices. When observing health worker practices, reassure the health worker before starting that you are not there to criticize. It is equally important, during the observation, to abstain from any comment, signal or posture that might convey disapproval. Showing disapproval of health worker actions when the patient is present may damage the trust that caregivers have in the health worker.

4. **A discussion of perceptions of services and activities with caregivers** or community leaders/groups (if a part of the supervision strategy).

5. **Feedback of results** directly to health workers and other facility staff and a discussion of findings. Some discussion may be with a group, and some feedback may be in a one-on-one interaction with a health worker to address specific problems seen in the individual's work. See section d) below.

6. **An opportunity for health workers to ask questions** and discuss their concerns openly, in a supportive interaction. Invite health workers to ask questions and express problems and concerns.

7. **Problem solving**. Some problems can be solved at the facility. Focus on problems that seem solvable and lead a discussion with staff to identify likely causes of the problems. When causes are agreed, jointly define appropriate solutions. Give support to the staff to facilitate solutions and give on-the-job training, if needed. Some problems need to be taken to the district level or higher, in order to look for solutions that cannot be provided at the facility. See section e) below.

8. **Plan for next steps**. Allocate tasks to both facility staff and the supervisor (yourself). Plans can be verbal and immediate, and should also be documented on a reporting form. Schedule the next supervisory visit.

9. **Action after the visit.** Complete a supervisory report and send a copy to district/regional and facility staff. Communicate needs to higher levels (facility to district; district to region). Take action locally to address problems and issues that can be dealt with locally. Share findings with colleagues in the local health team.

Note: Whatever actions supervisors promise to take to solve a problem should be taken as quickly as possible. If for some reason supervisors cannot do what they promise, they should inform the health staff and use the next planned visit to look for alternative solutions.

d) Techniques for giving feedback during a supervisory visit

Feedback means communicating to the staff your impressions of their work performance. The specific topics covered during feedback depend on the positive and negative findings of the visit. Feedback will be more effective when expressed in a **supportive** way. Comments should be:

- **Task-related.** Talk about what has been seen during the visit. Comment on the tasks that were observed or problems that were noted.
- **Prompt.** Give feedback during the visit, after the observation of how the health worker performs tasks, or after reviewing administrative practices or medicines and supplies. The longer you wait to give feedback, the weaker any effect will be.
- **Motivating.** Always start with the positive findings, and then move on to what needs improvement. Show interest in the facility, the staff and their work, and confidence that the staff can do a good job. Listen to their comments and concerns.
- **Action-oriented.** Focus on improvements that staff members can make through their own efforts.
- **Constructive.** For each item that needs improvement, discuss with the staff how improvements could be made and offer support, such as training. Ask staff to comment or summarize the plans as a way to ensure that they understand what has been agreed.

These techniques are demonstrated in two scenarios in the figure below.

Figure 35

Punitive versus Supportive Feedback

Example: Punitive (ineffective) feedback

"I've watched how you managed that child, Lena, and frankly, I did not like what I saw. You really did hardly anything right. You did not bare the child's torso to count the respiratory rate and check for chest indrawing. Why don't you have a watch to do what should be done? I wonder how you got lucky enough to make a correct classification! But I'm sure you did not trust yourself and that is why you prescribed co-trimoxazole after all, when that was not necessary. If you do that, then what's the use of telling the mother what to do at home? I wonder how you spent your time during your training? Do you know how much time and money was spent putting you through training? You even seem to have forgotten that you've got an IMCI chart booklet with you here. Go back to it and read it! It's all very clear when you use the chart booklet, so I hope not to see mistakes like this again!"

Punitive versus Supportive Feedback (continued)

Example: Supportive (effective) feedback

"When you managed Lena, you followed the assessment process systematically, and I came to the same classification as you did: no pneumonia, probably a simple cold. You also gave sufficient advice to his mother and I particularly liked the way you made sure she understood your advice on what to do at home and when to come back. It was good that you repeated what she did not seem to fully understand the first time.

There are two things you should do differently next time you see a child with ARI. You should bare the child's torso when you count the respiratory rate. This will also allow you to make sure there is no chest indrawing. I see you don't have a watch, so I will ask the district to send you a timer to help you count exactly. The co-trimoxazole you prescribed was not necessary for the classification we found. Many people think it doesn't hurt to prescribe co-trimoxazole for a case like this. However, prescribing an antimicrobial when it is not needed puts an unnecessary financial burden on the child's family. Also, and many people do not realize this, it will cause bacteria to become resistant, and the medicine will lose its value as a treatment for pneumonia. Before I leave, I will look at the sections on the assessment and classification of pneumonia in the chart booklet with you, to refresh your memory."

e) How to conduct a problem-solving discussion

When problems are identified during the supervisory visit, discuss them with staff. If a problem involves only one person's performance, discuss with that one person first. If a problem is widespread or involves several people, discuss it with the group. Your goal is to agree on a plan for solving the problems, with responsibilities clearly allocated.

Feedback should be task-related. Therefore, describe the problem to the staff in terms of the activity or task that is not done or not done well. Be clear about the difference in what **should** be done and what **is actually** being done.

When the problem is clearly stated, try to identify the likely **cause or causes**. Analyse which of the following categories of cause of a performance problem is occurring:

- Has responsibility for the tasks been **clearly assigned**?
- Does the health worker(s) lack the necessary **skill or knowledge** to do the work?
- Does the health worker(s) lack **motivation** to do it? (Do they know how to do it but not want to do it for reasons such as pressure from clients, unpleasantness of the task, or cultural or social attitudes towards the illness or towards some clients?)

- Are there **obstacles** preventing them from doing the task correctly, such as a lack of time, lack of authority, lack of money, lack of medicines or supplies, or geographic location?

Think about what you have heard and observed, and ask staff why they think the problem is occurring. Ask questions to test your ideas about the cause, and to uncover other possible views on the causes of the problem. Health workers often know the causes of a problem, but may reveal them only when they trust that the supervisor is showing genuine interest and will not assign blame.

When the causes of a problem have been generally agreed, continue the discussion with the health staff to jointly define one or more feasible solutions to address the causes. Figure 36 shows the type of solution that is appropriate for different categories of cause. Note that training can only solve the problem when a cause is lack of skill and knowledge. When health workers know how to do the task but are prevented or discouraged from doing it for some reason, a different type of solution is needed.

Health workers can often suggest good solutions and solve problems when they have the support of a supervisor to do so.

Figure 36

The Cause Determines the Solution

If the CAUSE is: →	Then an appropriate SOLUTION would be:
Responsibility for the work is not clearly assigned For example: ▪ *unclear assignment of responsibilities* ▪ *conflicts between staff about roles and responsibilities*	Review and assign responsibilities.
Health worker lacks necessary skill and knowledge to do the work For example: ▪ *under-qualified for job* ▪ *new tasks were introduced/assigned without training* ▪ *poor availability of training* ▪ *ineffective training* ▪ *tasks are done infrequently, and health worker has forgotten how to do them*	Provide skill and knowledge needed (such as in a training course, on-the-job training, refresher training, tutoring; or provide a job-aid/reference).
Health worker lacks motivation to do the work For example: ▪ *lack of supervision or irregular supervision (performance doesn't matter)* ▪ *overworked; time pressure causes rushing or shortcuts* ▪ *inadequate salary* ▪ *lack of recognition* ▪ *no career advancement* ▪ *too qualified for job* ▪ *pressure from mothers to give antibiotics/antidiarrhoeals/injections* ▪ *belief that families' practices will not change*	Improve motivation to do the work (such as by providing supervision, reducing punishing aspects of the work, providing recognition and other positive consequences for doing the work well).
Obstacles prevent correct performance of the work For example: ▪ *stock-outs* ▪ *limited medicines or vaccines (due to poor case management practices or poor ordering/distribution practices or ineffective distribution system or inadequate budget)* ▪ *lack of authority (to give antibiotics for example)* ▪ *limited supply of equipment and supplies (due to poor ordering practices, inadequate budget or careless use or wastage)* ▪ *inadequate potable water or lack of functional latrines* ▪ *high case-load (difficult to take the time to manage each child systematically)* ▪ *poor organization of work (making it difficult to review each case systematically).* ▪ *inadequate staffing*	Remove the obstacle or reduce its effects.

4.3 Ensure sufficient management of transportation and funding for supervision

Lack of resources for supervision is an important issue. It affects the frequency and reliability of visits and will eventually affect the quality of care provided by health workers. Use limited resources carefully through strategies such as:

- conducting joint supervisory visits with several programme areas supervised at the same time, using the same vehicle
- using every opportunity to make supervisory visits (if visits for other purposes are arranged)
- meeting health workers when they come to the district for other reasons and discussing problems.

Finding funds for supervision is always a problem. Sometimes the local budget includes a line item for this purpose. Sometimes other programmes have budgets for supervision that can be shared. In some cases, international agencies or NGOs can bring additional resources for supervision.

Ensure that functional procedures are in place so that supervisors may:

- schedule vehicles (or use of public transport)
- receive payment or reimbursement for fuel
- receive funds or reimbursement for use of public transport
- receive payment of per diem, when needed

Supervisors need to know the procedures and be confident that transport and funds will be available as needed to fulfil the supervisory schedule.

4.4 Supervise the supervisors

Bring supervisors together for meetings to share experiences, receive updates (such as on technical issues, checklists, scheduling, or reimbursement procedures), and receive feedback on programme achievements.

Provide feedback to supervisors on how they are completing supervisory checklists or recording forms. If they are leaving blanks, find out why. Describe examples of how supervisory reports allow you to be informed, or to identify and solve a problem.

Observe the supervisors' performance occasionally. The only way you can know what supervisors do when visiting health facilities and assess their manner of supervision with health staff is to observe it yourself periodically.

Demonstrate that supervision matters to you and to the programme. By training your supervisors and supporting their work, you will show them that supervision is important. Listen to their concerns and read their reports. Help them solve problems that they face when making (or trying to make) supervisory visits. Also share stories where supervisors were able to improve or sustain performance of health workers.

EXERCISE G – Analyse common problems

In this exercise you will work with your group to practise solving common problems in a child health programme. This will include thinking of possible causes of a problem and suggesting solutions.

Your facilitator will lead the discussion. Complete the worksheet on the next page. For each common problem listed, each participant will take a turn to suggest a possible cause of the problem. When the list of causes is complete, take turns suggesting one or more solutions that would be appropriate.

In the bottom row list one more problem that you or another participant has seen in the child health programme. Analyse possible causes and solutions to the problem.

WORKSHEET: Common problems identified during supervisory visits

Clinical Problem	Possible causes	Possible solutions
Health workers say that the case load is too large. They do not take time to manage every child using standard case management. Caregivers say that they wait too long at facilities.		
Nutritional status is not assessed; weight is measured but not used in assessment; health workers say that they do not have time to do feeding assessment and counselling.		
Problem that you have identified in your own programme:		

Remember to consider different possible categories of cause: Lack of clear assignments, lack of skill and knowledge, lack of motivation, and obstacles that prevent good performance.

EXERCISE H – Give feedback and solve problems

In this exercise you will observe and perhaps take part in a role play of a supervisor's visit to a health worker.

Part 1: Observe a problem-solving interview

In this exercise, you will watch two people act a script of a meeting of a supervisor and a health worker. The supervisor will give feedback on the health worker's performance. The supervisor should:

- Begin by commenting on what was observed today and some good things that the health worker did.
- Describe a problem with the health worker's performance observed today.
- Ask the health worker whether she or he has ideas on the cause of the problem and how to solve it. Agree on the cause(s).
- Offer support for solving it.
- Agree together what will be done.
- Ask the health worker if she or he has other questions or concerns to discuss.

As you listen to each interview, think about whether the supervisor is supportive or punitive, and whether all important aspects of a supervisory interaction are included.

* * * *

Script 1 – Supervisor's interview with a health worker after observing clinical practice at a clinic

Supervisor: I watched you managing Luke, the two year old, and I must say, there were several things that you did very well. You checked for the danger signs and all the main symptoms, and found that his only problem was diarrhoea. I saw you looking for sunken eyes, and doing a skin pinch. It was also good to see you offer Luke some water from a cup–we could all see that he drank very eagerly. I agree with your classification: diarrhoea with some dehydration. Well done.

Health worker: Thank you.

Supervisor: You recommended ORS at home which is the correct treatment. However, you also gave him antibiotics, which is not appropriate for watery diarrhoea. Also, you did not ask the mother whether she knew how to give ORS at

home, or demonstrate how to give it. Nor did you explain how to feed Luke at home or when to return immediately.

Health worker: The problem here is that the mothers really expect an antibiotic. If they don't get one, they talk about us badly, and complain to the village council. Also these same mothers will go and get an antibiotic anyway, from a village quack. And we know that the quack could give anything at all–often very dangerous antibiotics. So that is why we give the antibiotics here. As for the ORS–all the mothers in this area know how to give ORS.

Supervisor: I understand. Sometimes mothers can be demanding. However, we know that antibiotics do no good for watery diarrhoea. Also, using antibiotics when they are not warranted can contribute to the development of antibiotic resistance. In the long term, this means that none of these antibiotics will be effective any more. So we really **cannot** give antibiotics in these cases. This is our responsibility as health professionals.

Health worker: It is difficult to face pressure from mothers every day. I can't really see how to get out of it.

Supervisor: Let me make a suggestion. I think this is a problem of information and problem solving. It could be helped by counselling mothers and helping them find solutions. We should explain clearly to them why we are not giving antibiotics, and that antibiotics can be harmful. My suggestion is to take two or three minutes longer with these mothers to give a little more counselling. I do not think you can assume that all mothers know how to give ORS. Many of them do not know, particularly new mothers.

Health worker: OK. I should be using the mothers' counselling card that I received at training. But, actually, I have lost it.

Supervisor: That is no problem. I will make sure to get you a new counselling card. Also, in a moment, I will show you what I mean with a real case. I will assess and classify the child and do counselling, and you can watch and see what I do.

Health worker: Thank you.

Supervisor: Let me say that you did many things nicely today. The problem was that you gave antibiotics for watery diarrhoea and you did not give enough counselling about home management. Do you agree?

Health worker: I agree. I need to do more counselling. You will bring me a new counselling card. Also, I think I will meet the village council and give them some information about diarrhoea and discuss with them how this problem could be solved, so that they can understand that antibiotics are not the right thing to give.

Supervisor: That is a great idea. I will return in about three months, but I will send your counselling card in two weeks with the next vaccine delivery. Do you have any more questions or problems?

Health worker: Not at the moment.

Supervisor: Make sure to write down any problems that you have, so that we can discuss them next time.

* * * *

Script 2 – Supervisor's interview with a health worker after walking around in the clinic

Supervisor: I have looked around this clinic of yours and I am shocked. First of all, the people here today complain about how long they have to wait. I talked to them, so I know. Many have come more than ten miles, with small children, from villages on the other side of the lake. Some are waiting more than three hours.

Health worker: Yes, there are many...

Supervisor: If that is not bad enough, there is no toilet here and no running water. Why is there no toilet? This is a fundamental human right. Every household in this country is supposed to have a pit latrine at least, but this health centre cannot manage to provide one. No wonder the country is in ruins. If we cannot provide a simple toilet at a health centre, then we are no better than animals.

Health worker: On the issue of toilets, we have been asking the village committee to dig a ventilated pit latrine for over two years but they ignore us. They have given all the money to build a new HIV testing laboratory. I attend every monthly committee meeting, and ask them for support, but get nowhere. Perhaps you could stop by and talk to the committee chairman.

Supervisor: That is hardly my responsibility. You are from this area, and you know the people on the council. You need to be more forceful, perhaps visit the committee chairman at home. Better still, bring him down here during a clinic session and let him see for himself.

Health worker: On the issue of waiting times, this has been a problem since we got our IMCI training. It has slowed us down. There are two of us here and we both try to use the complete IMCI protocol, as we were taught. We have found that this takes a lot of time, half an hour or more per case. In the past we could get though a case in about three minutes. I know this sounds ridiculous, but IMCI has made it much harder for us. I actually feel happier with the quality of care we provide now, but it has made the lines longer.

Supervisor: The quality of care does not matter if people quit coming because they must wait so long. Have you considered changing how you organize the work? I saw a nurse at the front desk who did not appear to be doing much. Perhaps

she could help with the clinical work. I don't know the answer. You should decide what is best for you. But frankly, if you don't make some changes quickly, you will not have a clinic because no one will come. This is a scandal, because a small fortune was spent by the last government on new clinics.

Health worker: In my opinion, we have a problem with staffing. The clinics were built, but there are not enough staff to run them. We have people coming here from many villages all around the lake. We need three or four more staff. In fact, we work very hard, every day except Sundays.

Supervisor: It is no use complaining about these things. There is nothing you or I can do about staffing. It is over our heads. Re-organize your work to improve the manpower. Use that nurse who was doing nothing at the front desk. I think you have a pharmacist here, so use him better. He could give drug counselling. This is the answer – division of labour. Divide and conquer. It is getting late and I have another clinic to visit today, so I must be on my way. Next time I come, I hope to see some changes.

* * * *

Part 2: Practise giving feedback and problem solving

For this part of the exercise, your facilitator will organize some role plays to practise giving feedback and solving a problem during a supervisory visit. One person will play the role of the supervisor and one will play the role of a health worker at a first-level health facility.

Other members of the group will observe the role play and note:

- verbal and non-verbal communication
- whether the feedback was punitive or supportive
- whether the problem was clearly described
- whether causes were analysed and the health worker's ideas were considered
- whether the solutions to the problem were agreed, and
- whether the health worker had a chance to raise other concerns or questions.

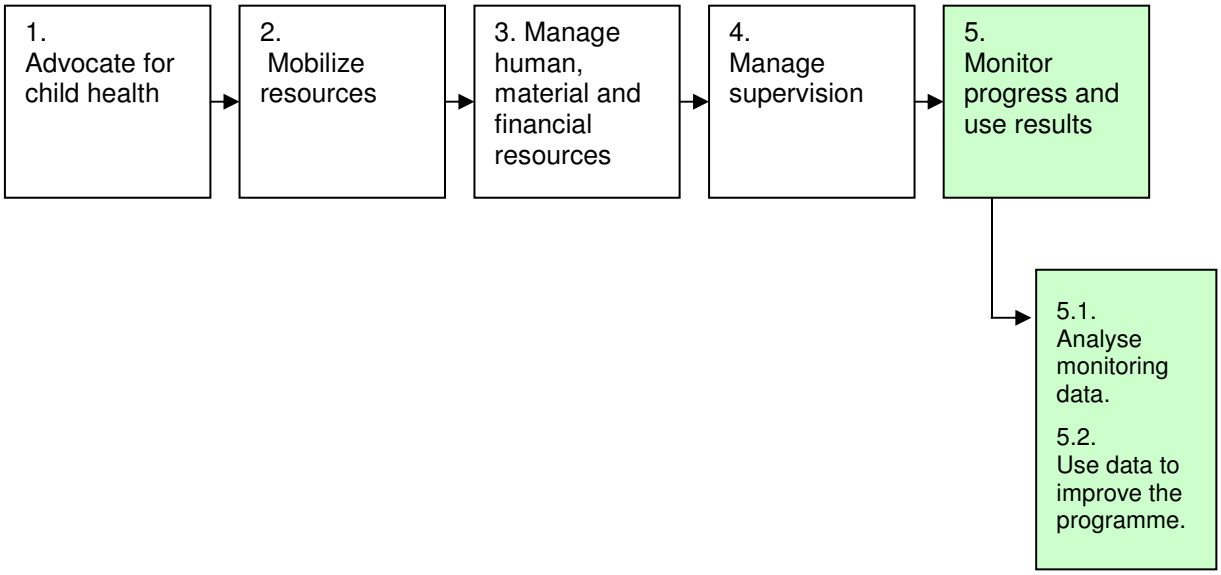
After the role play, the group will discuss whether the appropriate steps were taken during the role play and the manner of the feedback.

Other participants will act in additional role plays, as time allows.

Skill 5

Monitor Progress and Use Results

Figure 37



5. Monitor progress and use results

Figure 38

Key points about monitoring

- ✓ Monitoring is primarily concerned with aspects of the programme and its work that can be **counted**, whereas supervision deals with performance of health workers, including giving them support and assessing conditions in the health facility.
- ✓ Monitoring activities helps managers to track progress and to identify and solve problems before they cause further delay in implementation.
- ✓ To find effective solutions to problems identified in monitoring (or in supervision), the likely causes of the problems need to be identified.
- ✓ It is important to give feedback to staff on the findings of monitoring.

5.1 Analyse monitoring data

Summarizing monitoring data and calculating indicators is a process that has been made quicker and simpler by the use of computers. Computers will not make mathematical errors; however, one must always be aware of possible errors resulting from incorrect data entry or programming errors.

Calculating indicators involves identifying the correct numerator and denominator, determining a current value for each from the data, and doing the mathematical calculation. After indicators are calculated, check that they are reasonable, given the raw data and levels expected. A district manager might:

- Calculate indicators for a facility
- Calculate indicators for certain groups of facilities
- Calculate indicators for the district (sum of all facilities in the district).

When indicators are calculated, the manager would analyse progress by making comparisons, such as:

- For all indicators for which targets were set, compare the level of achievement for the indicator to the target.
- Compare levels of achievement to a past level, such as last month, or last quarter, or last year.
- Determine trends over time.
- Compare the level of achievement to that in other facilities or another district.

5.2 Use monitoring data to improve the programme

Programme managers should follow a systematic process to review monitoring data regularly, identify problems, describe the possible causes of these problems, and then work on solutions. To identify the most likely reasons for problems, managers need to talk with staff at all levels, including the district, facility and community. In addition, local staff should be involved in the process of finding and implementing solutions.

5.2.1 Review status of monitoring indicators regularly

Reviewing indicator data regularly will allow a manager to identify problem areas. The manager may identify indicators that are higher or lower than expected, or higher or lower than in other facilities, or higher or lower than they were last quarter or last year. When indicators seem to reflect a problem, investigate further to determine if there has been a change that is a concern. Sometimes a change in an indicator reflects good progress in implementing activities, or a significant problem in implementing activities, or it may merely reflect a change in data collection. (For example, if a denominator is only 2, an indicator that changes from 100% to 50% may not reflect as significant a change as it first seems.)

5.2.2 Identify problem areas and describe the specific problems

When an indicator shows that there is a problem with implementation of activities, it usually indicates a broad problem area. For example,

> *70 and 90 percent of facilities in the district had stock-outs of antibiotics in the 1st and 2nd quarters respectively*

It is important that health facilities do not run out of antibiotics for treating pneumonia. However, you cannot plan a solution to the problem until you narrow down this broad problem area further. **Who** is not doing **what**, that is, what is the specific problem (or the performance problem)?

In this example, **possible** specific problems include:

- District staff are not calculating and sending the necessary amounts of antibiotics to health facilities.
- Staff at the regional supply store do not send the antibiotics requested by the district.
- Health workers do not limit the use of antibiotics to children who need them, but give them also to children who do not need them, so the antibiotic supply is depleted quickly (high rate of irrational use of medicines).
- Management at the regional level reduced the budget for medicines.

By narrowing down the problem in this way, aspects to investigate become clearer. You need to determine **who** (what type of health staff) is not performing correctly, and then you can analyse causes and plan a solution. In this case, does the problem lie with the district staff, or the regional supply store, or health workers, or the regional budget? If you decided to do more training of health workers, but the problem was actually a lack of supply management skills at the district level, the problem would continue to occur. The most appropriate solution will depend on the specific nature of the problem, who is involved, and its causes.

Some investigation will be required to determine which of the specific problems is actually occurring, or there may be other monitoring information that verifies one or more of these problems (e.g. supply records at central or district levels may show inadequate ordering or distribution; supervisory reports may document incorrect prescribing practices).

Note: Generally, during supervisory visits, when a problem is identified it is clear who is not doing what. However, when analysing monitoring data, managers identify broad problems and must do further analysis to identify the specific problems.

5.2.3 Identify possible causes

Once the specific problem is defined, including **who** is not performing the work as required, causes can be investigated. Consider the possible categories of cause, as described in the previous chapter on managing supervision:

- Has the responsibility for tasks been clearly assigned?
- Do staff have the skill or knowledge to do the work?
- Do staff know how to do it but lack motivation?
- Are there obstacles preventing them from doing the work correctly, such as a lack of time, lack of authority, lack of money, lack of materials, geographic location?

Investigate possible causes using reports from supervision, and other reports such as those on training, supplies, or community activities. Discuss possible causes with supervisors who visit facilities and with other staff at the district or other levels to determine which causes are involved.

5.2.4 Identify and implement a feasible solution

Solutions will depend on causes identified, as described in Figure 36 (page 77). Solutions should:

- remove the cause of the problem (or reduce it as much as possible) so that planned activities can be carried out
- be affordable
- not create a problem in the delivery of another service, and
- be realistic

It is helpful to get input from staff to plan a solution and how it can be implemented. Be certain that responsibilities for implementing solutions are clearly assigned and agreed. Only when planned solutions are effectively implemented does the programme experience the improvements needed.

5.2.5 Give feedback to staff at all levels on the findings of monitoring, solutions planned, and actions taken

Feedback is an important part of any systematic process of monitoring. Feedback can be given in:

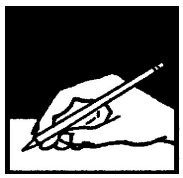
- written communication such as summaries or reports sent by mail or by e-mail,
- meetings or workshops at central and peripheral locations,
- one-on-one discussions during supervisory and other field visits.

Figure 39

EXAMPLE: Problem areas, specific problems, possible causes and solutions

Problem area	Specific problems	Possible causes	Possible solutions	Responsible for implementing solution
Stock-outs of essential medicines are common	• Health workers overuse antibiotics (do not apply standard case management). • Stock management at facilities (inventory and ordering) is done poorly.	▪ New health workers have not been trained in standard case management. ▪ Health workers like to make mothers happy by giving antibiotics. ▪ Stock management is not an assigned responsibility; staff take turns doing it. ▪ Health workers are not trained in stock management. ▪ Vehicles/fuel are inadequate for delivering medicines.	▪ Train new health workers in standard case management as soon as possible. ▪ Reinforce standard case management and appropriate prescribing during supervisory visits. ▪ Assign responsibility for stock management in those facilities. ▪ Give on-the-job stock management training to those responsible. ▪ Investigate options for supplying facilities better, such as giving medicines to staff who come to the district for other reasons, getting supervisors to carry medicines, or having EPI staff carry essential child health medicines.	Supervisors Supervisors/ programme manager Programme manager/ facility staff

Problem area	Specific problems	Possible causes	Possible solutions	Responsible for implementing solution
Planned training courses have not taken place	• Provincial health office has not printed training material. • Facilitators do not commit to be present for training. • Supervisors do not sign up health staff for training.	▪ Adaptation of materials not completed. ▪ Firm dates are not set for training, so facilitators do not plan to be present. ▪ Supervisors do not like health workers to go for training, because it leaves facilities without staff.	▪ Review status of adaptation and ensure staff are allocated to complete it. ▪ Review availability of facilitators and give them firm dates for training; if they cannot be available, select new facilitators. ▪ Discuss strategies for ensuring that health workers are available; ensure that facilities are not left without staff, and that other trainings are not scheduled. ▪ Emphasize to facility supervisors that it is their responsibility to ensure that all their health workers go for training over a period of time.	Programme manager Supervisors Programme manager
Outreach visits not taking place regularly	• Health staff are not making outreach visits to villages. • Stock manager has no extra medicines and other supplies available for outreach visits. • Health staff use financial resources for outreach visits (per diems, fuel) for something else Transportation not available.	▪ Staff do not have time to make outreach visits; no individuals are assigned that responsibility. ▪ There is no budget for additional medicines and other supplies. ▪ Stock manager does not know he should order additional medicines and supplies for outreach or how to calculate needs. ▪ Car is old and usually broken down.	▪ Discuss allocation of staff time at facilities and assign staff to do outreach. ▪ Discuss the importance of outreach visits with health staff. ▪ Assign responsibilities and schedule dates for outreach visits; set aside per diems, fuel for outreach visits. ▪ Ensure that budget allocation for outreach is available; ensure that some of budget is for medicines and supplies. ▪ Work with stock manager on a method for estimating additional needs for outreach. ▪ Review availability of vehicles; consider sharing a vehicle between several sites on outreach days.	Supervisors Programme manager Programme manager and supervisors




EXERCISE I – Monitor progress and use results

In this exercise you will analyse some monitoring results from a district to identify successes and problem areas in implementation of activities.

Background information

Mira District has:

- 12 health facilities
- 37 health workers currently in facilities who manage sick children
- 4 supervisors who share responsibilities to visit the 12 facilities (among many other duties)
- 72 communities/villages

IMCI training courses were planned to be held in 2008, 2 in the 2nd quarter and 1 in the 4th quarter. The trainers should make visits for follow-up after training to all recently trained health workers.

Efforts are ongoing to recruit CHWs (community health workers) so the numbers of CHWs are increasing. CHWs are being trained by the MOH in community case management of diarrhoea, fever and pneumonia. CHWs are being trained in counselling skills by an NGO. Staff from health facilities will supervise the CHWs.

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Below is the quarterly report of monitoring indicators that was prepared for the Mira District's manager of child health at the end of the 3rd quarter 2008. To aid in analysis, the data assistant listed below the indicators the relevant activity-related targets for 2008 that were set by the district.

First, review the monitoring data summary on the next 2 pages.
Then write answers to the questions that follow.
When everyone is ready, the facilitator will lead a discussion.

MIRA DISTRICT: Monitoring Data Summary
3rd Quarter 2008

YEAR: 2008 **DISTRICT:** Mira

Training				
Indicator	1st quarter	2nd quarter	3rd quarter	4th quarter
Proportion of training budget spent	0.29	0.55	0.24	
Proportion of planned IMCI courses completed	0/0	(2/2 courses) = 1.0	0/0	
Proportion of health staff needing IMCI training who are trained	12/38 = 0.32	12 +16 =28 28/38 = 0.74	27/37 = 0.73	
Proportion of health facilities that have at least 60% of health workers who care for children trained in IMCI	2/12 = 0.17	7/12 = 0.66	6/12 = 0.50	
Proportion of (recently) IMCI-trained health workers who received at least one follow-up visit	0/0	2/16 = 0.13	2+2 = 4 4 /16 = 0.25	
Proportion of CHWs trained in community case management	0/27	6/45 = 0.13	6+12 = 18 18/50 = 0.36	

Target for 2008: *75% of health facilities will have at least 60% of health workers who care for children trained in IMCI*

Medicines and supplies				
Indicator	1st quarter	2nd quarter	3rd quarter	4th quarter
Proportion of medicine deliveries received by district on time during the last 3 months	1/1 = 1.0	1/2 = 0.5	0/1 = 0	
Proportion of facilities with all essential medicines and vaccines available (no stock-outs) during the quarter	4/12 = 0.33	5/12 = 0.42	4/12 = 0.33	
Proportion of facilities with all essential vaccines available	9/12 = 0.75	10/12 = 0.83	9/12 = 0.75	
Proportion of facilities with appropriate record-keeping on medicines and supplies	2/12 = 0.17	4/12 = 0.33	5/12 = 0.42	

Target for 2008: *75 % of health facilities will have no stock-outs of essential medicines and vaccines in the last quarter of the year.*

(continued on next page)

MIRA DISTRICT: Monitoring Data Summary (page 2)

Supervision				
Indicator	1st quarter	2nd quarter	3rd quarter	4th quarter
Proportion of supervisors trained to use checklist with observation	0/4 = 0	3/4 = 0.75	3/4 = 0.75	
Proportion of health facilities that received at least one supervisory visit in the last 3 months	3/12 = 0.25	4/12 = 0.33	10/12 = 0.83	
Proportion of planned supervisory visits to health facilities completed	3/12 = 0.25	10/30 = 0.33	22/30 = 0.73	
Proportion of CHWs that received a supervisory visit that included observation of a home visit	0/35 = 0	0/45 = 0	0/50 = 0	

Target for 2008: *90% of health facilities will have received at least one supervisory visit in the previous 3 months*

Household and Community				
Indicator	1st quarter	2nd quarter	3rd quarter	4th quarter
Proportion of communities with CHW recruited	35/72 = .49	45/72 = 0.63	50/72 = 0.70	
Proportion of communities with CHW trained in community case management	0	6/72 = 0.08	6+12 = 18 18/72 = 0.25	
Proportion of communities with CHW trained in counselling skills	13/72 = 0.18	25/72 = 0.35	30/72 = 0.42	
Proportion of villages with village health committee in place	42/72 = 0.58	42/72 = 0.58	44/72 = 0.61	

Target for 2008: *40% of communities will have a CHW trained to provide community case management (of diarrhoea, fever and pneumonia)*

Questions to discuss:

1. What are main successes according to the monitoring data?

2. What are the main problems according to monitoring data?

3. Is the Mira District is likely to achieve these activity-related targets by the end of 2008? Write a comment on your analysis of each.

   Target: 75% of health facilities will have at least 60% of health workers who care for children trained in IMCI.

   Target: 75% of health facilities will have no stock-outs of essential medicines and vaccines in the last quarter of the year.

   Target: 90% of health facilities will have received at least one supervisory visit in the previous 3 months.

   Target: 40% of communities will have a CHW trained to provide community case management (of diarrhoea, fever and pneumonia).

4. a) There is no indicator related to quality of case management at health facilities, but what do you think the quality might be?

b) How can the manager find out about the quality of case management?

5. Specify a few specific problems (i.e. who is not doing what) that are occurring, or that may be occurring in the left column.

   Then, for each specific problem, list in the right column who the manager should contact to discuss the possible causes and to plan actions to take.

Specific problem: Who is not doing what	**Who to contact to discuss possible causes and solutions**

6. To whom should the manager give feedback on the findings of monitoring? (Remember to think about all levels of staff.)

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

Annex A

Example Press Information

WHO/NIGERIA
"WOMEN AND CHILDREN ARE MY PRIORITY" . . . MINISTER OF HEALTH
17 AUGUST 2007

Abuja, 17 August 2007 -- The new Nigerian Minister of Health, Professor Adenike Grange has said that women and children as well as malaria control would be the Ministry's priorities during her tenure. Prof. Grange disclosed this when the WHO Representative in Nigeria, Dr. Peter Eriki paid her a courtesy call in her office and also to brief her on the forthcoming WHO Africa Regional Committee meeting. The Minister added that it was her belief that men, women, children and the aged should enjoy good health. To this end, she remarked that efforts would be made to carry health interventions to the grassroots, using institutions in those communities. According to her, "health must be felt, it must be seen and palpated in every household".

Professor Grange lamented that tertiary health institutions had been turned to Primary Health Care (PHC) centres, and promised that this would be changed, as staff at tertiary health institutions would be given new orientation. She added that States, Local Government Areas (LGAs) and civil society would be made to work more closely with the Federal Ministry of Health in the delivery of health services at their various levels. She also disclosed that the National Council on Health (a meeting of top officials of the Federal and State Ministries of Health), to be held later in the year, would be used to articulate common agendas, objectives and strategies for the country to achieve delivery of better health services.

On immunization services, the Minister said she would look at the system in place, with a promise to expand and strengthen the Inter-agency Coordinating Committee (ICC), for it to accommodate other health interventions. The Minister expressed happiness that WHO is present in all states of the country, with knowledgeable staff prepared to give technical support at that level and requested the support of WHO in the building of capacity of staff, specially at LGA level.

Referring to the forthcoming WHO Africa Regional Committee meeting scheduled for Brazzaville later this month, Professor Grange noted the need for delegations to adequately prepare for the meeting. She hoped that such meetings would be used to standardize approaches to health delivery in the Region and for countries to have the opportunity to emulate best practices from other countries.

Speaking earlier, the WHO Representative to Nigeria, Dr. Peter Eriki congratulated the Minister on her appointment, saying WHO looked forward to collaborating with her as she builds and strengthens the health systems of this great country, Nigeria. Noting that WHO is the government's closest collaborator and most reliable ally in the health sector, he assured her of WHO's continuous technical support to the country.

Dr. Eriki intimated the Minister of the WHO Director-General's six point agenda and the Africa Regional Director's five point strategic orientation, which he said were the guiding principles for WHO as a Secretariat engaging with Member States. Dr. Eriki added that the Africa Region and indeed the entire world looked up to Nigeria because of its size, economic capability, institutions of excellence and her people, which should deliver credible and affordable health to her citizens.

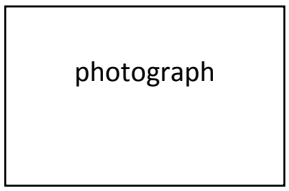
While congratulating the Government and partners for increased funding to health, he said there was need to harness and use such resources properly. The WHO Representative advised the Minister

to ensure that the Government was always on the “driving seat” and to adequately coordinate partners for support to the Government agenda.

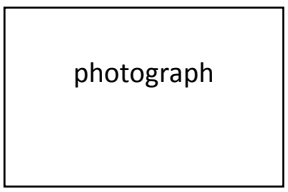
Dr. Eriki further noted that in-roads have been made into immunization in the country, as evidenced by polio cases significantly going down, routine immunization coverage increasing and measles cases drastically going down. He urged the government to further strengthen routine immunization as a way of sustaining the gains achieved this far, and to use this as a critical building block for revitalizing primary health care and to strengthen vibrant health systems. He emphasized that interruption of polio transmission and thereafter eradication are paramount, which call for continued government and partners’ financial commitment to complete the remaining challenging job.

The WHO Representative also advised government to strengthen PHC, so as to reach the poor and marginalized populations with health services. Dr. Eriki was also of the opinion that the country should develop a common agenda and plans with active participation of all stakeholders, which then all partners in the country can buy into. Dr. Eriki also extensively briefed the Minister on the forthcoming 57th WHO Africa Regional Committee meeting in Brazzaville, 27th to 31st August 2007, emphasizing what is expected of Nigeria at the meeting.

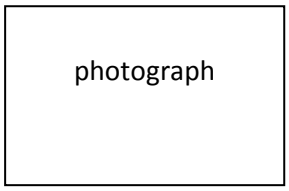
Dr. Eriki led a team of WHO Nigeria country technical staff on the courtesy call and briefing. Some WHO publications were shared with the Honourable Minister.



Minister of Health, Professor Adenike Grange (left) making her speech at the event



Dr. Peter Eriki, WHO Representative to Nigeria (middle) speaking on the occasion of the courtesy call



The WHO Representative presents some WHO Publications to the Minister

For more information, please contact:
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Annex B

Health Facility Supervision Checklist

(Example checklist used in Nigeria)

HEALTH FACILITY SUPERVISION CHECKLIST

(To be administered to the head of the health facility)

A. BASIC INFORMATION

Name of health facility _____
Type: Tertiary _____ Secondary _____ Primary_____
Name of LGA _____
Ownership (tick appropriate) Public _____ Private _____
Ward map [ ] Available [ ] Not available
Source of funding _____Govt._____Community _____Private _____Others

User-fee charges for children < 5yrs? [ ] Yes [ ] No
Imprest account Available ___ Not available ____

B. ORGANISATION AND MANAGEMENT

B.1 Organisation

Reception area	Available _____	Not available____
Triage system	Available _____	Not available_____
Potable water	Available _____	Not available_____
Sanitation:		
Toilet facilities	Available _____	Not available _____
Proper disposal of syringes, needles and refuse	Adequate _____	Not adequate _____

B.2 Management

Ward Development Committee Available ____ Not available ____
Ward bank account Available ____ Not available ____

C. CLINICAL STAFF

	Number of Staff In Facility	Number that see children < 5 years
Paediatricians	_____	_____
Other Doctors	_____	_____
Nurses	_____	_____
CHOs	_____	_____
CHEWs	_____	_____
Total	_____	_____

D. TRAINING

Number of staff members who see sick children who have received training in the following, tick applicable:

IMCI	_____
HIV/AIDS counseling	_____
Breastfeeding counseling	_____
Baby-Friendly Initiative	_____
HIV/AIDS and Infant Feeding counseling	_____

How many IMCI-trained staff have been followed up? _____

E. SUPERVISION

How often are you visited by LGA supervisor?
[ ] Weekly [ ] Monthly [ ] Quarterly [ ] Annually [ ] Not at all

When was the last supervisory visit? [ ] months ago
Feedback given? [ ] Yes [ ] No
Is there a schedule of supervisory visit from health facility to the community?
Available___ Unavailable___

F. COMMUNICATION

Are there IEC materials on key family practices? Available _____ Unavailable ___

Does the facility give health talk during ANC clinic on:

HIV/AIDS	_____Yes	____ No
Use of ITNs	_____ Yes	____ No
Intermittent Preventive Therapy (IPT)	_____ Yes	____ No

G. DRUGS AND SUPPLIES (*To be administered to the pharmacist)*

G.1 Drugs: Source

SMOH____ LGA ____ DDC/WDC ____ NGOs_____
Others (specify) _____

Availability	Now	During the last 3 months		
	In stock	In stock all the time	Out of stock once	Out of stock > once
ORS	_____	_____	_____	_____
Paracetamol	_____	_____	_____	_____
Chloroquine	_____	_____	_____	_____
Sulfadoxine-Pyrimethamine(fansidar)	_____	_____	_____	_____
Co-trimoxazole	_____	_____	_____	_____
Amoxycillin	_____	_____	_____	_____
Nalidixic acid	_____	_____	_____	_____
Iron syrup	_____	_____	_____	_____
Folic acid	_____	_____	_____	_____
Vitamin A	_____	_____	_____	_____
Mebendazole	_____	_____	_____	_____
Multivitamins	_____	_____	_____	_____
Gentian violet	_____	_____	_____	_____
Chloramphenicol eye ointment	_____	_____	_____	_____
Nevirapine syrup	_____	_____	_____	_____
Rifampicin	_____	_____	_____	_____
Isoniacid	_____	_____	_____	_____
Parazinamide	_____	_____	_____	_____

G.2 Other drugs for IM/IV administration

Quinine	_____	_____	_____
Chloramphenicol	_____	_____	_____
Benzyl penicillin (Xtalline pen)	_____	_____	_____
Paraldehyde	_____	_____	_____
Diazepam	_____	_____	_____
Streptomycin	_____	_____	_____
IV infusions (Ringers Lactate, Darrows)	_____	_____	_____

G.3 Other Supplies

Mosquito Nets	_____	_____	_____
Insecticides	_____	_____	_____
ITN Re-treatment kits	_____	_____	_____
Condoms	_____	_____	_____
IV equipment	_____	_____	_____
Nasogastric tube	_____	_____	_____
Oxygen	_____	_____	_____
ORT unit supplies (spoons, cups mixing bowls etc)	_____	_____	_____
Sterile needles & syringes	_____	_____	_____
Cotton swabs & spirits	_____	_____	_____
Disinfectants	_____	_____	_____
Registers	_____	_____	_____
Case records	_____	_____	_____
IDSR forms	_____	_____	_____
NHMIS forms	_____	_____	_____

G.4 Vaccines (*To be administered at the immunization section)*

Vaccines	Quantity in stock	During the last 3 months			Condition		Comments
		In stock all the time	Out of stock		Adequate	Not adequate	
			Once	> Once			
BCG							
DPT							
OPV							
Measles							
TT							
Yellow Fever							
CSM							
Hepatitis B							

H. EQUIPMENT

No.	Equipment	Number available	Number functional
1.	Weighing scales a. adults b. children		
2.	Thermometers		
3.	Freezers		
4.	Refrigerators		
5.	Cold boxes		
6.	Vaccine carriers		
7.	Ice packs		
8.	Vaccine monitors		
9.	Generator		

I. SERVICES

I.1 Outpatient services

a) Clinic hours opened for sick children? 8 hours ___ 12 hours ___ 24 hours ____

b) How many days in a week is service available? _____ days

c) Functioning ORT units/corners Available____ Not available____

d) Is there a trained staff in the ORT unit? [ ] Yes [ ] No

e) If yes, how many? [ ]

f) Hours of operation [ ] Hrs

g) Is routine immunization available? [ ] Yes [ ] No

h) If yes, how often? _____ days/week

i) Does the health facility run growth monitoring services? [ ]Yes [ ]No

j) How often? [ ] daily [ ] weekly [ ] monthly

k) Is there a food demonstration unit at the health facility or nearby? ** ____Yes ____No ____ nearby

l) Is Caesarian section performed at the facility or nearby? _____Yes _____No

m) Is there a breastfeeding counselor available here or nearby? Available__ Not available__

n) Is there facility for Voluntary Counseling And Testing (VCT) for HIV _____Yes _____No

o) If no, is any available nearby? _____Yes _____No

p) Are there HIV/AIDS and infant feeding counselors? _____Yes _____No

q) IMCI chart booklet Available__ Not available__
r) Mothers card Available__ Not available__
s) Growth monitoring chart Available__ Not available__
t) Standard case management definitions available and used Available__ Not available__
u) Case management guidelines for epidemic prone diseases [ ] Yes [ ] No

(** __ nearby = within I hr travel time)

I.2 Referral

Is facility a referral center? [ ] Yes [ ] No
If yes, what type?
___ 1st level ____ 2nd level ____ 3rd level

Does facility refer cases? [ ] Yes [ ] No

What problems (if any) are there with referring children?
a. No ambulance [ ]
b. Too far [ ]
c. Referral facility inadequate [ ]
d. Caretakers do not want child admitted [ ]
e. Cost implication [ ]
f. Others (specify)
_____
_____
g. Nil [ ]

J. ASSESSSMENT OF HEALTH WORKERS SKILLS

(Interview and observe health worker manage 2-3 sick children)

J.1 Assessment

Can the health worker correctly assess for:

- Presence of general danger signs Satisfactory__ Unsatisfactory__
- Presence of all main symptoms (cough, diarrhoea, fever, ear problem) Satisfactory__ Unsatisfactory__

Correctly checked weight for age [ ] Yes [ ] No
Correctly checked immunization status [ ] Yes [ ] No
Immunization given according to schedule [ ] Yes [ ] No

Health worker assessed feeding and counselled accordingly Satisfactory__ Unsatisfactory__

Health worker assessed for presence of other problems for the child [ ] Yes [ ] No

H/W assessed mother's own health Satisfactory__ Unsatisfactory___

J.2 Treatment

Are severe cases correctly referred? Correctly___ Incorrectly__

No	Treatment given	Satisfactory	Unsatisfactory	Comments
1.	Give first dose of antibiotic before referral			
2.	Give IM quinine before referral			
3.	Give antibiotic for pneumonia			
4.	Give antibiotic for ear infection			
5.	Give antibiotic for dysentery			
6.	Give antimalarial for malaria			
7.	Give ORS solution in the health facility			

J.3 Advice on Home Care

Did health worker give instruction on extra fluid, continued feeding and 2 signs for when to return? [ ] Yes [ ] No

Gave immunization today according to schedule? [ ] Yes [ ] No

J.4 Assess and counsel on feeding

Assess feeding including breastfeeding (<2 yrs) [ ] Yes [ ] No

Provide advice appropriate for age and feeding problems? [ ] Yes [ ] No

J.5 Recording

Does the health worker record cases managed? [ ] Yes [ ] No

If unable to observe health worker manage a sick child, ask how he/she will manage a child with any of the IMCI targeted conditions or review the case record of previously managed cases.

K. PROBLEMS, SOLUTION AND RECOMMENDATION

No.	Problems encountered	Solution proffered

Comments _____

Recommendations_____
_____
_____
_____

Signature of supervisor _____

Name of supervisor _____

Designation _____

Names and designation of health workers supervised:

Annex C

References on Management Skills

References on management skills

General

McMahon R, Barton, E, Piot M. *On Being in Charge. A Guide to Management in Primary Health Care,* Second edition. Geneva, World Health Organization, 1992.
ISBN: 92 4 154426 0 http://whqlibdoc.who.int/publications/9241544260.pdf

Regional framework for community IMCI. World Health Organization, Regional Office for the Western Pacific, 2003. ISBN 9290610514.

Wilson R et al. *Better Management 100 Tips*. Washington, DC, Aga Khan Foundation, 1997.

Young, A. *The manager's handbook. The practical guide to successful management*. Time Warner Paperbacks, 1992. ISBN-10: 0751514144 ISBN-13: 978-0751514148

Figure 40

MAKER, WHO Website on Management

The WHO website called MAKER (Managers taking Action based on Knowledge and Effective use of resources to achieve Results) is targeted to staff who manage service delivery at the sub-national, facility and community levels. It is designed to help managers in their daily work of organizing and delivering health services. It provides tools and guidance, country experiences, links to other relevant websites, and opportunities to share knowledge and material with other managers. The content is organized into the following areas:

- ✓ General management
- ✓ Partnerships management
- ✓ Sub-national and district management
- ✓ Facility management
- ✓ Programme management
- ✓ Community health services
- ✓ Resource management
- ✓ Quality management
- ✓ Country experiences

The website can be accessed at: www.who.int/management

Essential skills

The Conflict Resolution Network. www.crnhq.org

Haddock P. The Time Management Workshop: A Trainer's Guide (Trainer's Workshop Series). New York, NY, AMACOM, 2001.

How to negotiate. Western Organisation of Resource Councils. www.worc.org.

MacKenzie A. *The Time Trap: The Classic Book on Time Management*, Third edition. New York, NY, AMACOM, 1997.

Maxwell J, Thuman C, Werner D. *Where there is no doctor: A Village Health Care Handbook*. Palo Alto, CA, HealthWrights, 1992. http://www.healthwrights.org/booksonline.htm

Mayer JJ. *Time Management for Dummies*, Second Edition. New York, NY, Hungry Minds Inc, 1999.

McMahon R, Barton E, Piot M. *On Being in Charge. A Guide to Management in Primary Health Care,* Second edition. Geneva, World Health Organization, 1992. http://whqlibdoc.who.int/publications/9241544260.pdf

McCoy D, Bamford L. *How to Conduct a Rapid Situation Analysis: a Guide for Health Districts in South Africa*. Durban, South Africa, Health Systems Trust, 1998. ISBN 1-919743- 21-9 htpp://www.healthlink.org.za/hst/isds

An Overview of Disaster Management, 2nd edition. Geneva, United Nations Development Program, Disaster Management Training Program, 1992.

Seely J. *Oxford Guide to Effective Writing and Speaking*. New York, Oxford University Press, 2002.

Werner D and Bower B. *Helping Health Workers Learn: A Book of Methods, Aids, and Ideas for Instructors at the Village Level*. Palo Alto, CA, HealthWrights, 1982. http://www.healthwrights.org/books/HHWLonline.htm

Communication Manuals

Adam G, and Harford N. *Health on air - a guide to creative radio for development*. London, Health Unlimited, 1998.

CORE, WHO and UNICEF. *Child health in the community "Community IMCI" briefing package for facilitators. Reference document*. Geneva, World Health Organization, 2004. ISBN 92 4 15 9195 1v.1.

Education for health – manual on health education in primary health care, Geneva, World Health Organization, 1988.

Hubley J. *Communicating health! An action guide to health education and health promotion*, 2nd Edition. Oxford, Macmillan, 2004. http://www.communicatinghealth.com

O'Sullivan GA, Yonkler JA, Morgan W, and Merritt AP. *A Field Guide to Designing a Health Communication Strategy.* Baltimore, MD, Johns Hopkins Bloomberg School of Public Health/Centre for Communication Programmes, March 2003.

Radio Guide: Guide to using radio spots in national CDD programmes (adaptable to other health programmes). Geneva, World Health Organization, 1994 (WHO/CDD/94.48).

TB advocacy - a practical guide. Geneva, World Health Organization, 1999 (WHO/TB/98.239).

Communication web sites

International Union of Health Promotion and Education (http://www.iuhpe.org)

Communications Initiative (http://www.comminit.com)

Johns Hopkins Communication Project (http://www.jhuccp.org)

Leeds Health Education Database of evidence-based health communication http://www.hubley.co.uk

Resource mobilisation

Standard format for AFRO project documents, A standard format, description and presentation of a project proposal and project document to be used internally by AFRO for fundraising. Brazzaville, AFRO Region, World Health Organization, 2000.

Raising funds and mobilizing resources for HIV/AIDS work – a toolkit to support NGOs/CBOs. Brighton, UK, International HIV/AIDS Alliance, 2002.

McMahon R, Barton E, Piot M. *On Being in Charge. A Guide to Management in Primary Health Care.* Second edition. Geneva, World Health Organization, 1992. ISBN: 92 4 154426 0 http://whqlibdoc.who.int/publications/9241544260.pdf

Resource management

Cash M. In: Collins RR, ed. *Effective Management*. North Ryde, NSW, CCH Australia, 1996.

Child health in the community: 'Community IMCI': briefing package for facilitators. Geneva, CORE, WHO and UNICEF, 2004. ISBN**:** 9241591951 http://www.who.int/child_adolescent_health/documents/9241591951/en/

Creese A, Parker D. eds. *Cost analysis in primary health care. A training manual for programme managers.* Geneva, World Health Organization, 1994. http://whqlibdoc.who.int/publications/9241544708.pdf

Determining skill mix in the health workforce: guidelines for managers and health professionals. Geneva, World Health Organization, 2000.
http://www.who.int/management/determining_skill_mix.pdf

Drug supply management in the context of IMCI: report of an intercountry training workshop in Bali, Indonesia, 18-24 March 2000. New Delhi, World Health Organization, 2001.
http://whqlibdoc.who.int/searo/2001/SEA_Drugs_152.pdf

Drug Supply Management Training: Handbook for Drug Supply Management at the First-level Health Facility. Geneva, World Health Organization, 1998.
http://whqlibdoc.who.int/hq/1998/WHO_CHD_98.4d.pdf

Drug Supply Management Training: Participant's Manual for the Drug Supply Workshop. Geneva, World Health Organization, 1998.
http://whqlibdoc.who.int/hq/1998/WHO_CHD_98.4c.pdf

Emergency Triage Assessment and Treatment (ETAT) Package: Manual of Participants and Facilitator Guide. Nonserial Publication. Geneva, World Health Organization, 2005.
ISBN-13 9789241546881 ISBN-10 9241546883

Falk S, Shapiro I. *A guide to budget work: a systematic overview of the different aspects of effective budget analysis*. Washington DC, International Budget Project, 1999.
http://www.internationalbudget.org/cdrom/papers/analysis/IBPbudgetguide.pdf

Financial management: an overview and field guide for district management teams. Republic of South Africa, Health Systems Trust and Department of Health, 2002.
http://www.doh.gov.za/docs/reports/2002/finance/index.html

Kaddar M, Makinen M, Khan M. *Financing assessment tool for immunization services: guidelines for performing a country assessment*. Health reform tools series. Bethesda, MD, Partnerships for Health Reform Project, Abt Associates Inc, 2000.
http://www.healthsystems2020.org/content/resource/detail/734/

Management Sciences for Health in collaboration with the World Health Organization. *Managing Drug Supply: The selection, procurement, distribution and use of pharmaceuticals*, Second edition, Revised and expanded. Kumarian Press, 1997. ISBN: 1-56549-047-9

Management Sciences for Health. Family Planning Manager's Handbook: managing your finances. Manager's Electronic Resource Center, 2005.
http://erc.msh.org/fpmh_english/chp9/index.html

Management Sciences for Health. Managing community health services. Manager's Electronic Resource Center, 2005.
http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=chs&language=English

Pocket book of hospital care for children: guidelines for the management of common illnesses with limited resources. Geneva, World Health Organization, 2005.
ISBN 92 4 154670 0 http://whqlibdoc.who.int/publications/2005/9241546700.pdf