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District Team Problem Solving Guidelines

for

Maternal and Child Health, Family Planning and other Public Health Services

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Preface

District Team problem-solving is one outcome of over twenty years of continual health planning methodology development by the World Health Organization. It is based on the problem-oriented, "rational-analytical" planning concepts and methods embodied in the project management approach developed in the early 1970's entitled "Project Systems Analysis". The initial procedures description for this method was published in Health Project Management, WHO Offset Publication No. 12, 1974. During the 1970's the method was applied and taught around the world in a variety of situations in which major health development projects were being formulated for national and external funding.

In this same period many of the concepts and procedures were incorporated in a more general health sector planning approach called "Country Health Programming". This process was supported by WHO principally in the South East Asia region during the period in which national health administrations were revamping their national health policies and programmes toward the concepts of Health For All through the Primary Health Care approach. Gradually, WHO health planning methods development and promotion gave way to a broader-based promotion of a "Managerial Process for National Health Development" which espoused principles across all phases of management including programme budgeting, implementation, evaluation and replanning.

As health systems infrastructure development progressed in most developing countries, decentralization of management authority and control became a common policy and phenomenon, partly because government-wide reform was going in this direction, but particularly in health, because the full implementation of primary health care and community involvement in health demands planning and action-taking below the central level. It was at this time (the mid 1980's) that WHO began receiving requests from countries (and states within countries) for support in strengthening the management of health at lower levels of the health system, particularly the district level.

Another kind of message began to be communicated from countries reflecting dissatisfaction with the common workshop approach for training health staff in management concepts and techniques. A good example of this came from Dr O.P. Gupta, then the Director of Health Services of Gujarat State in India, who wished to raise the management capability of all his District Medical Officers through some kind of action learning. It was in Gujarat State that District Team Problem-solving was born. It was found possible to boil down the situation analysis and project planning steps to essential ingredients for use by district and service staff with their limited data and to have them actually implement and evaluate the resulting proposal. Following that successful experience, the South East Asia Regional Office of WHO extended the problem-solving approach for training District Medical Officers to other states in India including Himachal Pradesh, Madhya Pradesh, Karnataka and Orissa.

The first formal application of DTPS in the present style (four teams and a very structured analysis and planning process) was undertaken by the Public Health Institute in Kuala Lumpur, Malaysia in 1985. The results were so promising that the further development and application of the method was included within an interregional project of the Family Health Division of WHO in Geneva, funded by the United Nations Population Fund (UNFPA). Subsequent applications have taken place in:

Malawi* (1987-88)
Zimbabwe* (1989-90)
Malaysia (1990-91 and 1991-92)
Zambia* (1990-91)
Tunisia* (1990-91 and 1992-93)
Thailand* (1991-92)
Tabasco State, Mexico (1992-93)
Senegal (1992-93)
Sudan (1992-93)
Tanzania* (1992-93)
Republic of Maldives (1993-94)
(* report available on request)

This guideline is written in an effort to share the accumulated experience from these applications and to encourage other countries to engage in action management learning-by-doing through district team problem-solving.

Section 2 of this guideline presents the DTPS and its implementation and would be of first interest to decision-makers. Section 3 provides guidance on the steps to follow for organizers of DTPS workshops. Section 4 deals with practical aspects of DTPS workshops and their actual conduct and is of prime interest to both organizers and facilitators.

The World Health Organization thanks UNFPA for the financial support provided for the development of the method through country applications and also thanks DANIDA for supporting DTPS implementations in Zimbabwe and Zambia.

1. PURPOSE OF THE GUIDELINES

These district team problem-solving (DTPS) guidelines have been prepared mainly to assist facilitators of DTPS workshops. They may also be useful for national programme managers who decide on whether to undertake DTPS, for organizers of the DTPS process, and for training institutions and other agencies interested in supporting or using DTPS.

The guidelines describe how the DTPS process is designed to facilitate learning by doing, and how it improves services by empowering health personnel with practical management skills.

The guidelines describe:

- what DTPS is
- how DTPS improves maternal and child health (MCH), family planning (FP), and other public health services
- how DTPS enables health personnel to manage services better
- how to set up, organize and conduct DTPS successfully.

The guidelines are based on experience gained in implementing the approach in different country settings and working with health personnel who have different types and levels of training and experience.

2. WHAT IS DISTRICT TEAM PROBLEM-SOLVING?

District team problem-solving (DTPS) is a process, which takes approximately one year, in which teams of health workers are guided, via two workshops (with rigorously structured sequences of assignments) in:

- conducting their own analysis of one high priority public health problem, for example in MCH or FP in their district

- devising and then implementing their own solution to this problem over a one-year period

- conducting and presenting the results of their own evaluation of their implementation (progress, constraints, service improvements, and health impact)

- developing the ability to gather and use data

- developing good team-work and improved managerial skills.

During an initial planning workshop of 9-10 days, each team develops its most feasible solution and its implementation plan. The team then carries out its implementation plan over a predetermined period (10-12 months).

Finally, the team presents its self-evaluation at a 3-day follow-up workshop. The team then programmes its future activities, usually for the next year.

2.1 How does DTPS strengthen management of MCH/FP or other Public Health services?

Teams learn a "bottom line" approach. Their efforts are focused on health outcomes or end-results with the aim of achieving a better health status of the population. They plan to improve the delivery and utilization of the critical services that will produce this. The "problem" they analyze and attack is some unacceptable MCH/FP (or other

public health) condition that is important to the Ministry of Health (MOH), to the district team, and the community. Their challenge is to reduce this specific health problem over a relatively short period of time.

As part of the DTPS process, teams will:

- systematically analyze a problem

- identify principal causes and locally feasible solutions within the national policy and programme framework

- plan and put into operation the team's implementation activities within a realistic time frame

- decide how they will monitor and evaluate both their efforts to implement and the success of their envisioned solution

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

- learn to listen to and to use all members during the one-year DTPS period, thus to function as a real team (often for the first time), and to develop team spirit.

Thus, DTPS builds problem solving and solution implementing capacity among district personnel.

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

DTPS furnishes top officials of the Ministry of Health with an opportunity to exert leadership, for example, in order to inspire improved management of MCH services for the improved health of mothers and children. It does this by enabling them to challenge personnel constructively. This challenge occurs in a structured planning situation that leads to demonstrable results without additional budget.

The structure of DTPS produces a results-oriented dialogue between MOH staff at central (headquarters), regional (province), and district levels, and in facilities. Senior decision-makers are first put in the role of challenging their district staff. Then they must listen actively to their staff's systematically developed solutions. The initiatives and actions discussed are those coming from the district staff. They are based on local resources and circumstances. Hence, DTPS creates the organizational dynamics required for effective delegation and decentralization of responsibilities.

DTPS improves communication and team-work among district health staff through constructive and responsible dialogue within the group and with other staff. This tends to continue beyond the elaboration of a locally feasible solution, implementation, and evaluation of results.

Through all these effects, DTPS strengthens management of district health services.

DTPS produces better health status through improvement in performance of targeted health services, as a result of the initiative, effort and team-work of district health personnel, usually in combination with the communities they serve.

2.2 Why does DTPS succeed in improving management of services while conventional management training often fails?

DTPS produces sustained district team action and results because it avoids some of the many causes of inaction that so frequently follow conventional management training:

- A sizeable group of individuals (5-7) from each district are trained together. They continue as a team that has learned to work together, a mutual support group. Usually, they are emotionally involved in their commonly designed plan. In contrast, individual trainees returning to the workplace after normal management training frequently find that colleagues and superiors do not understand their new language or concepts, and do not appreciate or encourage the changes they may try to initiate. The isolated trainee usually lacks the confidence to convince uninitiated colleagues, or the spirit to undertake the difficult task of changing health service routines.

- A feasible solution to a real problem, with a detailed workplan document, is in hand, ready for implementation by the end of the planning workshop. Trainees in conventional management courses commonly learn "useful" management techniques by applying them to hypothetical, simplified problems, or to problems in other health services. However, they usually experience difficulty, upon return, in actually applying these techniques to the complex problems of their own services. Typically, they do not find enough time and support to make effective use of the management techniques they have learned.

- Before the planning workshop is over, central decision-makers and regional support staff actively listen to, discuss, and approve each district team's problem analysis and solution proposal. Trainees of conventional management courses often doubt that their superiors, including mid-level supervisors, understand their view of the problem or the changes they would like to undertake. They are, therefore, unsure of support, and fearful of misunderstanding and opposition. Proposals developed are often left awaiting future review.

- At the outset, teams know that they must present their own evaluation of their effort in about a year at an evaluation workshop. This further motivates each team to sustain action and to monitor its results. Most management training efforts lack such a follow-up mechanism or any evaluation of actual health improvements achieved.

2.3 Who participates in DTPS?

Teams of five to seven health workers in the same service area, drawn from each of four districts, carry out the main work of DTPS. They should be chosen because they are the right people to work on resolving the particular, high-priority public health problem that was selected for their district. The four districts can be all from the same region or province, or from different ones.

The district medical (or health) officer and the chief district nursing officer should always be included. The choice of other team participants should be made by the district medical officer in consultation with provincial and central officials supporting the DTPS exercise.

It is impractical to include more than four teams in one workshop, as the number of presentations would make sessions rather long and tedious.

2.4 Who facilitates DTPS and what is their role?

The DTPS workshops are facilitated by one or more professionals experienced with the methodology and actively assisted by 5-10 health professionals to be "trained" as facilitators for future workshops. The main criteria for selecting facilitators include experience in the health services, educational skills, ability to conceptualize problems, and in the position to institutionalize the DTPS process. Facilitators are chosen from several different groups:

- managers and central level staff of national health programmes, where relevant, e.g. director of family health services, manager of the expanded programme on immunization, etc.

- regional or provincial health personnel

- health personnel with special, relevant expertise, e.g. statistician, epidemiologist, nutritionist, demographer, experts in clinical fields, etc., as needed

- staff of relevant training institutions, e.g. public health Institute, national training centre, community medicine faculty of a collaborating university, etc.

- staff of support agencies (e.g. WHO, UNFPA and UNICEF)

The facilitators take turns in introducing the plenary sessions. These session introductions are not conventional teaching exercises; they are brief and non-didactic. The facilitator merely clarifies, in about 10-15 minutes, what tasks the teams are to accomplish during the session, what paper products they must produce, and how they should fill in the formats they are given, presenting clear examples.

For continuity, it is preferable that each team has one facilitator who remains available to it throughout the planning workshop. Facilitators should sit quietly, listening at the edge of their teams as they work through their assigned tasks. They should respond to questions that are addressed to them by team members. Only if the team strays into assumptions or conclusions that are clearly in error, or into an approach that is patently unproductive, should a facilitator intervene with his or her own point of view. This should be to guide, but not to direct, leaving the group to conduct its own business. After such an intervention, the group must be left to determine its own, independent conclusions, and to complete its assigned tasks within the time available.

It is recommended that national facilitators visit teams two or four times during the actual implementation of their solution, between the planning and evaluation workshops. At such times they may assist in a specific action such as a survey, or preparations for the team's evaluation report, or they may merely observe progress being made.

2.5 What kinds of problems can be addressed through DTPS?

In DTPS, team members must be convinced that the team is addressing a real, very important public health problem in the population for which it is responsible, so that they feel justified in undertaking a sustained effort to solve that problem.

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

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

2.6 How is implementation achieved and facilitated?

DTPS is based on a results-oriented approach to strengthening of management. As a team works to solve its population's health problem, it discovers how to improve its management of health services.

This point is emphasized here because there is a natural tendency for those interested in improving management of basic health services to focus immediately on problems of management processes (e.g. unsatisfactory coordination, delegation of tasks and responsibility, decentralization, etc.) or support systems (e.g. poor functioning of management information systems, personnel administration, communications, transportation, supply, logistics, etc.). While such managerial process problems inevitably come up and are dealt with in DTPS team discussions, they are dealt with not as ends in themselves, but as obstacles that must be overcome in order to improve services to the population and thereby reduce the assigned problem. It thus becomes fairly evident to teams exactly what changes in their methods of work will be needed to make a difference in services and health status.

As the teams work systematically through their structured tasks during the planning workshop, they are under continual time pressure. They are thus obliged to reach a consensus on the few most important considerations after every discussion, then to write them up immediately (within given formats). This is a realistic preparation for normal managerial decision-making in the course of their day-to-day work, while providing health services.

The initial condition that no extra resources are available makes DTPS a robust technique. It is workable in a wide range of health systems, even when continuing support from the centre or region or external help are unlikely.

It is important to set the initial constraint of no extra resources, even though some teams may be able to attract additional funding, as it leads to sensible planning and sound project documents. The constraint also forces each team to turn inwards. Team-mates are obliged to re-examine together their own district situation - its needs and resources. As it will not be waiting for an external budget, the team will be able to start implementing its action plan immediately. Teams usually respond to the constraint by becoming more resourceful.

After the planning workshop, the teams return to their districts to carry out their action plans. They are under their own mutual guidance as they carry out the solution which they jointly designed. Each of them understands the strategy of the team's plan and will be able to see better than any supervisor or outside party how to adjust that strategy along the way as necessary.

Of course, it is desirable for provincial or regional and central units to support the district teams during project implementation. Such higher level support should be encouraged. This can be done by ensuring that the names of regional staff appear in the team action plans as responsible for supporting specific activities.

Each team implements its project in anticipation of the evaluation workshop where it will present the results of its work. The methods and materials used by each team for detailed planning of project activities - the implementation plan, schedule, etc. - assist it in monitoring ongoing work during implementation.

The team's self-evaluation will be based on the evaluation framework it developed at the end of the planning workshop. From the outset, the team knows it will assess, at the end of the implementation period, how well it was able to carry out the activities it scheduled, to what extent the results it envisioned were actually produced, and to what extent these achievements were successful in improving the health services received by the population. Depending on the indicators chosen, some teams may be able to show an improvement in the health problem they were addressing.

Hence, the district is called upon to conduct a "real" evaluation, one designed to enable team members to learn from their own experience how they can improve the use of their own skills and of those resources over which the team has continuing control.

3. HOW TO SET UP A DTPS PROCESS THAT WORKS

Some of the special features that contribute to the success of DTPS are that the district teams:

- are initially challenged by high-level Ministry of Health (MOH) superiors to devise ways to ameliorate one public health problem in the population for which they are responsible; to present 9-10 days later their proposed solutions to the MOH decision-makers in an effort to obtain approval to go ahead with their planned activities; to proceed to implement their action plans, if given the "go-ahead"; then, 10-12 months later, to present their own evaluation of their results to the same officials.

- are driven hard to accomplish pre-specified team tasks, generating products on paper using specific, simple formats, all in limited periods of time.

- are assisted by central, regional and sometimes by external facilitators. Facilitators must spend most of their time listening, continuously resisting the temptation to take over. They must avoid interventions, however well intentioned, that will deprive the team members of a sense of ownership of the defined problem and of the solution.

- are obliged to work through their tasks together interactively (with only the most minimal guidance from facilitators) which usually leads to the development of good morale, group functioning, communication, and coordination (i.e., team-work).

- receive almost no lectures or didactic instruction, but learn through doing what is required.

- produce creditable solution proposals, in the form of typed action plan documents which they present and defend on the last day of the planning workshop.

- devise their solution strategies assuming that no additional resources are available and thereby develop the capacity to make better use of existing resources.

- actively explore the potential for intersectoral and community collaboration, and the particular functions that need to be integrated within government services, wherever these are found to be necessary to improve the public health problem being analyzed.

- are brought into a more constructive form of dialogue with regional and central ministry officials about how to improve health services, thereby strengthening the capacity of the government health system to decentralize its activities in an effective manner.

The steps needed to ensure a successful DTPS process are outlined below.

3.1 Step 1: Obtain the sponsorship, support and participation of senior decision-makers

A senior Ministry of Health decision-maker such as the Director-General of Health Services (DGHS) must feel the need to strengthen district health management and demonstrate this by assuming responsibility for:

- selecting, in consultation with other health officials, the four districts to participate in DTPS

- either selecting/approving the priority health problem to be assigned to each district, or providing criteria for selection of these problems in the districts

- guiding the selection of district team members

- appointing a staff member to be in charge of coordinating DTPS and bringing together a group of appropriate facilitators

- attending the opening of the planning workshop to challenge teams with the assignment to develop solutions within available district resources for a specific health problem, and then on the last day, listening to the presentation of team proposals in order to approve their implementation

- attending one or two of the three days of the evaluation workshop to listen to and discuss each team's evaluation of its results.

In every country, each team must be aware of top-level interest in its particular problem and in its efforts to solve the problem. Also, the health problem chosen must be seen by both top-level and district personnel as being of such high priority that it is well worth the investment of time and effort.

Thus, the organizers of DTPS must confirm the interest and participation of the senior decision-maker at the outset. He or she must understand the nature of the process and the importance of his or her role in it.

3.2 Step 2: Select the DTPS coordinator and the core group of interested facilitators

The person selected to take charge of the DTPS process should be someone familiar with the administrative procedures of the MOH, from the unit sponsoring the DTPS exercise (e.g. MCH, primary health care, etc.). He or she should be charged with the responsibility of making the many necessary arrangements, and of coordinating activities among the different units and individuals involved. This could be someone from a training institution that would subsequently proceed with the institutionalization of DTPS.

To enhance communication and collaboration, and to spread the load of preparatory work a core group of facilitators should be appointed. This can include staff members from relevant central programmes, the regions, the statistics unit, and institutions providing facilitators, e.g. university, training and research centres, a management school, the planning unit, or any other service to be involved. This group must be available to help the participants throughout the DTPS process, and to provide follow-up support as needed. If feasible, it would be very helpful for members of the group to visit the selected districts 1-2 months before the workshop to brief local health authorities on DTPS and to assist them in selecting problems, teams, and data documents.

If facilitators from external agencies are to be used, their availability throughout the planning workshop should be assured.

In the initial application of DTPS there are generally three types of facilitator:

- senior programme managers drawn from the programmes associated with the problems being addressed (e.g. from MCH, FP, immunization, nutrition, etc.)

- trainers from an institution that may become responsible for the subsequent application of DTPS on a continuing basis - an institute or faculty of public health, a department of a medical school, etc.

- staff already experienced in the planning and conduct of DTPS; these may be staff from neighbouring countries, WHO staff, or consultants who have applied the process before.

All those selected as facilitators must be able to function in a quiet, supportive manner. They must be willing to take responsibility for introducing and guiding one or more of the sessions, which implies giving briefings on the tasks to be performed, and moderating the presentation of results. Facilitators must agree to avoid lecturing to the group; they should only intervene in group work when absolutely necessary to keep a team moving. They need to understand and accept the learning-by-doing concept.

Facilitators should be chosen for their interest in the problems being addressed, and in health systems action research. They should have a positive attitude showing confidence that the participants can develop and apply the skills needed to improve their services.

The facilitators must be available to spend time on the preparation of the planning workshop and the individual sessions they will be handling. They must also be available to visit teams in the field during the implementation period, and to prepare and attend the evaluation workshop at the end of the process.

3.3 Step 3: Select districts and teams

Criteria for the selection of districts to participate in DTPS vary from one country to another; districts may be selected on the basis of having national priority for health or social/economic development, a need to develop staff motivation, a need to react to results of recent evaluations, complaints from the public, etc. Generally, one district is chosen from each of four different regions or provinces. However, in some instances, the districts may be chosen from the same region or province, perhaps because the provincial medical officer is interested in improving the performance of his or her district services. Districts chosen may be those with the highest incidence of the various problems being assigned.

The members of each team are chosen by the provincial and/or the district medical officer from among supervisors and clinic staff most associated with the problem selected. Generally, central programme managers will wish to review and approve those being proposed for participation in the team. To ensure effective implementation, teams should include the district medical officer and the chief nursing officer.

During the planning workshop, regional health staff may function as either facilitators or as district team members. If provincial or regional supervisors actually join the district team during the planning and implementation periods, however, they must do so as equal team members, without directing the others. They must also assume an equal share of the responsibility.

In choosing staff for the teams, efforts should be made to avoid selecting those who will soon be reassigned or retiring, since it is important that the members of the team remain working together for the duration of the implementation and evaluation.

District teams should include 5 to 8 staff. Teams might also include members from other sectors (e.g. agriculture, education, etc.), from the community, from private practice or from an indigenous practitioner group, as judged relevant for the problem being addressed. It is not practical to have teams of less than 5 members, as they would be unable to carry forward the work should one or two leave during the implementation period.

3.4 Step 4: Select important district health problems

The public health problems selected should be those that are known to be particularly important in the district to which they are assigned. They may be diseases which are excessively prevalent or virulent, or about which there have been public or political complaints. In one country, for example, these turned out to be high maternal mortality

in one district, close mean birth intervals in a second, high immunization drop-out in a third, and poor nutrition status of children aged under five years in the fourth. In another country, the same problem (maternal mortality) was assigned to all the district teams.

Who should select the problem - the Director-General of Health Services, the head of MCH services, the regional health officer, the district medical officer, district team members or community representatives from the district?

Generally, once the participating districts have been selected, the problems to be assigned to each are decided by the Director-General of Health Services and national programme managers (e.g. directors of MCH, FP, the Expanded Programme on Immunization, epidemiology, primary health care, etc.). Central level managers may suggest both the problem and the districts on the basis of data held in the Ministry. Sometimes a health problem is chosen because of current political or public interest, and then assigned to districts in which the problem is most acute, or in which the service performance needs special attention.

It is possible to ask districts to choose their own initial problem for DTPS. This seems, intuitively, to accord with the universal need to decentralize government service systems and district personnel often prefer to make this choice themselves. Also, the important team feeling of "ownership" of the problem would be assured by such self-selection. However, there is a certain advantage in having the DGHS assign the problem in that the teams are then made to feel directly responsible to the Ministry for resolving the problem, and central authorities may feel more commitment to listen to the solutions devised by the district teams.

It is notable that in the past, where the initial problems were selected by central Ministry authorities, all the district teams ultimately agreed that the problem assigned to them was of high priority. Generally, however, the teams found it necessary to redefine, within the broad problem assigned, a particular, more limited aspect which the team felt was both important and which it could influence using its limited resources and time available. For example, one district was assigned by the DGHS the broad problem of "poor management of high-risk pregnancies". However, the team finally defined its project objective as "to reduce maternal deaths due to post-partum haemorrhage".

The alternatives for selection of district health problems are:

- direct assignment by the DGHS (with assistance from his or her technical staff)
- selection by district teams from a short-list of priority problems sent by the DGHS
- selection by district teams according to criteria provided by the DGHS.

However the problem is selected, both the DGHS and the members of the district team must believe that the health problem being addressed is of great importance, in fact, an indisputable priority for that district. The best results are likely to be obtained if the DGHS is involved in the final selection and then directly, personally charging the district team to find the solution.

Why is this so? If the DGHS selects the problem, then all MOH personnel up and down the line will see the team's project as important and worth toiling over. The DGHS will be more likely to keep to his or her scheduled participation in the workshop despite the pressure of competing obligations. Also, selection at this level is more likely to benefit from the epidemiological and statistical expertise that is usually available centrally in the MOH, but often deficient at district level. The DGHS is also more likely than district personnel to understand the nature of the DTPS process at the time the problem is chosen.

In summary, it is essential that both the district team members and the central MOH agree that the health problem chosen is of great importance, is in need of more effective action from the district health services, and that there is some hope of improving it through better use at district level of existing resources.

3.5 Step 5: Choose between feasible variations in the process and set the time frame

The undivided version of the DTPS process includes the following phases:

(a) **Planning workshop** - 9-10 consecutive days during which all teams work in one location to analyze their problem (including some field data collection), design a solution, and plan its implementation and evaluation. A proposal is prepared and presented to decision-makers for approval.

(b) **Implementation period** - about one year (10-12 months) in which all teams are functioning within their services while implementing their planned solution. Towards the end of this period the teams will conduct the evaluation of their solution according to the evaluation framework they prepared in the planning workshop.

(c) **Evaluation workshop** - 3 days during which decision-makers and all the teams hear the results of each team's evaluation. Sometimes the next phase of implementation is prepared at this workshop.

The most common alternative is to undertake a divided planning workshop in which the tasks are split into three periods:

- initial problem analysis, design, testing and revision of instruments for collection of any missing/additional data - 4-5 days.
- field data collection - 2-5 weeks by each team back in its home district.
- final problem definition, solution design and implementation and evaluation planning, followed by presentation of project proposal to the decision-makers - 5 days.

This divided planning process has the advantage of allowing each team to collect missing data in its own district. Another advantage is that health workers leave their work for shorter periods. However, it complicates travel and facilitation and makes the exercise more expensive.

Other variations are possible, especially when DTPS is institutionalized and used in different parts of the country, but it is unlikely that good results can be obtained if the number of workshop days is reduced.

3.6 In summary

The following steps are necessary before the detailed preparation of the planning workshop begins:

- The MOH (the DGHS and programme managers) is oriented to and commits itself to the DTPS process.
- Concerned senior staff in the MOH commit themselves to participate in both workshops.
- A DTPS coordinator and a core group of facilitators are appointed for the DTPS process.
- External agencies, where applicable, commit their support and agree to the dates set for the DTPS workshops.
- Districts, health problems, and team members are selected.

In addition, the following preparations are essential for the successful use of DTPS as a tool for strengthening management at the district level:

- DTPS must be supported by a high-level champion in the MOH. Once the approach is adopted various roles must be performed by provincial and district authorities as well as by involved training institutions.

- The MOH should identify an appropriate training institution to provide facilitation for DTPS implementation and to assist in the development of a core group of facilitators.

- The DTPS coordinator and the core group of facilitators should receive an in-depth briefing in the theory and practice of DTPS, with a thorough review of the process of DTPS, its learning methods and content. However, real understanding of the methodology by facilitators is achieved only after active participation in DTPS application.

- As soon as problems and teams have been selected, team members should be briefed on DTPS, provided with guidance materials, and helped to gather available documents and information on the selected problems before coming to the workshop. The availability at the beginning of routinely collected information is very important for team progress in the planning workshop.

4. HOW TO CONDUCT EACH PHASE OF DTPS

Effective use of DTPS to improve management of an ongoing health services system requires different kinds of efforts over the five phases, or periods, shown in Figures 1a and 1b.

There are the three core periods of the DTPS process during which the teams plan, implement and then evaluate their solution. These are preceded by an initial setting-up period in which the central MOH must make preparations for the DTPS process. Finally, during follow-up, the MOH determines whether and how DTPS will be extended and institutionalized in the health services system.

The approximate length and the main task of each of these periods is as follows (see Fig. 1a and 1b).

Phase 1. Setting-up period (about 1-2 months), in which the MOH makes preparations to assure that the prerequisites for successful application of DTPS (see section 3) are in place.

Phase 2. The planning workshop (9-11 days) in which selected district personnel come together as a team by preparing an action plan for their solution to a priority health problem (see section 4.1, 4.2 and Annex 1).

Phase 3. Implementation (10-12 months) by the team of its action plan in its district plus its monitoring and evaluation of this effort (see section 4.3).

Phase 4. The evaluation workshop (3 days) at which the district team presents its own assessment of its progress and success in dealing with its problem, and its evaluation of the relevance of the DTPS process for improving management at district level (see sections 4.4 and 4.5, and Annex 2).

Phase 5. Assessment of and follow-up by the Ministry of Health on the experience, skills, progress, team morale and methods generated by completion of the one-year cycle of the DTPS process (see section 4.6).

4.1 Preparing for the planning workshop

The following notes are intended to assist organizers, facilitators and MOH personnel to organize and conduct effective DTPS planning workshops that will lead to stronger team-work and to community health and service improvements through effective district team implementation of workable projects.

4.1.1 *Nature, objectives and content of the DTPS planning workshop:*

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

Figure 1a: **Phases of the DTPS Process**

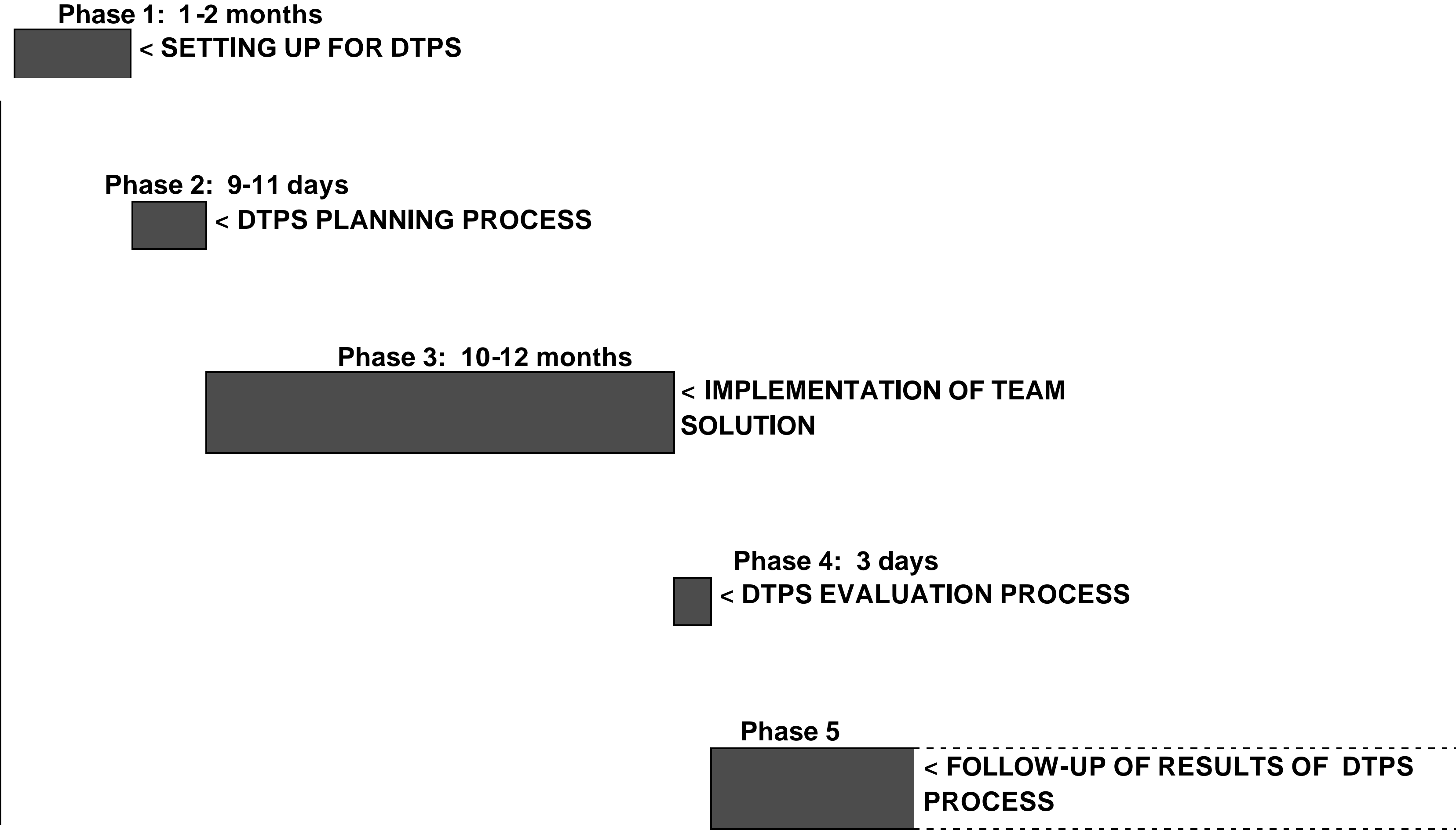

Figure 1b: **Phases and facilitation of the DTPS process**

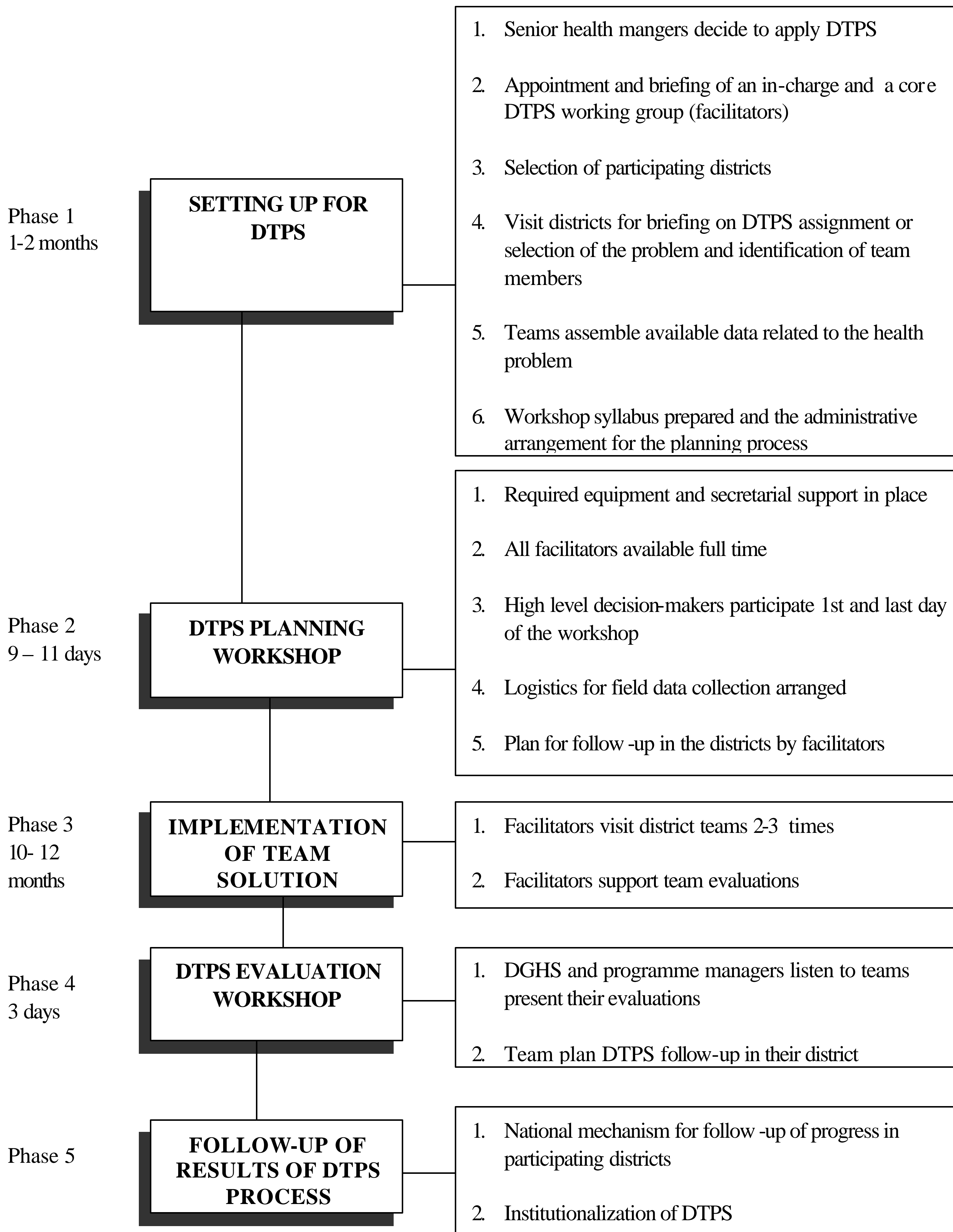

Figure 2: **Objectives for the DTPS planning workshop**

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

1. be able to function in a multi-disciplinary, problem-solving team within their district with the ability to:

   a) apply basic epidemiological analysis in the planning, management and control of MCH, family planning and other public health services;

   b) define and diagnose health, organizational and operational problems at various levels;

   c) formulate practical solutions for such problems, solutions which can be implemented with existing resources and organizational set-ups;

   d) strengthen supervision in their district;

   e) monitor the progress and evaluate the effect of changes resulting from the implementation of their solutions;

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

3. be able to evaluate the effectiveness of their district problem solving effort sometime in May, 1994, according to indicators and methods prescribed in the proposal, and to report the results of their evaluation to decision-makers within a follow-up evaluation process of the same participants to be held at that time.

At the end of the planning phase, the ***decision-makers*** *and* ***facilitators*** *should:*

be in a position to tentatively assess the effectiveness and practicality of this type of action learning and whether the approach should be more broadly applied in the future. (An in-depth assessment of the problem-solving effort will be undertaken at the time of the evaluation process).

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

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

An example of the scheduling of sessions in a DTPS planning workshop programme is shown in Figure 4.

4.1.2 *The structure of a typical workshop session:*

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

Team effort to accomplish the assigned tasks and products. Most of the time of the session (2-3 hours) is devoted to this active team-work: teams review data, organize their work, discuss, reach consensus, and prepare their products, again with very little outside support. Facilitators are present to provide support if required.

Presentations by teams in plenary (no more than once a day, and sometimes less) of their products.

4.1.3 *Workshop syllabus and session guide*

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

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

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

Figure 3: **Sessions, tasks and products of the DTPS planning workshop**

SESSION	PROBLEM-SOLVING TASKS	MAIN PRODUCTS
1	Opening - Assignment of health problems	Teams given responsibility by DGHS to solve problems
2	- Review available data - Identify problem indicators - Idenify missing data	- Initial problem table and indicators -List of additional data needed
3	Analyze problem variables	-Problem diagram -Final list of additional data needed
4	Design field data collection	- Data collection instruments - Dummy tables for data presentation
5	Collect field data	-Completed data instruments - Initial data tabulation
6	Analyze field data	-Completed data summary tables
7 8	Redefine/describe the problem Generate and select ideas for solving the problem	-Final problem diagram -Final table of problem indicators -List of selected ideas
9	Formulate and set objectives and targets	-Table of objectives and targets
10	Design and describe the solution	-Brief solution description
11	Plan implementation of the solution	- Implementation plan (activity schedule and responsibilities)
12	Develop monitoring and evaluation plan	-Table of evaluation indicators - Description of evaluation method
13	Write proposal document	-Proposal document -Prepared presentation
14	Present proposal	Decision-makers reaction to the proposal
15	Evaluate and close the planning process	-Summary of participant evaluations -Closing challenge by DGHS

Figure 4: **Schedule for the DTPS planning workshop**

DAY	MORNING	AFTERNOON
1	*Session 1* Opening Assignment of the problem	*Session 2* Review of available data
2	*Session 3* Problem analysis	*Session 4* Design field data collection
3	*Session 4 cont'd* Design field data collection	*Session 4 cont'd* Organize field data collection
4	*Session 5* Field data collection	*Session 5 cont'd* Field data collection
5	*Session 6* Analysis of field data	*Session 6 cont'd* Analysis of field data
6	*No Session* Time to rest and catch up if necessary	
7	*Session 7* Problem definition and description	*Session 7 cont'd* Problem definition and description
8	*Session 8* Idea generation and selection	*Session 9* Formulation of objectives and targets
9	*Session 10* Solution description	*Session 10* Solution description
10	*Session 11* Implementation planning	*Session 12* Evaluation plan and indicators
11	*Session 13* Proposal preparation	*Session 13* Proposal preparation (and prepare presentation)
12	*Session 14* Presentation of proposals	*Session 15* Workshop evaluation and closure

Planning Workshop syllabus contents

- Cover page
- Description of the DTPS approach
- Objectives of the planning workshop
- Workshop method of work
- Workshop schedule
- Session guides
- Formats and examples of major products for each session
- Design criteria for team solution design
- Relevant national policies and targets

Each session guide contains the following sections:

- Objectives - what the participants will have done or will be able to do by the end of the session.

- Materials - what documents, diagrams, tables, formats, etc. will be made available to, and will be used by the teams to help them accomplish their tasks and understand the products they are assigned to make.

- Tasks - specific work assignments the team must accomplish during the session, e.g. review available data, produce a problem diagram, complete the quantitative problem table with the addition of the most useful data collected in the field, etc.

- Products - specific tabulations, data collection forms, lists, diagrams, written descriptions, etc. that must be produced on paper by the teams as the concrete results of the tasks they have accomplished. Most of these products will then be given to the secretariat to be retyped and reproduced for inclusion, as the main substantive materials, in the team's solution proposal document.

Teams will use their earlier products as necessary input materials in producing later products. This focus on finalizing specific products in relatively brief periods of time, guided by formats and specific examples, helps teams to set about tasks with a knowledge of what must be produced. It also helps them to discipline their own discussions, to steer debate toward closure, and to keep solutions limited to what is feasible. It also permits the teams to produce in a few days, often to their own surprise and with some pride, quite presentable solution proposal documents.

4.1.4 *Collecting relevant data before the workshop*

Having all the relevant data available for teams when they are supposed to start reviewing it on the first day of the workshop has been a continuing problem. A facilitator, or one epidemiologically competent person in the MOH, should be given the responsibility of helping each of the districts identify all of the census data, studies, reports, surveys, evaluations, summaries of reported data, etc. that would be relevant to the chosen health problem. The same person should ensure that these documents, or copies of relevant portions of them, are brought to the workshop. In addition, a team member in each district should be designated as responsible for bringing to the workshop all relevant district-level service statistics reports, plans, notes of meetings, special studies (e.g. by nongovernmental organizations), research reports etc. Thus, each district needs to be contacted well in advance and informed of the minimum data requirements for the planning workshop. The persons responsible at central and district levels should jointly review the information materials to be gathered and made ready for the workshop.

4.1.5 *The planning workshop facility*

The planning workshop should take place in a building that:

- is close to suitable overnight accommodation for participants and facilitators

- has a room which is large enough to accommodate a plenary grouping of about 50 people, and in which several screens and flip-chart easels can be placed for presentation purposes

- has separate rooms or areas for each team where about 9 people working around a flip chart can carry on discussions free of noise interference from other groups, or other activity

- has the necessary rooms arranged in way that permits efficient movement between plenary and working group areas

- has adequate office space for the secretariat, including areas for typing and document reproduction

- has adequate catering facilities

- is located in one of the districts participating in the process, if possible, especially for the undivided form of workshop, and thus near some of the health facilities to be studied.

4.1.6 *The secretariat*

Secretarial assistance must be provided for typing, reproducing, and keeping track of the team products following every session, producing and assembling the solution proposal documents, preparing limited printed materials for the facilitators, reproducing information documents, etc. Two secretaries and one driver/office machine assistant working full time are the minimum necessary.

4.1.7 *Facilitator meetings*

During preparation for the planning workshop it is convenient to organize a meeting at which the facilitators are briefed about the entire planning workshop by someone familiar with the implementation of the DTPS process. It is decided which sessions facilitators will be responsible for introducing and managing. They individually review their sessions, decide how these might need to be revised in the forthcoming workshop, determine the required support materials (formats, filled-in examples, data, policy documents, technical guidelines, etc.) and ensure that these materials are prepared. This group decides how the data collection will be undertaken, how team products will be prepared, and how the facilitators will work with the teams during the workshop.

4.1.8 *Supplies and materials*

The following are needed to assure rapid and clear communication of the large amount of information that will be shared by the teams, facilitators, and MOH senior personnel during short periods of presentation:

- two typewriters (one word-processing machine is desirable)
- one photocopying or document reproduction machine
- one mimeograph machine
- 2-4 overhead projectors and screens (optimum is one for each team)
- 5 flipcharts (one for each team and one for the plenary room)

- 5 sets of felt-tip pens for flip charts
- 200 sheets of transparency plastic for overhead projection
- 6 sets of felt-tip pens for transparencies
- 300 stencils
- about 70 reams of paper for mimeographing and photocopying
- about 50 writing tablets, pencils, erasers, folders, etc.
- about 65 workshop syllabuses.

4.1.9 *Variations in the Planning Workshop*

Although the structure of the DTPS planning workshop may seem rigid - with pre-determined tasks, products, formats, sessions, etc. - this carefully designed and field-tested framework permits and stimulates a great deal of individual and group initiative and creativity. The teams are quite free to decide what is most important in defining the problem and in crafting their solution for it. By simply using the formats supplied, and thus avoiding a debate about what form of implementation schedule it should produce, for example, a team is able to get right to work deciding what specific activities it should put into a table. The teams are more likely to be productive, to use their time well, and to feel involved if the workshop protocol is respected.

The sequence of sessions has proven to be effective both logically and didactically. While variations in the sequence have been attempted, it is recommended that the sequence shown in the annex be used until experience is gained with the method.

Undivided or divided schedule for the planning workshop?

The DTPS planning workshop has been run successfully in two different schedules: an undivided block of 9-10 days, or a divided pattern consisting of three separate periods (see section 3.5).

The undivided workshop is cheaper and less complex to organize in that it requires one less round-trip in-country of all participants. It is easier for external agencies to provide technical assistance, since it requires participation for only 2 rather than for 4 or 5 weeks. It may avoid an additional trip to the country by external consultants. It also assures an uninterrupted momentum of the groups.

The divided workshop, on the other hand, allows teams to gather and use relevant data from their own districts in designing their solutions and evaluation plans. It also gives teams more time and opportunity to involve community and other groups in the design of the solution. Once DTPS is institutionalized and decentralized in a country, the divided scheduling of the planning workshop is likely to be preferred.

The use of facilitators to assist the teams during data collection will probably improve collection and use of data, but will cost more and require more organization and coordination.

4.2 Conducting the planning workshop

4.2.1 *Guiding the sessions in the workshop*

The required tasks of each session are detailed in the session guides included in the workshop syllabus. These clearly direct the teams towards what they must accomplish. The teams are also provided with excellent conditions for their group work. But the teams are given little guidance as to how they should proceed. They are told to ensure that all their members participate freely. They are also instructed to make good use of their audiovisual materials (e.g. paperboard flipcharts, hand-drawn transparencies and standard formats) to ensure that all members can follow the team's progress and to speed up presentations in plenary.

The teams are thus forced to decide how they will organize themselves, what portions of their many tasks should be done individually or as a group, what portions should be delegated to which individuals, etc.

The 15 sessions of the DTPS planning workshop are described in Annex 1. The team tasks that must be accomplished, and the products that must be produced during each session, are presented in its session guide. Each session guide is followed immediately by notes and suggestions for facilitators on how to introduce and to provide support in that session.

4.2.2 *Optional techniques used in the planning workshop*

The following have been used successfully in DTPS planning workshops, and have been found useful:

- The nominal group process (Delbecq technique), or modifications thereof, to ensure participation of all group members. It is particularly useful in sessions 2 and 8.

- A solution diagram has been produced quickly and easily by teams in session 8 as a part of their design and description of their solution strategy. The procedure for constructing it is the same as for constructing the problem diagram.

- Use of small cards on which each participant writes ideas during problem analysis, rather than one large flipchart for the group. This use of individual cards, which are then assembled into a pattern of ideas on the board before the group, attached by adhesive putty, has been used to advantage in similar analyses in other project planning workshops. The cards permit the group to reorganize easily the elements in their problem or solution diagrams. However, this technique requires materials that have to be purchased in advance.
- Use of 2 to 4 overhead projectors permits simultaneous projection of tables or diagrams that the presenter wishes to compare. A map of a district can be shown together with the elements of an action plan. This facilitates the presentation in a brief time of the large amounts of factual detail required. Similarly, several projectors can be used at the same time to compare the products from different teams.

4.2.3 *Facilitators' critique and session preparation*

During the workshops, it has proved necessary to hold a meeting of all the facilitators each evening to review how things have gone during the day and, most importantly, to prepare for adequate facilitation for the next day. Facilitators discuss any problems that have arisen, and any modifications that should be made. This meeting provides an opportunity for each facilitator to discuss the objectives, hand-out materials, team tasks and products for the next day's session. The formats and examples that facilitators plan to present when introducing the next day's sessions are discussed, to benefit from the suggestions of the group. This is particularly helpful for facilitators who have not introduced a DTPS session before. It is also a good time to discuss any necessary logistics, such as secretarial arrangements, reproduction and distribution of hand-outs, arrangements for transportation, for scheduled visits, etc. If the facilitators are fatigued, or the group's discussions tend to be lengthy, it is advisable to prepare for the next day's sessions first, to ensure that all understand and are well prepared for what needs to be done the next day.

4.2.4 *Time pressure in the DTPS planning workshop*

The teams accomplish all the tasks and products by dint of hard work under continual time pressure during 15 sessions that require a minimum of 9 working days. Most teams will spend, on their own initiative, some evenings and weekend hours working together.

The teams have so much to do that the DTPS planning workshop must be run tautly on time, and by the syllabus. Thus, the timing of the schedule, suitably adapted, and presented in the syllabus must be respected. This means that the content of the sessions should be limited to what is programmed in the session guides. If such discipline is exercised by the facilitators, it allows sufficient time and opportunity for the various members of the district teams to participate in planning creative and realistic activities that will solve their health problem. Teams must complete the assigned tasks and products each day in order to move on to the next day's tasks.

If those managing the workshop let sessions drag on beyond their allotted times, or if they allow facilitators or visiting experts to expand on their pet topics, then teams will find insufficient time left for all of their members to participate effectively in hammering out a feasible solution. Hence, good team member participation, clever team modification of general strategies to accommodate local conditions, and high team creativity in developing solution strategies are all fostered when the workshop is run strictly by the syllabus and kept on schedule.

4.2.5 *Workshop Evaluation*

It is customary to conduct an evaluation of the planning workshop through the use of a structured questionnaire.

The questionnaire asks each participant (team members, regional supervisors and national facilitators) to assess the degree to which the objectives and tasks of each session were achieved. They are also asked to assess the effectiveness of the preparation, conduct and support to the workshop and the likely usefulness of the planning and analytical methods in their everyday work.

The participants are asked to complete these questionnaires individually at the end of the session in which they present their proposals. The results are quickly analyzed and a summary is presented to the workshop during the closing session. The detailed results are provided in the report of the workshop.

The evaluation questionnaire is attached in session 14 of Annex 1. Rapid analysis of the results is facilitated through the use of an EPI-INFO programme available from the MEP Unit, WHO, Geneva.

4.2.6 *Post-workshop meeting*

Health officials and facilitators meet to discuss follow-up of the teams during implementation and steps needed to prepare for the evaluation workshop.

4.3 Supporting team implementation

The period of implementation, which extends from the end of the planning workshop to the evaluation workshop, ranges from 10 to 12 months. It should be long enough to enable the team to show measurable improvements in health service performance and, hopefully, an impact on the health problem.

It seems evident that teams will accomplish more if they are supported by regional and central level staff during implementation of their projects. Such support might include, for example, epidemiological assistance in the collection, analysis and interpretation of programme-related data or administrative follow-up on remedies agreed upon in the planning workshop, such as posting personnel to fill vacant positions, release of materials or budgets that are due, typing reports where appropriate, etc.

Ideally, the DTPS core group should keep in touch with each of the teams, at least quarterly, to facilitate higher level support that was programmed, or that is needed, and to track progress. To promote better support of district team efforts from intermediate and higher levels, it would be worthwhile trying to formalize the engagement of regional personnel. One approach is to have names, products and activities of regional personnel included in the team's implementation schedule along with those of the district personnel.

4.4 Team self-evaluation

From the very outset of the DTPS process, each district team knows that it will return to a second workshop in 10-12 months to report and discuss what it has been able to accomplish. This will also enable the team to assess how its performance as a district team has been affected by the whole DTPS process and to judge and modify the solution approach it has designed.

Each team thus has the responsibility for preparing in advance its own evaluation report. The teams evaluate and report on at least the following evaluation components:

- solution implementation: actual activities carried out as compared with the planned activities
- service achievement: service output and coverage achieved as compared with the targets
- difficulty reduction: actual difficulty reduction as compared with the targets
- solution effectiveness: improvement in the health problem indicators as compared with the objectives
- team performance: how well the team worked together and generated cooperation from other staff, agencies and communities.

The teams need to be informed, several months before, of the dates for the evaluation workshop. The teams should also be reminded to forward their short evaluation report in time for reproduction and distribution at the workshop, and offered any technical assistance they may need. However, neither facilitators nor support staff should actively participate in the team's evaluation or the preparation of its evaluation report.

Depending on the availability of secretarial services at the district level, the MOH may have to type the team's evaluation report centrally.

Teams get much less assistance in producing their evaluation reports than they received in producing their solution proposal documents. The entire planning workshop assists each team in producing and then presenting its solution project proposal. However, each team must have written and forwarded its evaluation report before the opening of the evaluation workshop.

The observed high motivation and morale of the district teams during implementation is probably due in large part to the fact that each team becomes a self-supporting group carrying out its own ideas and solution. However, this pre-scheduled opportunity for follow-up, to recount at the evaluation workshop what the team was able to accomplish, may well be another source of motivation that stimulates teams to persevere in trying to achieve some progress by the end of the year.

The team does not produce another document during the evaluation workshop. It does prepare and present transparencies in most of the sessions in order to present its own assessments and answers to the basic evaluation questions.

4.5 Conducting the evaluation workshop

The learning-by-doing philosophy of the planning workshop is extended to the design of the evaluation workshop. This is based on the premise that service staff will learn best how to evaluate by doing it themselves.

The evaluation workshop is attended, in addition to the teams and facilitators, by the DGHS and senior programme staff who were at the planning workshop. Each team has the opportunity to present to this high-level group its self-evaluation of its own efforts, progress, successes, lessons learned and team-work. Each team also assesses the impact that the DTPS has had upon district team management.

The evaluation workshop is tightly scheduled into 3 days during which the teams formulate their own answers to a series of evaluation questions. The teams' assessment are presented and discussed during a series of 10 sessions.

The usual sessions of the evaluation workshop are

1. Opening
2. Brief project overview and principal "success story" of each team
3. Team evaluation of project implementation
4. Team evaluation of service achievement and difficulty reduction
5. Team evaluation of project effectiveness
6. (Optional) Focus group appraisal of team working relationships
7. Team assessment of team performance
8. Evaluation of the year-long DTPS process
9. Planning the "next steps" of each district team
10. Panel discussions and closure.

After each team has presented its own self-evaluation in these sessions, and this has been discussed by the other teams and facilitators, the principal decision-maker and other relevant officials share their own reactions and assessments of the progress and of the team process during the implementation period.

As was done at the end of the planning workshop, prior to the closing session, all participants fill out a questionnaire with their own evaluation of the achievement of each planning and evaluation step and the impact that the whole DTPS process has had on their own capabilities, on district team management, on health services, and on problems at the district level. This includes an evaluation of the evaluation workshop. Again, this questionnaire is analyzed and summarized at the closing session.

Finally, the next steps to be taken, follow-up and potential future use of DTPS are discussed.

In evaluation, when comparing what was done against what was planned, it is important to recognize that many unforeseen environmental events (e.g. drought, epidemics, war, etc.) and

Figure 5: **Schedule for the DTPS evaluation workshop**

DAY	MORNING	AFTERNOON
1	*Session 1* Opening *Session 2* Overview of project and main "success story" of each team -briefing -team preparation -team presentations (plenary) *Session 3* Team evaluation of project implementation	*Session 3 cont'd* -team presentations and plenary discussion *Session 4* Team evaluation of service achievement and difficulty reduction -briefing -team preparation
2	*Session 4 cont'd* - team preparation (continued) -team presentations and plenary discussion *Session 5* Team evaluation of project effectiveness -briefing (plenary) -team preparation	*Session 5 cont'd* -team preparation (continued) -team presentations and plenary discussion *Session 6* Team self-appraisal of working relations during implementation
3	*Session 6 cont'd* -presentation of focus group results *Session 7* Team assessment of team performance -team preparation -panel presentations and plenary discussion *Session 8* Planning the next steps of each district team	*Session 8 cont'd* *Session 9* Evaluation of the DTPS process and of the evaluation workshop -evaluation by individual staff -panel discussion (team representations and decision-makers) -plenary discussion -summary of evaluation results Closure

variables may have intervened during the year of implementation. Also, many unforeseen changes in service capacity (e.g. transfers of personnel, delays in receipt of budget, launching of other health service initiatives, etc.) must be considered in judging achievements. Hence, considerable understanding must be given to the teams in their efforts to assess what worked,
what did not, and how their team-work evolved in the circumstances actually encountered and under the influence of the entire DTPS process.

A typical programme for the evaluation workshop is shown in Figure 5. Session guides which present the objectives, the materials needed, and the tasks or programme for each session are presented in Annex 2.

4.6 Follow-up and institutionalization of the DTPS approach

The DTPS process has had a striking impact on district team performance and morale by building solid team spirit and team-work. In every country where it has been applied it has enhanced dialogue with high level officials, other staff in the districts and communities, and added credibility to the districts. Most importantly, real health improvement has been achieved in a relatively short period.

The question of institutionalization of DTPS is often raised. The following are some approaches for institutionalizing DTPS:[1]

- Institutionalization of DTPS is facilitated when a high-level manager such as the Director-General of Health Services sponsors its application, and promotes its use across programmes and provinces.

- The Ministry of Health should assume responsibility for DTPS in collaboration with a key training institution whose staff provide much of the facilitation.

- Following initial applications, DTPS may be applied in different situations such as within major hospitals, and within special programmes (e.g. malaria control) to foster integration at the district level.

- A training plan for DTPS, to extend the group of facilitators from various institutes and provinces, should be established.

- The problem-solving concept, as applied in DTPS, should be incorporated into post-basic training and also in basic training under certain circumstances.

- DTPS may be applied as an in-service training approach for many types of service (e.g. immunization), and for service strengthening in general.

- As additional districts are involved in DTPS, observers may be brought from other districts and other countries to decide for themselves whether they wish to apply the process.

- Exchange of experiences and in-depth evaluations of DTPS results with and by other agencies active in problem-solving approaches should be encouraged.

- DTPS may be used as a research, training and development activity within major donor-supported programmes and projects, as a proven technique for making service improvements and raising staff capability. This can help with initial financing.

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[1] These ideas were shared at an Interregional Meeting on Management Strengthening of MCH/FP Programmes, held in Geneva, from 11-15 November, 1991.

ANNEX 1

DTPS PLANNING WORKSHOP SESSION GUIDES, FORMATS AND NOTES FOR FACILITATORS

This annex contains, for each session of the planning workshop

- the session guide as it might appear in the workshop syllabus
- notes for the guidance of facilitators
- formats used in the session including both blanks and completed examples.

Session 1: OPENING

Objectives

At the end of the session, participants should:

1. Understand the objectives of the workshop and its methods of work.

2. Be familiar with the workshop syllabus, its session guides and background materials.

3. Understand the rationale of the team approach to problem-solving.

4. Understand, in general, the problem their team has been assigned and their team's responsibility for addressing and reducing the problem over the next 9-10 months, and evaluating their results.

Materials

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

Programme

1. Administrative matters.

2. Introduction of dignitaries, participants and facilitators.

3. Welcome address by DTPS coordinator.

4. Keynote address: e.g. the problems of maternal and child health.

5. The district team problem-solving approach.

6. The workshop objectives and method of work.

7. The workshop programme.

8. The assignment of team responsibility for reducing their assigned problems.

Session 2: REVIEW OF AVAILABLE DATA

Objectives

At the end of the session, teams should have:

1. Assembled the available data needed:
   (a) to define the problem, the target population, and high-risk groups.(b) to assess current service coverage.
   (c) to describe relevant health resources.
   (d) to define the "difficulties" in reducing the problem.

2. Initially filled in a PROBLEM TABLE format to present selected indicators.

3. Identified additional data needed to complete the problem definition.

4. Understood some basic epidemiological definitions and differences between indicators.

Materials

1. Results of pertinent surveys, research and extracts of data from the health information system.

2. Data brought by the teams from their district describing the general health and service situation and the selected health problem.

3. Population data for each district.

4. Maps and distribution of health facilities in the participating districts.

5. Problem table format and examples.

6. National guidance materials for the health problems chosen.

Tasks

1. Review all available data to assess its usefulness in analyzing and describing the health problem. Assess the apparent reliability and validity of this data.

2. Produce an initial problem table by filling in the format with relevant indicators for **health, services** and **difficulty**, after considering the sample problem tables provided.

3. List additional data (quantitative and qualitative) felt necessary for completing the problem definition.

Products

1. Initial problem table.
2. List of additional data needed to define the problem.

ANNEX 1

Figure 1: **Table of problem indicators**

HEALTH INDICATORS			SERVICE INDICATORS			INDICATORS OF DIFFICULTY	
Indicator	**Baseline**	**Projection**	**Indicator**	**Baseline**	**Projection**	**Indicator**	**Baseline**

Figure 2: **Example: Table of problem indicators of a team for problem of "too closely spaced pregnancies"**

HEALTH INDICATORS			SERVICE INDICATORS			INDICATORS OF DIFFICULTY	
Indicator	**Baseline**	**Projection**	**Indicator**	**Baseline**	**Projection**	**Indicator**	**Baseline**
% pregnancies too closely spaced (birth intervals <24 months)	23.6 % (or 3900) of 16,526 inter-birth intervals <24 months	24%	% MWRA who ever accepted a modern child spacing method	About 0.5%	About 0.8%	% oral contraceptive acceptors who discontinue all protection by 3,6,9 months	35% at 3 months 55% at 6 months 70% at 9 months at Hosp.X in 1990
% MWRA* with 3+ children and protected from unwanted pregnancy	?	?	% of clinics in the district offering child spacing services in			% women who know 1+ child spacing method	29%
						% men who know 1+ child spacing method	35%
% women 15-49 using any form of child spacing	About 3%	About 4%	a) static units	3/25 (12%)	4/25 (16%)	% men who would NOT like their wives to use any child spacing method	33%
% 1-4 y.o.s underweight for age	48%	50%	b) mobile units	6/15 (40%)	8/15 (53%)		
infant mortality rate	142 Infant Deaths per 1000 livebirths per year	140 ID/1000LB/yr	% service providers in health centres who have been trained to provide child spacing services	7/42 (17%)	12/45 (27%)	% who know that interbirth interval of 24+ months protects health of mothers and children among a) women b) men c) HC nurses d) HC midwives	? ? ? ?
% MWRA anaemic	38% of MWRAs in ANCs** anaemic	38% of MWRAs in ANCs anaemic				average no. months out of stock for oral contraceptives in clinics	?
						average minutes women wait for o.c. resupply in clinics	?

* MWRA: Married women of reproductive age (15-49)
**ANC: Antenatal clinics

Session 3: PROBLEM ANALYSIS

Objectives

At the end of the session, teams should have:

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

Materials

1. Example problem diagrams.

2. Example problem tables.

Tasks

1. Discuss the assigned problem in general. Review the sample problem diagram and tentatively list the variables that are needed to describe the problem.

2. Place this list of variables into a problem diagram and show the likely cause and effect relationships.

3. Produce a final list of additional data needed to define the health problem and plan the solution.

Products

1. Problem diagram.

2. Final list of additional data needed.

Figure 3: **Example of a problem diagram for child spacing**

CLOSELY SPACED PREGNANACIES
Interval of less than 24 months between BIRTHS

Illiteracy (+)
Early age of union (+)
Divorce and marriage (+)
Tradition and beliefs (+)
Child spacing education (-)
Misconception (-)
Ignorance (-)
Sex preference (+)
Poverty (+)
Land shortage (+)
High population density (+)
Malnutrition (+)
High infant mortality and morbidity (+)
High maternal mortality and morbidity (+)
Unavailability of child spacing services (+)
Shortage of trained child spacing providers (+)
Inadequate child spacing equipment facilities and supplies (+)
Poor accessibility to child spacing services (+)

- Distance
- Frequency of services
- Integrated services

Session 4: DESIGN OF FIELD DATA COLLECTION INSTRUMENTS

Objectives

At the end of the session, teams should have:

1. Identified the best sources of additional data needed.
2. Designed the dummy tables to be used to present the data once collected.
3. Chosen data collection methods and planned the data collection process.
4. Designed recording instruments to be used at each field location to be visited, and data tabulation formats.

Materials

1. Sample field data collection instruments.
2. Field data collection instruments from other survey evaluations in the country.
3. A concise reference on conducting focus group discussions.
4. List of additional data needed from session 3.
5. Job descriptions, operations/field manuals, etc.
6. List of additional data needed from session 3.

Tasks

1. Review the additional data requirements listed in sessions 2 and 3, decide which are the most needed and feasible for immediate collection and propose the best sources for each.
2. Prepare the formats (dummy tables) in which the results of the analysis of the data to be collected will be presented.
3. Review the available data collection instruments used in the past and then design questions and data collection formats for use in obtaining and recording the needed data at each field source (Health Centre, District Hospital, community, etc.).
4. [Optional] Work with other teams to consolidate the questions and formats for all teams to be used at each level (data source) and in focus group discussions.
5. Organize the field data collection, selecting sites, assigning team members, arranging the logistics, preparing data tabulation formats.

Products

1. Field data collection instruments.
2. Dummy tables for presenting the data to be collected.
3. Data collection plan.

Session 5: FIELD DATA COLLECTION

Objectives

At the end of the session, teams should have:

1. Completed the field data gathering.

2. Completed the initial data tabulation.

Materials

1. The data collection instruments, group discussion outlines and tabulation formats designed in session 4.

Tasks

1. Undertake the field data collection at the designated sites.

2. Complete the initial data tabulation.

3. Note what changes should be made in data collection instruments and procedures prior to collecting data in their home districts.

Products

1. Completed data collection instruments.

2. Initial data tabulation.

3. Notes for revision of data collection instruments, procedures and tabulation.

Figure 4: **Example of field data collection**

Team	Service Facility Data	Community Data
A (*Nutrition*)	- **1 hospital, 1 rural hospital nutrition centre** Structured staff interview on under-five rehabilitation services; records check - **Mobile under-five clinic** Checked mothers wt/ht, and the wt/age n	**3 villages** - 30 mothers interviewed for growth rviewed for local nutrition activities - Interviewed village chief
B (*Maternal Health*)	**2 General hospitals, 1 mission hospital** - Checked theatre registers - KAP* (risk) of AN patients - Reviewed labour graphs - Knowledge of midwives	**1 village** KAP on health facilities, traditional beliefs and risk factors with 30 mothers, 30 fathers, 30 grannies
C (*Child spacing*)	**1 hospital child spacing clinic** - Staff interview - Focus discussion - 4 groups of patients - Analysis of child spacing records	**1 village** - KAP interviews with fathers and - Interview with PHC coordinator
D (*Immunization*)	**1 hospital, 2 health centres** - Checked vaccine supply and cold chain - Checked registers for measles cases	**2 villages** 30 households and the village health committee on knowledge, coverage and local action related to immunization

* KAP: Knowledge, attitude and practice

Session 6: ANALYSIS OF FIELD DATA

Objectives

At the end of the session, teams should have:

1. Completed their analysis of field data, and finalized their data tabulations and tables.
2. Described any qualitative findings from informant interviews, group discussions, etc.
3. Revised, based on the field experience, their data collection instruments and procedures.

Materials

1. Formats and dummy tables designed in session 4.
2. Notes for revision of data collection instruments and procedures.

Tasks

1. Review the field data collection experience and initial tabulations. Assess the validity and reliability of the data collected.
2. Complete the required data tabulations (with the acceptable data). Prepare summary tables.
3. Summarize briefly in writing the quantitative and descriptive findings pertaining to the assigned health problems and difficulties of service delivery which were being investigated, in preparation for adding this information to the problem statement.
4. Note the revisions needed to the data collection instruments and procedures in preparation for their application in the home district.

Products

1. Completed data summary tables.
2. Description of quantitative and qualitative findings.
3. Note on revision needed to the data collection instruments and procedures.

Session 7: PROBLEM DEFINITION AND DESCRIPTION

Objectives

At the end of the session, teams should have

1. Completed their analysis of the assigned problem.

2. Completed the problem description including the diagram and quantitative problem table.

3. Prepared a written problem summary.

Material

1. Problem table developed in session 2.

2. Problem diagram designed in session 3.

3. The additional quantitative and qualitative information obtained during the field data collection.

Tasks

1. Review the results of the field data collection along with the existing data.

2. Revise and finalize the problem diagram to provide the best possible description of the problem variables and their interrelationships.

3. Complete the initial table of problem indicators from session 2, with the addition of the most useful field data.

4. Prepare a short written summary of the problem, with its determinants and consequences. Prepare the transparencies needed to present the problem definition and analysis in plenary (and for use in the proposal document).

Products

1. Final problem table.

2. Final problem diagram.

3. A short written summary of the problem.

Session 8: IDEA GENERATION AND SELECTION

Objectives

At the end of the session, teams should have:

1. Reviewed and understood design criteria which will help ensure that proposed solutions are feasible and acceptable to decision-makers.

2. Identified and selected critical points of intervention in the problem diagram.

3. Generated ideas for interventions and selected those felt to be most feasible and effective.

Material

1. List of design criteria.

2. Expert opinion, guidelines, reference materials and other documents made available.

3. Final problem diagram from session 7.

Tasks

1. Review and discuss the design criteria.

2. Review the problem diagram; identify and indicate by heavier lines which variables are the best entry points for realistic team interventions that can improve the health problem.

3. List ideas for interventions that adhere to the design criteria and are felt to have the potential for reducing the problem.

4. Consider the likely effectiveness of the most promising potential interventions, and then select those interventions that the team feels can be implemented with the greatest success in the next 10-12 months.

5. Draw a solution diagram to display the team's strategy for solution.

6. Write a brief description of the solution strategy and interventions selected.

Products

1. List of selected ideas for addressing the problem.

2. Brief description of the team's solution.

3. A solution diagram.

Figure 5: **Design criteria for district team solutions**

1. All solutions must support the goals and objectives of the National Health Development Plan.

2. The strategies and activities of the **National Maternal and Child Health Programme** (March, 1992) should be taken into account when designing district solutions.

3. The district solution should support the **Primary Health Care Strategy** (January, 1992).

4. Community support and involvement should be utilized to the extent possible in all district solutions.

5. Solution proposals should be designed to be implemented with existing resources such as staff, facilities, transport and recurrent budget.

6. Solutions should focus upon improving staff and service performance, quality of care and efficiency at all levels.

7. Teams are encouraged to introduce or expand the use of the ANC-Labour Chart, and the Pregnancy Monitoring Form.

Figure 6: **Example of intervention ideas for sexually transmitted diseases**

VARIABLES SELECTED FROM THE PROBLEM DIAGRAM ("ENTRY POINTS")	IDEAS FOR INTERVENTIONS
1. Poor case management	(a) Conduct two workshops on STDs* in the next 10 (b) (i) To use audio-visual aids to illustrate the lso to visit the Medical Centre and Gweru Hospital for the ing the workshop. (ii) For each workshop there will be a pre and a post (iii) Counselling skills. (c) Supportive and supervisory visits to health centres.
2. Poor distribution and use of condoms	(a) To highlight the importance of keeping records from the o as to determine the need for condoms. (b) To ensure the availability of condoms to mobile special
3. Inadequate Health Education	(a) (i) STDs/AIDS campaign to discourage promiscuity. (ii) Manpower to take part: District, Ministry of Development, Ministry of Local Government, Ministry of nt of Social Services and ZNFPC.
4. Lack of Drug Supplies	(a) To compile a report to the ZEDAP highlighting the nd the results of the survey on drug shortage. For example st line treatment for gonorrhoea but it is not available. NB The report on drug shortages also to be sent to the Chief Pharmacist. Meanwhile clinics will be advised to use cortrimoxazole or procaine penicillin as a first line treatment for gonorrhoea instead of kanamycin. The present minimal stocks of kanamycin will be directed to clinics e.g. Medical Centre and Lalapanzi which have more STD patients

* STD: Sexually transmitted diseases

Figure 7: **Example of a solution diagram**

Pregnant woman

ANC

Recognition of risk factors marked on ANC card

Timely referral

Safe delivery

Use of a standard measuring stick to identify CPD* by the family, community, TBAs**, FVHW***

Use of partograph at all levels of the service

Timely referral

Reduction of prolonged labour, ruptured uterus, sepsis

Fewer maternal deaths

* CPD: Cepholo-pelvic disproportion
** TBA: Traditional birth attendants
*** FVHW: Female village health worker

Session 9: FORMULATION OF OBJECTIVES AND TARGETS

Objectives

At the end of the session, teams should have:

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

Material

1. Problem table and diagram from session 7.

2. The list of interventions and solution diagram from session 8.

3. Format for objectives and targets table.

4. Sample objective/target tables.

5. Existing health policy and plan documents.

6. "Steps for setting objectives and targets".

Tasks

1. Review current health policies to determine whether objectives and targets exist which dictate the amount of problem reduction or service delivery expected.

2. Select the problem indicators felt most appropriate and, with reference to the policies, the problem table and the listed interventions, set the desired problem level for an appropriate point of time in the future, e.g. end of the 5-year plan period.

3. Considering the assumed effectiveness of the critical services and interventions, set targets for these services and interventions for the implementation period.

4. Prepare a consolidated table of indicators of objectives for the health problem, and of targets for the services and difficulties.

Products

1. Table of objectives and targets.

Figure 8: **Objectives and targets format**

HEALTH INDICATORS			SERVICE INDICATORS			DIFFICULTIES		
Indicator	**Baseline**	**Objective**	**Indicator**	**Baseline**	**Target**	**Indicator**	**Baseline**	**Target**

Figure 9: **Objectives and targets of a district team attempting to reduce high incidence of closely spaced pregnancies**

HEALTH INDICATORS			SERVICE INDICATORS			DIFFICULTIES		
Indicator	**Baseline**	**Objective**	**Indicator**	**Baseline**	**Target**	**Indicator**	**Baseline**	**Target**
% pregnancies too closely spaced, i.e. % of interbirth intervals that are less than 24 months	23.6 % (3900 short interval pregnancies / 16,526 estimated pregnancies; assumed same as in national survey)	17% in 4 yrs. 10 % in 8 yrs.	% MWRA* who ever accepted a modern child spacing method	0.5%	10% in 9 months 25% in 4 years 50% in 8 years	% of men and women who know of one or more modern methods of child spacing	35% of men 29% of women (from National survey) to verify by KAP survey in two selected areas	50% of men 75% of women in 9 months
% women 15-49 using any form of child spacing	About 3%	10% in 9 months 25% in 4 years 50% in 8 years	% of clinics in district offering child spacing services in a) static units b) mobile units	 3/25 (12%) 10/15 (67%)	15/25 (60%) in 9 months 14/15 (93%) in 9 months	% women who are aware pregnancies with interval less than 24 months are a risk	Est'd at 5%; Baseline to be established by KAP survey in two selected areas	50% in 9 months
			% service providers in health centres who have been trained to provide child spacing services	7/42 (17%)	30/42 (71%)	% women who say they are interested in using modern contraception	Est'd at 10%; Baseline to be established by KAP survey in two selected areas	40% in 9 months
			Total Clinic-days per month when FP services available	32	141	% population living within 5 kilometers of a child spacing service	Est'd at 10%	75% in 9 months
			% static clinics with integrated FP/MCH services	0/25 (0%)	3/25 (12%) in 9 months 25/25 in 4 years	No. local organizations oriented in child spacing	1 of about 37	30 of about 37 (to verify no. organizations)

Figure 10: **Steps for setting objectives and targets**

1. Identify the indicators of the central health problem to be reduced.

2. Identify the critical services felt effective for problem reduction.

3. Note the projected size of the target population group.

4. Note the current output and coverage with the critical services.

5. Consider the ideas for expanding the coverage of critical services (as listed in the last session) and the presumed effectiveness of the critical services and

SET:

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

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

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

GENERAL ALTERNATIVE APPROACHES TO TARGET SETTING

1. Raise the coverage with critical services evenly throughout the district.

2. Set coverage targets in selected, currently under-served areas of the district.

3. Set targets in terms of the number of villages to be progressively brought into the scheme with the intent that there would be full coverage with critical services in each village.

Session 10: SOLUTION DESCRIPTION

Objectives

At the end of the session, teams will have:

1. Produced a brief written description of their proposed solution to the assigned health problem in their district.

Materials

1. Selected ideas for problem-solving from session 8.

2. Table of objectives and targets from session 9.

3. Relevant problem-specific documentation available to the group.

4. Outline of a solution description.

Tasks

1. Based on the nature of the team's proposed set of interventions, produce a brief written description of the "solution" to the problem which the team feels will justify its acceptance by decision-makers. Include tables, diagrams and illustrations as necessary.

Product

1. Brief solution description.

Figure 11: **Outline of a solution description**

Using five of the seven Guideline Words

WHY, WHAT, HOW, WHICH AND WHERE

1. **Why are we proposing this solution?**

   Briefly explain the problem situation in terms of the health problem, the service coverage deficiencies, and the various difficulties to be overcome.

2. **What is to be achieved?**

   State what is expected to be achieved in terms of reducing the health problem, reducing the difficulties currently encountered, and increasing the coverage and quality of critical services.

3. **How will it be done?**

   Explain the strategy chosen, the interventions in the problem situation in terms of the changes being proposed to service procedures, the approaches for involving the community and raising awareness of the problem and its resolution, and the means for reducing the difficulties currently being encountered.

4. **Which things will be needed?**

   Which levels of the service will be affected, which staff and community workers and leaders must be involved, what supplies and equipment become critical and what additional resources must be mobilized within the district?

5. **Where will the interventions be implemented?**

   In which areas, villages, facilities will the plan be put into operation?

Session 11: IMPLEMENTATION PLANNING

Objectives:

At the end of the session, teams will have:

1. Produced a list of the activities and their products needed to carry out the proposed solution.

2. Placed the activities in a time frame indicating who is responsible for each.

Materials:

1. Ideas and solution description from sessions 8 & 10.

2. Format for project implementation schedule.

3. Example of a project implementation schedule.

Tasks:

1. Review the list of selected interventions and the solution description in order to identify the specific activities required for each element of the solution devised.

2. List the specific activities that will have to be carried out in order to implement each change or development.

3. Determine what staff within the district must provide support to the project (members of the team and others who are not present), and who should be responsible for each activity (by name).

4. Schedule the full set of activities over the next 10-12 months.

5. Describe the implementation plan within an activity schedule form and add a brief narrative description telling how the district team will continue to work together during the implementation period.

Product:

1. Implementation plan (activity schedule and brief description).

2. (Optional) A Gantt chart or activity network.

Figure 12: **Implementation schedule**

A C T I V I T Y			SCHEDULE		RESPONSIBLE OFFICER	SUPPORT STAFF
No.	Title or Description	Expected Product	Start	Compl.		

Figure 13: **Example of implementation schedule (partial)**

A C T I V I T Y			SCHEDULE		RESPONSIBLE OFFICER	SUPPORT STAFF
No.	**Title or Description**	**Expected Product**	**Start**	**Compl.**		
1.1	Organize staff from the 3 hospitals for briefing on integrated services in child spacing	Integrated daily child spacing service in 3 hospitals and 1 health centre	2nd wk Nov. 87	1 day	Dr Spurr	Miss Gondwe Ms Ndema
1.2	Check and order equipment to run the daily services	List of supplies/equipment	1st wk Nov. 87	2nd wk Nov. 87	Miss Kalira/ Mrs Ndema	Miss Gondwe
1.3	Identify personnel to run the services		Dec. 87		Miss Gondwe	
1.4	Inform health staff		Late Nov.	1 day	Miss Gondwe	
2.1	Training staff identification	Training identified	Nov. 87	Dec. 87	Dr Spurr Dr Malenga	Miss Gondwe Mr Kantiki (MCH worker in Dec.)
2.2	Identify staff requiring orientation i.e. M/assist., midwives, HSA & Health Assistants	List of trainees	Early Nov. 87	Late Nov. 87	Dr Spurr Dr Malenga	
2.3	Identify venue for training	Designated training site	Early Nov.	End Nov.	Dr Spurr	Mr Kantiki
2.4	Plan training programme	Training Plan	Nov. 87	Early Dec.		
2.5	Identify teaching material	List of training material	Nov. 87	Early Dec. 87	Dr Malenga Mr Manda Miss Banda	
2.6	Identify funds and transport		Nov. 87	Early Dec. 87	Dr Malenga Mr Manda Miss Banda	
2.7	MCH Seminar, identify transport		Dec. 87	Early Dec. 87		
2.8	Supervision and follow-up		Dec. 87	Continue	All Manag. staff on district visits	

Session 12: EVALUATION PLAN AND INDICATORS

Objectives:

At the end of the session, teams will have:

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

Materials:

1. The problem table from session 7.
2. The objectives and targets from session 9.
3. The implementation plan from session 11.
4. Format for table of monitoring and evaluation indicators.
5. An outline of the evaluation report.

Tasks:

1. Review the problem table and the objectives and targets table. Choose the only a few of the indicators (1-3) which are felt to be required, measurable, and appropriate for evaluating the effectiveness of the "solution", in reducing the health problem once the solution is implemented.
2. Review the objectives and targets table. Choose a few (3-6) of the indicators which are felt to be required, measurable and appropriate for monitoring, during implementation, the progress in improving services and reducing difficulties.
3. Review the implementation plan and select a few activities and products which are felt most important for the team to use in monitoring implementation progress.
4. Describe in writing when and how the evaluation and monitoring indicators will be measured during and following the implementation period.
5. Produce a summary table of monitoring and evaluation indicators.
6. Discuss and revise the outline for the Evaluation Report the team will produce in the district towards the end of the implementation period.

Products:

1. A table of monitoring & evaluation indicators.
2. A brief description of the team's evaluation method.
3. Revised outline for the team's evaluation report.

Figure 14: **Table of indicators for monitoring and evaluation**

Indicator	Definition	Source	Baseline	Target	When to Evaluate

Figure 15: **Evaluation plan for a birth spacing solution**

Indicator	Definition	Source	Baseline	Target	When to Evaluate
1. % recent inter-birth intervals less than 24 months	For preceding 12 months, Interbirth intervals < 24 months Total births to mothers with parity of 1 or more	Community-based sample survey	23.6% (to verify this assumption)	17% in 4 yr. 10% in 8 yr.	In months 0, 12, 48
2. cumulative % of women of reproductive age who have accepted modern child spacing methods	100x Cum. No. of women acceptors Total No. of women 15-49 y.o.	Monthly CS returns. Census projections.	Approx. 0.5%	3.6% in 2 yr. 10% in 5 yr.	Monthly
3. % women 15-49 using any form of child spacing	100x No. who say they are using CS Total no. of fertile women 15-49 interviewed	Community-based sample survey	About 3% (to verify this assumption)	?	In months 0, 12, 48
4. % of health centres offering child spacing services	100x No. HC** offering child spacing Total No. HCs in our district	Mo. HC reports. Supervisor reps.	33%	73%	In months 3, 6, 9, 12
5. % of men/women who know one or more child spacing methods	100x No. men/women who can name 1+ modern CS methods Total No. of men and women 15-49 y.o. interviewed	Community-based sample survey in two selected areas	Men 35% Women 29% (to verify)	Men 50% Women 60%	In months 0, 11
6. No of local organizations oriented in child spacing	Local organizations such as MCP, CCAM, women's league, farmers clubs, etc. visited and given CS presentation	Project Logbook	1	about 30	In months 6, 9 and 12

7. % health service staff in district trained in CS*	100x health staff trained in CS Total service staff in district	Payroll reg. & MCH seminar register	Approx. 17%	71%	In months 2, 4 and 11

* CS: Contraceptive services
** HC: Health centre

Figure 16: **Possible content of evaluation report**

(To be prepared and presented by teams at the Evaluation Workshop).

1. Project Implementation

1.1 Planned activities
1.2 Completed activities
1.3 Intended products
1.4 Actual products

2. Service Achievements

2.1	Critical activities	?	Base-line
2.2	Critical activities	?	Target levels
2.3	Critical activities	?	Current levels
2.4	Service difficulties	?	Base.line level
2.5	Service difficulties	?	Target level
2.6	Service difficulties	?	Current level

3. Health Problems

3.1	Problem indicators	?	Base-line level
3.2	Problem indicators	?	Objective level
3.3	Problem indicators	?	Current level

4. District Team Management

4.1 Team composition and leadership
4.2 Other support received
4.3 How activities were managed and coordinated
4.4 Problems encountered, and how they were resolved
4.5 Other characteristics of the team and how well it worked together
4.6 Any change made to the strategy
4.7 Any managerial aid (charts, schedules, etc.) introduced during the workshop, or designed and used by the team which proved very useful?

5. Team Evaluation of the Planning Workshop

5.1 Which sessions were found most useful during implementation?
5.2 Which sessions were found least useful?
5.3 What other topics should have been covered?
5.4 General assessment of the effectiveness of the workshop and the team problem-solving approach

Session 13: PROPOSAL PREPARATION

Objectives:

At the end of the session, teams will have:

1. Created an outline for their proposal document.

2. Written their solution proposal.

Materials:

1. Outline of a proposal.

2. Planning workshop evaluation form.

Tasks:

1. Discuss the major issues which the decision-maker must consider, and may raise for discussion, in order to approve the proposal.

2. Refer to the outline for the proposal document. Discuss how best to describe briefly the problem as your team has defined it, and the proposed approach for solving it, including the analytical and planning products produced thus far. Write brief texts which describe and connect these products. These connecting texts should make it clear why the team's proposed interventions are both feasible and potentially effective.

3. Draft a proposal document according to the agreed outline. Make sure that the proposal addresses the issues felt most likely to concern decision-makers.

4. Prepare a brief (15 minute) verbal and graphic (transparencies or flipchart) presentation of the proposal which highlights its features, to be delivered to decision-makers in Session 14. The presentation should show the main features of the problem, the solution developed, its implementation and evaluation.

5. Each team presents its proposal to a group of facilitators, and uses their feedback to improve the presentation to decision makers in the next session.

6. Each participant takes and completes an evaluation questionnaire about the planning workshop, and hands it in at the time indicated by the facilitator. Alternatively, this questionnaire, might be distributed and filled out at the end of session 14.

Product:

1. Solution proposal document.

2. A prepared presentation.

Figure 17: **Outline of a proposal**

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

Session 14: PRESENTATION OF PROPOSAL

Objectives:

At the end of the session

1. Each team will have made a verbal and graphic presentation of its proposal to the workshop participants, facilitators and attending decision-makers.

2. Participants will have heard the reaction to their proposal from decision-makers.

Materials:

1. The solution proposal prepared in session 13.

2. The presentation prepared in session 13.

Programme:

1. Each team delivers a verbal and graphic presentation of its problem analysis and solution proposal within a 20 minute period.

2. Following the presentation, 20 minutes are allowed for questions from other participants, facilitators, and decision-makers.

3. Decision-makers give their immediate reactions to each proposal including guidance.
4. At the end of the session, each participant (team member, regional supervisor and facilitator) completes the evaluation questionnaire about the planning workshop and turns it into the facilitators.

Results

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

2. Completed evaluation questionnaire.

Session 15: WORKSHOP EVALUATION AND CLOSURE

Objectives:

At the end of the session participants will have:

1. Heard and discussed the analysis of their evaluation of the DTPS planning process and given suggestions for its improvement in the future.

2. Been charged with the responsibility to proceed with the implementation of their solution and its evaluation, and to report the results to this same group in approximately one year.

Materials:

1. Analysis of completed workshop evaluation forms.

Programme:

1. The DGHS charges the teams with the responsibility to implement their solution and evaluate it prior to the evaluation process in 10-12 months.

2. Presentation by facilitators of the results of the workshop evaluation.

3. Discussion by participants, facilitators and decision-makers about the DTPS planning process and how it can be improved.

4. Closing comments by facilitators, participants and decision-makers.

Figure 18: **Evaluation of the DTPS planning process**

Rec. No. _______

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

I am (please tick one):
- 9 a district team member
- 9 a zonal/regional supervisor
- 9 a national facilitator

I worked with team:
- 9 X district, Y region
- 9 A district, B region
- 9 C district, D region

		Degree of Achievement			
		Full	Partial	Minimal	Nil
I.	**ACHIEVEMENT OF SESSION OBJECTIVES AND TASKS**: (Numbers refer to sessions)				
1.	Understood the team problem-solving process				
2.1	Became familiar with available data				
2.2	Identified additional data needed				
3.	Used a problem diagram to identify critical variables				
4.1	Identified sources of additional data needed				
4.2	Designed tables for data presentation				
4.3	Planned data collection methods				
5.1	Completed field data collection				
5.2	Completed tabulation of field data				
6.	Analyzed and summarized the field data				
7.1	Completed the problem diagram				
7.2	Completed the problem table				
8.1	Used the design criteria				
8.2	Selected critical points for intervention				
8.3	Generated ideas for the problem solution				
9.	Formulated objectives and targets				
10.	Described the proposed solution				
11.	Prepared the implementation plan (schedule and responsibilities)				
12.	Specified indicators and methods for monitoring and evaluating the solution				
13.	Completed the outline and proposal of the solution				
14.1	Presented the solution proposal				
14.2	Received a reaction to the presentation from decision-makers				

II.	**EFFECTIVENESS OF THE PREPARATION AND CONDUCT OF THE PLANNING PROCESS**			
1.	Explanation of session tasks			
2.	Background materials/information			
3.	Participation of team members			
4.	Support by facilitators			
5.	Workshop accommodations			
6.	Living accommodations			
III.	**GENERAL ASSESSMENT**			
1.	The subject matter is relevant to my work			
2.	The methods applied will be useful in my work			
	This method of problem analysis and planning can be used in: (tick which is applicable)			
3.1	Health Centre			
3.2	District Hospital			
3.3	District Office			
3.4	Ministry of Health			
4.	I feel able to participate in my district problem -solving work			
5.	I feel able to lead or teach such work at my level of the service			
6.	I feel the solution my team proposed will be:			
	- successfully implemented			
	- effective in improving maternal health			
7.	The extent to which the data collected in Mtwara is relevant to my district			
8.	The amount of additional data collection that will be necessary when we return to our district			

Other comments:

NOTES ON EACH SESSION OF THE PLANNING WORKSHOP

Notes on Session 1: Opening

Duration: about 1½ to 2 hours

1. It is important that the Director-General of Health Services (DGHS), or another high-level service manager viewed by the teams as their hierarchic superior, is present and stresses his or her personal interest in this activity. The DGHS must confirm his or her role in selecting the participating districts and in choosing their health problems, and explain the particular relevance of each health problem for the team for which it was chosen. He or she directs a challenge to each team to analyze its problem and to design a solution that will require no additional resources, and that it will present to him or her in 10 days. He or she should express confidence that the staff from district and facilitator level know their populations and service conditions better than anyone else, and that they will generate innovative ideas for reducing the problem. The DGHS thus impresses them with his or her personal interest in their work.

2. When the participants are introduced they should be sitting together and be clearly identified as a team. This emphasis should continue throughout the workshop.

3. The workshop objectives (see example in Figure 2 of the guidelines) included in the workshop syllabus, and the working methods - brief plenary introduction, team-work, plenary presentation of team products, discussion - are noted and discussed. The workshop programme (see example in Figure 3 of the guidelines), the schedule, and the working areas for each district team are discussed.

4. Reference is made to the description of the DTPS approach in the workshop syllabus, noting that solutions will come out of the work of the teams and that time will be strictly controlled in order to allow the maximum time possible for team-work. From this session on, each facilitator should control the time quite strictly to make sure that teams perform their tasks within allocated time. The workshop coordinator should ensure that the overall schedule is followed.

Notes on Session 2: Review of available data

Duration:	about 5 hours	
Timing:	20 minutes	Briefing
	about 3½ hours	Team preparation
	20 minutes/team	Plenary presentation

1. In this session team members tackle the question: "What is known about this health problem and the adequacy of our services for addressing it?" They start by reviewing all the available sources of data (both quantitative and qualitative) on their problem. They begin to identify appropriate indicators for measuring the level of their health problem and the services it needs. They also begin to narrow in on some specific, improvable aspect of the broad health problem they are analyzing. Finally, they produce two products: (1) a summary problem table (a table of indicators for measuring the severity of the health problem in the population, the services needed to resolve it, and the difficulties which impede a resolution); and (2) a list of additional data needed to define the problem.

2. Plenary briefing by a facilitator (these briefings should be rotated among the facilitators) who:

- calls attention to available data.

- gives examples of data that are is useful and not useful, reliable and not reliable, valid and not valid.

- shows, by example, how to extract, analyze, and format data.

- introduces the format for a problem table and its three categories of indicators.

- illustrates how to fill in a blank format for a problem table (Fig. 1) using selected indicators to measure the extent of a health problem, the state of the most effective services addressing it, and a few of the most important difficulties that impede improvements in the health indicator ("difficulty" might be an insufficiency in service capacity, in population behaviour, in community resource mobilization, etc.), and shows an example of an initial problem table produced by a team in an earlier exercise (Fig. 2).

- discusses and explains the reason for a team's list of additional data needed to define its health problem.

3. The data made available may include any or all of the following, as appropriate to the particular health problem being addressed by the team:

   - existing results of pertinent surveys or research (on attitudes, utilization, symptoms, etc.).

   - extracts of data from the health information system (on cases, deaths, human resources, activities, etc.).

   - plans, service reports, and study data brought from the district (cases, activities, etc.).

   - policy/procedure guides, e.g. definition of high-risk pregnancy.

   - population and target group data for each district, e.g. census information.

   - statistics of coverage, e.g. of antenatal care and delivery by traditional birth attendants.

   - maps with distribution of health facilities and catchments.

4. This is one of the most challenging and difficult sessions for the teams. They are just starting to settle into the physical area where they will do their group-work. They are also just beginning to relate to each other as members of a problem-solving team. They must assemble and organize a jumble of different documents, go through these to identify the most relevant data, and then identify and abstract just those bits of information, both qualitative and quantitative, that are most relevant to their health problem. Many of the team members will not be very good at this kind of quantitative thinking, although a few may be. The group may be uncertain as to whether and how to parcel out the work. Also, at this initial, and usually somewhat confused, stage of their discussions, the exact definition or focus of their problem is still not clear for some members of the team. However, the necessity of identifying useful indicators to fill in the assigned problem table will force the team to focus on some particularly important aspect of the health problem and will make their discussions more concrete.

5. It is important for facilitators not to be intrusive during this session. The team members are just beginning to test whether they, rather than the facilitators, are really in charge. Facilitators should show interest in the data, to encourage the team to review, for <u>all</u> its members, what is available and to discuss what is potentially

useful. However, the teams must be left with the feeling that they are dealing with their own problem, for which they must find their own solution.

6. Briefing papers on recent developments in the understanding of the particular health problem being addressed, and of alternative approaches for dealing with it - for example WHO technical documents, continuing education or distance learning materials, etc. - may be made available to the teams in this session, along with all of the survey and statistical reports. It should be realized, however, that the team members have an enormous number of things to do at this point, and little time or energy for additional reading. Hence, discussion with knowledgeable experts or programme managers present, who are able to detect and fill in gaps in knowledge of the teams, is likely to provide a more readily assimilable form of information about the health problem and how to deal with it. Ideally, a few, judiciously selected and targeted technical briefing papers, ideally, might be sent out to the appropriate teams several weeks in advance of the workshop. But this would require the particular district health problems to be identified early enough, followed by a rapid, discriminating technical assistance response from the supporting agencies.

Notes on Session 3: Problem analysis

Duration:	about 4 hours	
Timing:	10-15 minutes	Briefing
	about 3 hours	Team preparation
	15 minutes/team	Plenary presentation

1. In this session the teams create a simple problem model by visually depicting, in a diagram, the critical variables that affect their health problem.

2. Plenary briefing by a facilitator who:

   - demonstrates how the teams can easily construct a problem diagram which is a visual display of the network of variables that aggravate or ameliorate the health problem (in the example shown here (Figure 3) the health problem is child malnutrition). This is done by, first, writing the problem in the centre of a flip chart, then by getting various participants to indicate what they can think of in their district that tends to make this problem either better or worse. The variables they suggest are displayed by one of two methods, by writing then directly onto the flipchart or onto separate cards.

   - guides teams toward getting active participation of <u>all</u> their members.

3. The problem diagram is visually a very communicative technique. It takes only about 5 minutes of demonstration for the teams to understand adequately how to go about constructing their own problem diagrams. Participants are encouraged to be creative, not just to imitate the example shown.

4. Problem diagram variables may be written on a flipchart directly, then circled and connected by arrows, or they may be written on small individual cards by participants, then collected and attached to the growing diagram. The simpler method is to write directly onto the flipchart. The more complex, but also more flexible, method is to stick them up on 3x5 cards using adhesive putty, and then to rearrange the cards at will into the pattern of relationships desired. The former method allows the diagram to be drawn quicker initially and requires less material. The card method collects a large number of ideas at one time as it allows all the team participants to write at the same time. The card method also facilitates reorganization of the relationships among the variables in the problem diagram. Hence it tends to keep the participants thinking

creatively about the many factors which influence their health problem. On the other hand, it requires having a stock of cards, a felt-tip pen for each participant, and adhesive material.

5. During the team's discussions of the services that are critical to its health problem, the facilitator should note whether the team members are aware of recent developments in technical understanding of the problem and/or of alternative approaches available for dealing with it. During this session, and again during the listing of ideas for intervention in session 8, the facilitator may judge it appropriate to discuss with the group recent informational materials from WHO or other sources. These materials were made available to the teams, according to the nature of their health problems, in session 2. The concerned facilitator should have read these documents carefully, in order to be able to quickly convey anything that is new and useful for his or her team. However, facilitators should be sensitive to the danger, when conveying expertise in this manner, of taking over from the team. Facilitators must resist the temptation to tell their teams what they should do.

6. The facilitator may choose to introduce some simple method to ensure that groups are encouraging active participation of all their members, regardless of how junior in rank or modestly educated they are. The creation of the problem diagram is an excellent assignment in which to use a group process technique. One of the best, and easiest, is the first four steps of the nominal group process:

    - The current discussion leader (a task which should be rotated in the team) will clearly state the critical question, e.g. "What are the main variables that either raise or lower the level of our health problem?"

    - Maintain <u>silence</u> in the group for 10-15 minutes while each participant is generating his or her own answers and writing them in a notebook (or onto cards).

    - Take just <u>one</u> answer or idea from each person, listing it on a flipchart visible to all (or attach the card to the board near the problem). Then proceed to the next person, take just one idea, and continue around the group in this manner until all of the ideas from every participant are displayed. Postpone discussion or disagreements during this step. Allow only requests for clarification when someone does not understand what is intended by one of the ideas displayed.

    - When all of the ideas are displayed, and can be seen by each group member, open a free group discussion of each of the ideas in turn.

    - This discussion should indicate the additional information needed to proceed with the solution design, such as knowledge of the community about the problem and their attitudes toward the relevant health services.

Notes on Session 4: Design of field data collection

Duration:	about 7 hours	
Timing:	30 minutes	Briefing
	about 6½ hrs	Team preparation

1. In this session the teams identify their best sources and target populations for missing data. They design model tables to be used to present the data after they have collected them. They design the data collection process and the recording and tabulation formats they will use when collecting data in the field.

2. Plenary briefing by a facilitator who:

   - reviews the informational materials that have been made available to the teams relevant to this session.

   - demonstrates, through carefully selected examples, how the list of additional data needed can be used to identify sites to be visited. Illustrates the kinds of data to be gathered. Demonstrates the use of model tables for presenting final information.

   - outlines the different types of data that may be sought, and their potential sources. These may include registers in health centres, household questionnaires, special records (e.g. immunization cards, growth charts, mothers' health cards, etc.), and routine administration records such as stock supply records.

   - outlines the basics of good questionnaire design, i.e. focused on critical information, short (<15 questions), field tested, non-leading questions.

   - introduces basic ideas for conducting a focus group discussion. Calls attention to the distributed reference article on such discussions. Discusses the value of qualitative, in-depth data in managing health services.

   - facilitates plenary discussion of where and when teams intend to gather their data, and what kinds of pre-arrangements, transportation and facilitator assistance will be needed.

3. This is a long session in which the teams are required to make a large number of decisions. By asking probing questions, facilitators can help the teams to simplify and improve their initial attempts to create questionnaires. The same is true for other data collection instruments, such as model tables for summarizing the analysis of clinic registers. Since the preparation of model tables involves hard work and no one likes to make them, they are not likely to be produced by the teams unless their facilitators ask to see them. Teams that do produce them, however, are very happy to have them. They help teams to focus on just what are the most important data to obtain, and in what form to obtain them. It also helps them to format and present their results after they have analyzed the data.

4. If it is a 9-10 day, undivided workshop, most of the teams will be gathering their data in the form of a field-test of their instruments and a trial-run of their procedures and techniques in a district other than their own. They will be practicing skills and testing instruments primarily in order to revise them before they use them again to gather data from, and for use in, their own districts. With the limited time available, it is advisable to promote, as a priority, the visiting and collection of data from nearby facilities.

5. An option in this session is to combine the questions from each team into one set of integrated, consolidated questionnaires that will be used by each of the teams. This requires more coordination and time. However, it adds an element of integration to the exercise, as well as cross-fertilization of ideas, and it allows a larger sample of health facilities and communities to be surveyed. Such consolidation may require an additional half day of preparations.

Notes on Session 5: Field data collection

Duration: 1-2 days
Timing: Undivided workshop 1-2 days Teams, assisted by facilitators, collect and

tabulate field data Divided workshop 2-6 weeks. Teams, visited by facilitators, collect, tabulate, and do preliminary analysis of field data in own district

1. During this session the teams collect data from communities and service facilities, and then tabulate it. The full time is needed, and the logistics of the day should be prepared well in advance.

2. All aspects of this field experience -- collecting data, then analyzing them and presenting the results -- produce important learning for team members on how to collect and use non-misleading information for decision-making. This includes selecting sites, facilities, populations and records; scheduling logistics and transport of survey teams; finding households; introducing interviewers and/or analysts; conducting interviews and/or analysis of facility records; checking data collection instruments for completeness, and handling them; making tally sheets and cross tabulations by hand; drawing results and conclusions from analysis of data; making clear summary tables and graphics for presentation of results etc.

3. Usually, there is no plenary session. Facilitators assist the teams in scheduling the logistics of their field visits. They provide back-up support as the teams visit communities and service sites to use the data collection instruments developed in the previous session. Facilitators provide any assistance requested or obviously needed in sampling sources and in collecting, recording and tabulating data.

4. The volume and variety of types of data that may be collected are illustrated in the example shown in Figure 4.

5. The initial field collection for revision of instruments and procedures takes place during one whole or two half days. In the divided workshop, both sessions 5 and 6 are repeated during the collection of data in the teams' own districts, which may last several weeks.

Notes on Session 6: Analysis of field data

Duration: about 5-6 hours
Timing: about 4 hours Team preparation
20 minutes/team Plenary presentation

1. In this session teams complete their analyses of field data, finalize their data summaries, and write descriptions of their findings.

2. Usually there is no initial plenary session. Facilitators provide back-up support as needed while their teams analyze the data they collected. It may be useful for facilitators to enquire about the use teams are making of the model tables they prepared in session 4.

3. The products (tables and conclusions or narrative descriptions of the results of the analysis) should be prepared in the form in which they will be used in the proposal document to be prepared at the end of the workshop.

4. Based on the insights from their initial visit to the field to collect data, the teams revise their data collection plans, procedures and instruments to improve the further collection of field data in their own districts.

Notes on Session 7: Problem definition, description

Duration: about 5-6 hours

Timing:	20 minutes	Briefing
	about 4½ hrs.	Team preparation
	15 minutes/team	Plenary presentation

1. In this session the teams complete their analysis of their assigned health problem, redefining it as appropriate in consideration of the additional information they have gathered. They write a description of their redefined problem that includes their problem diagram and their problem table of quantitative and qualitative indicators.

2. Briefing in plenary introduces this session as the last scheduled for team analysis and definition of the problem. A facilitator instructs the teams to use the products of their data analysis from session 6 in order to revise and produce final versions of their problem diagram and problem table. Each team will then present these final problem products in plenary. It will use them to identify clearly the set of variables, and their indicators, that represent the redefined health problem and the associa ted services and obstacles (i.e. difficulties) that the team intends to address with its solution.

3. Facilitators should be vigilant in assisting their teams, as needed, with the three major challenges they face in this session:

   - how to be epidemiologically correct and well organized in the presentation of the relevant data and findings

   - how to be clear and brief in presenting, with clearly drawn transparencies, their findings and conclusions to the other teams and facilitators in plenary

   - how to limit the number of indicators-across the three categories: health problem, service performance and service difficulties-that are finally chosen to define the problem.

4. In the case of a divided workshop and where teams have advanced their work to cover tasks under this session facilitators will make sure (in group work) that all indicators are well selected, that the presentation of the data is epidemiologically correct and that teams are well prepared to make a clear presentation, in plenary, of the ir problem statement and their operational problem diagram.

5. The products of this session should be suitable for use in the proposal document.

Notes on Session 8: Idea generation and selection

Duration:	about 3 hours	
Timing:	15 minutes	Briefing
	about 2 hours	Team preparation
	40 minutes	Plenary presentation

1. In this session the teams select critical points in their problem model for interventions that might lead to a solution. They then generate ideas for intervention, and select the most feasible and promising ones. They use design criteria to help ensure that the proposed solutions are consistent with national policy and will be acceptable to decision-makers. These design criteria (Figure 5) will have been prepared in advanc e by the core group with advice and approval from senior decision-makers.

2. Plenary briefing by a facilitator who:

- introduces and discusses the list of design criteria (Figure 85) that each team will use in selecting several ideas for potentially effective interventions.

- illustrates the use of a problem diagram to identify entry point variables, i.e. those where interventions are most likely to offer the potential for reducing the problem, and shows how the problem diagram is "operationalized" by visually marking the variables selected as entry points.

- illustrates the use of a solution diagram to display the key interventions planned for resolution of a problem.

- suggests that each team takes steps to ensure full participation of all its members.

- shows examples of how to choose among suggested interventions those:

    - that satisfy the design criteria

    - that have the greatest potential for reducing the problem, i.e. those service activities that are likely to be most effective in decreasing the health problem

    - that can be implemented with greatest probability of success in the next 10-12 months

    - that can be extended to the majority of the population in the target group, with priority given to those currently with least access, or most vulnerable.

3. Facilitators should be prepared to discuss any technical or programmatic issues that might be raised by teams in their search for good interventions for dealing with their health problem, and to clarify any of the expert opinion, guidelines, or other documents made available. During this session, however, the facilitators should consciously remain quietly in the background as the team members actively debate what they think they could actually do in their district to deal with their health problem.

4. Facilitators should avoid prescribing their solutions to the team's problem. Team members will come up with many potential intervention ideas of their own; they must be allowed to feel that the solution strategy they eventually develop is, indeed, their very own.

5. The main products will be:

    - a list of briefly described idea statements for changes (in policy, procedures, community involvement, information, organization of effort, etc.) that can be made in how services address the problem.

    - the solution diagram, which provides a visual overview of these interventions.

    - the operationalized problem diagram, which shows the logic of the interventions, i.e. where they address the causes of the health problem.

    - a one-page description of the basic strategy and interventions chosen.

Notes on Session 9: Formulation of objectives and targets

Duration:	about 4 hours	
Timing:	15 minutes	Briefing
	about 2 ½ hours	Team preparation
	60 minutes	Plenary presentation

1. In this session each team produces a table of health improvement objectives, and health services and difficulty reduction targets. These are expressed as quantitative estimates for some of the indicators the team defined earlier in its problem table. The amount of change planned for these indicators measures the extent of health problem reduction planned within the time frame specified, the improvement in the level of health services that is required, and the degree of reduction of difficulties that will be necessary to achieve this much reduction of the problem.

2. Plenary briefing by a facilitator who:

   - introduces the session by noting the format for the objectives and targets table (Figure 6), that each team will produce, and shows an example (Figure 7), pointing out that while teams have already decided what they will do in the preceding session 8, now they will need to decide how much of it they might reasonably accomplish in the 10-12 months that they will have for implementation, and what effect it will have on the problem.

   - advises teams to start by reviewing their final problem table from session 7, existing health programme objectives and targets, and their list of selected ideas from session 8. Shows an example of how another team had set an objective for the amount of desired improvement in its central health problem which was logically proportionate to the targets it had set for the improvements of critical health services and for reductions in key difficulties.

   - clarifies and illustrates the use in this exercise of the terms "objective" (level to be reached in the improvement of a health or fertility problem indicator in the population) and "target" (planned level of improvement in a services indicator, or of diminution in a difficulty indicator). The targets should be high enough to make attainment of the objective feasible. Objectives and targets should be realistic, not overoptimistic; they should depict each team's best estimate of the amount of progress it might reasonably make with the effort it intends to invest, given the real constraints in its district. The latter include, of course, the competing demands of ongoing services on the time of the team, and the familiar limitations of transportation, supplies, travel allowances, etc.

   - may propose a sequence of steps to set objectives and targets (Figure 6), as well as alternative approaches to target setting (Figure 7).

3. Facilitators respond, as requested, with assistance in definition and calculation of selected indicators. They encourage teams to be realistic rather than excessively ambitious, and to consider their other obligations as they estimate what they are likely to be able to accomplish in the next year.

4. In past DTPS exercises, teams have had no difficulty completing this assignment in the time allowed. Setting of objectives and targets in this exercise amounts to selecting among the indicators already identified and defined by the teams earlier in their problem tables. The team's major challenge is to determine the amounts of change it can accomplish in the actual working context of its district during the next year.

Notes on Session 10: Solution description

Duration:	about 4 hours	
Timing:	15 minutes	Briefing
	about 3½ hours	Team preparation

1. In this session each team finalizes its solution strategy and produces a brief description of its proposed solution to the assigned health problem, including appropriate tables, diagrams and illustrations.

2. Plenary briefing by a facilitator who:

   - introduces this session as one in which each team will produce a brief written description of its solution to its health problem.

   - explains that this brief solution description should be clear, and designed to be understood and to justify acceptance by Ministry of Health decision-makers.

   - identifies materials needed by the team for this assignment:

     - its list of selected ideas (from session 8)
     - its objectives and targets table (from session 9)
     - relevant problem-specific documentation (provided in session 2).

3. The facilitators remain ready to hear and read the team's draft solution description, as requested, and to offer criticisms and suggestions. However, most teams should be able to function on their own and will need little or no facilitation in this assignment.

4. An example of a solution description produced by one team is shown in Figure 8.

Notes on Session 11: Implementation Planning

Duration:	about 4 hours	
Timing:	15 minutes	Briefing
	about 3½ hours	Team preparation

1. In this session each team produces a list of activities it needs to carry out in order to implement the proposed solution. It places these activities and the products that mark their completion in a time-frame indicating who is responsible for each of them.

2. Plenary briefing by a facilitator who:

- presents the Implementation Schedule Format (figure 15) and illustrates how an example (figure 16) had been filled in.

- distinguishes between "activity" and "product". Illustrates the notion of concrete products (e.g. a health committee constituted, a report prepared, etc.) which are generated by, and mark the end of, logically sequenced activities. Some of these products may, themselves, be inputs needed in order to complete other activities which are necessary for a successful "solution".

- emphasizes the importance of team members putting their own personal names on the implementation schedule (not merely their titles) next to those activities for which they will be responsible.

- encourages teams to detail their activities on large sheets of paper in order to ensure full understanding and participation of all team members over the next 12 months. Notes that teams may need to rework these lists of activities several times before each team member is confident that the activities planned can actually be carried out in addition to other ongoing responsibilities.

3. Teams will probably not need much facilitation during this session. As the team makes a detailed listing and scheduling of the activities that it has decided it must perform over the 9-12 month implementation period, it will become fairly evident to most of the team members what they must do.

4. Some team members may display reluctance to putting their personal names, rather than just their titles, on the implementation schedule. With a little persuasion, however, participants will do this. Individual motivation and commitment are heightened and sustained when team members, and their colleagues, see their own names on the implementation schedules. Most of these schedules will be posted in the district offices. Also, it aids realism during the setting of targets and schedules. It causes individuals to consider seriously whether they, personally, can really commit themselves to accomplish each particular activity, and within the specific time-frame, under discussion.

5. Teams should be reminded that each of them will have to evaluate their solution toward the end of the implementation period and prepare an evaluation report. Some teams may wish to conduct a baseline survey at the beginning of the implementation. These activities should also be scheduled.

6. Activities and products that regional (provincial) personnel have agreed to undertake in support of the team's project during the implementation period should also be included in the Implementation Plan opposite their names.

Notes on Session 12: Evaluation plan and indicators

Duration:	about 4½ hours	
Timing:	25 minutes	Briefing
	about 3 hours	Team preparation
	60 minutes	Plenary presentation

1. In this session the teams specify the indicators they will use for monitoring progress and for evaluating the effects of their solution. They also describe the methods they will use in monitoring and evaluating.

2. Plenary briefing by a facilitator who:

- notes the format for a summary table of monitoring and evaluation indicators (figure 11). Teams will use this format to present those indicators they have selected to measure and monitor progress during implementation. Ultimately, they will use the same format to evaluate the success of their solution project. Illustrates the use of this format by showing and discussing a concrete example (figure 12).

- illustrates that the burden involved in collecting valid data and calculating indicators obliges teams to be very selective in choosing a small number, perhaps 4-9, of only key indicators that they will actually measure and actively follow for monitoring and evaluation. Monitoring indicators should be calculated periodically to compare actual progress with the targets that were planned.

- shows, by example, how teams will be able to use the levels they set for indicators in their Objective and Targets Table to judge the relative success of the solution they proposed, and of the progress they achieved in implementing their project. Notes that teams will compare these planned Objective and Target levels with the levels which will actually have been achieved and measured. This will show the extent to which teams were actually able to accomplish what they set out to do.

- shows an example of how objective and/or target indicators are calculated, starting from source data.

- illustrates the difference between data to be gathered for final evaluation of the success of the solution project, on the one hand, and for monitoring progress to guide redirection of effort during implementation, on the other. Illustrates how the data to be gathered will be used by the teams to make the comparisons needed for evaluation, as indicated in the outline for the possible content of the evaluation report (figure 13).

  a. Project Implementation:

     - completed compared to planned activities
     - achieved compared to planned products

  b. Service Improvement Achievements:

     - targeted compared to achieved compared to baseline service Levels
     - targeted compared to achieved compared to baseline difficulty Levels

  c. Solution (project) effectiveness in reducing health problem

     - objective compared to current compared to baseline level of the health problem

  d. District team management improvements.

     - presents and discusses the outline possible content of evaluation report, which the team is to consider and modify to produce its own outline. This outline will guide the team in evaluating its project, and in producing (in the district) its Evaluation Report before, and as the main basis for, the evaluation workshop.

- notes, also, how teams can use the summary table of monitoring and evaluation indicators to compare the levels of health and service indicators actually achieved with those that they had projected assuming no solution project. This comparison indicates the difference made by the project.

3. In this session teams may need assistance epidemiologic reasoning and/or calculations that they do not request. The facilitator may be of assistance to his/her team by inspecting carefully each of the evaluation and monitoring indicators chosen. In particular, has the team carefully defined the correct denominator for each numerator of interest? Are there any adjustments of rates (e.g. for age groups) that the team will need to make? Does the team understand how to do this? Has the team identified adequate and available data sources for both the denominator and numerator? Has the team chosen more indicators for monitoring or evaluation than it will be able to cope with in terms of gathering the basic data that will be needed?

4. While some baseline and evaluation surveying may be necessary, the teams should be encouraged to use routine records and reports to the maximum extent, and other innovative measures, such as observation of clinic procedures, focus group discussions with traditional birth practitioners, general practitioners, etc.

Notes on Session 13: Proposal preparation

Duration:	about 10 hours	
Timing:	25 minutes	Briefing
	8-9 hours	Teams work on tasks to prepare proposal
	15 minutes/team	Each team makes its "practice presentation" to a group of facilitators
	15-30 minutes	Critique by facilitators with each team

1. In this session the teams create an outline for, then write a draft document of their team's solution project proposal. The teams also make a practice presentation of their proposal to facilitators as a rehearsal for their presentation to Ministry of Health decision-makers.

2. Plenary briefing by a facilitator who:

- points out that each team, by the end of this session, will have finalized a satisfactory solution proposal document using the Outline of a proposal (figure 14) and will have prepared it for presentation to the decision-makers in plenary during the next session 14.

- notes that the proposal document should clearly define the problem and show the feasibility and potential effectiveness of the solution proposed by the team in such a way as to win the approval of the decision maker.

- notes that the team has already produced, in its session products, most of the materials needed for its solution proposal document. The principal challenge now is to select and organize these products, and to write a small amount of connecting and explanatory text.

- urges teams to keep their proposal documents brief (about 20 pages or less), selecting only those products, diagrams, maps, etc. which are essential for a clear and convincing proposal.

- explains the opportunity each team has to make a practice presentation of its proposal to a panel of several facilitators, and the logistics doing this (probably in the evening).

3. In addition, the facilitator:

- notes the benefits of teams preparing well for the presentations of their proposals:

    • to ensure a common understanding of the proposal by the entire team
    • to gain the understanding and approval of the decision-makers
    • to encourage sharing of ideas about problem-solving with the other teams.

- offers guidelines for an effective presentation, for example:

    a. Distribute the complete proposal document, in advance, to the decision-makers who will review the proposal.
    b. Present the highlights or important points, and the logic of the proposed changes.
    c. Control the time frame, i.e. 15 minutes for presentation and 10 minutes discussion for each team.
    d. Use clear visual aids (clearly written or drawn, attractive, concise, and visible to all). Use a pointer during presentation.
    e. Prepare an outline of the presentation in logical sequence.
    f. Arrange materials in order of presentation.
    g. Use teamwork during the presentation - assign different team members to present different parts. Assist the presenter with visual aids.
    h. Make a practice presentation (in this case, to the facilitators). Use the feedback to finalize the proposal and revise the presentation.
    i. Rehearse the final presentation.

4. Facilitators should take special care to manage the logistics of teams working with the Secretariat, where traffic is likely to be dense. It is helpful if one calm and well-organized facilitator takes on the role of overall coordinator and traffic controller of this interaction between the Secretariat, the several teams, and the other facilitators during this hectic period when the Solution Proposal Documents are being typed, reproduced, assembled, and distributed.

5. Each team will need to assemble a complete set of all of its products and materials in order to review and select from them. Then it will have to write connecting text to finalize its Proposal Document.

6. The Secretariat will need to prepare to reproduce the requisite number of copies for all pages included in each team's Proposal Document. Then the team will need to assemble and staple together the requisite number of documents for distribution by each of the teams before its major presentation.

7. Once their assignments and guidelines have been made clear, the teams will be able to carry out their tasks with very little facilitator assistance, judging from past workshops.

8. The practice presentations have been very helpful to and appreciated by the teams in previous DTPS workshops. Panels of two or more facilitators inform each team that they will be available to hear the presentations when the teams are ready to make them. The teams are told to take their time in getting prepared. Teams will present their proposal in rehearsal just as they actually would for the decision-maker the following day. These practice presentations frequently run on into the evening. The facilitators time each

presentation. They give feedback on its strong and weak points, as well as suggestions on how it might be improved. These suggestions may concern defining terms, describing procedures, shortening the presentation by reading only the highlights of a projected table, redrawing an unclear transparency, standing not in front of a projected table but beside it while using a pointer, speaking louder or slower, etc.

9. The evaluation questionnaire (see Sample in figure 22) for the planning workshop should be handed out during this session, then collected at a time that will allow two facilitators to analyze it and present the results the next day in session 15. If it is available, Epi Info 5 is a useful tool both for preparing the questionnaire and for analyzing the returns. (Optionally, this evaluation questionnaire may be filled in at the end of session 14, after the team presentations to decision makers. The advantage is that participants evaluation would then cover the culminating achievement of the workshop, i.e. those final presentations and the discussion with the decision makers; the disadvantage is that neither participants nor facilitators have much time, to reflectively fills out or to analyze the questionnaire forms, respectively. The later, quicker option has been done successfully in Anglophone countries, but was much resisted in Francophone countries because it impinged upon and caused hurried work during the lunch hour.

Notes on Session 14: Presentation of Proposals

Duration:	about 4 hours	
Timing:	20 minutes	Opening by chairperson
	80 min. (20 min. per team)	Each team presents proposal in plenary
	80 min. (20 min. per team)	Discussion after each presentation
	45 minutes	Decision-makers give their reactions

1. This session is a formal plenary with invited guests and Ministry of Health decision-makers. It is usually chaired by the ranking Ministry person who has been in charge of the DTPS process. The Director General of Health Services and/or other senior decision-makers whom he/she has designated constitute the panel to whom the teams present their proposals. The official who assigned the problems at the beginning should be present to hear the results.

2. The chairperson keeps the session on a tight time-track. Each team delivers a verbal and graphic presentation of its problem analysis and solution proposal within 20 minutes. Following each presentation, 20 minutes are allowed for questions and comments from other participants, facilitators and decision-makers, usually in that order.

3. Before the end of the session, decision makers give their immediate reactions to each proposal including guidance for proceeding with implementation. They may ask for a break at the end of the presentations in order to discuss among themselves the comments they wish to make. If they have serious reservations about any of the proposals these should be expressed, but hopefully suggested amendments can be offered so that all teams can be authorized to proceed with implementation.

4. (Optional) If this was not already done at the end of session 13, a planning workshop evaluation questionnaire (see Sample in figure 22) is distributed, filled out and handed in by participants before they break for lunch. Two facilitators analyze the results over the lunch period and prepare a brief presentation with summaries on transparencies, which they present in plenary in the next session.

Notes on Session 15: Workshop Evaluation and Closure

Duration: about 2 hours
Timing: 15 minutes Facilitator presents results of evaluation questionnaires in plenary
60 minutes General discussion
45 minutes Closing comments

1. The chairperson invites the facilitators to present to the plenary the preliminary results of the workshop evaluation questionnaire tally.

2. The chairperson invites comments from the other decision makers, participants, guests and facilitators on the team proposals, the DTPS workshop, or the DTPS method.

3. In a closing address, the most senior health official charges the teams with the responsibility of proceeding with the implementation of their solution, then of evaluating their results, and report back to this same group after approximately 10-12 months during the evaluation workshop.

POST-WORKSHOP MEETING

1. The DTPS workshop coordinator and the facilitators meet to determine the next steps to ensure support of team efforts during the 10-12 months implementation phase. The facilitators should have an action plan for supporting the team, with dates and responsibilities for field visits.

2. Early planning is made for the subsequent 3-day evaluation workshop.

3. It is decided how the planning workshop report is to be written, produced, printed and distributed.

ANNEX 2

DTPS EVALUATION WORKSHOP SESSION GUIDES, FORMATS, AND NOTES FOR FACILITATORS

This annex contains for each session of the DTPS evaluation workshop

- the session guide as it might appear in the workshop syllabus
- notes for guidance of facilitators
- formats used in the session including both blanks and completed examples.

Session 1: OPENING

Objectives:

At the end of the session, participants should:

1. Understand the objectives of the evaluation workshop and the method of work.

Materials:

1. Evaluation workshop objectives, programme and session guides.
2. District team proposals (from planning workshop).
3. District team evaluation reports.

Programme:

1. Welcome.
2. Introduction of participants.
3. Workshop purposes and objectives.
4. Workshop programme and methods of work.
5. Administrative matters.

Session 2: OVERVIEW OF PROJECT AND MAIN "SUCCESS STORY" OF EACH TEAM

Objectives

At the end of the session, teams should have:

1. Presented a brief overview of the health problem and the solution strategy of their team clearly so that participants who had not attended the planning workshop will be able to follow the subsequent evaluation findings of the team.

2. Identified and presented an account of their most significant success during implementation and how they accomplished it.

Materials

1. District team evaluation report.

Tasks

In team subgroup:

1. Make a brief summary of the definition of the health problem, the strategy, and the main interventions devised by the team.

2. Select one aspect of the project that the team feels was its most important achievement, describe it, and interpret how it was done and what made it work.

In plenary:

3. One team member presents this overview and "success story" (15 minutes).

Products

Overview and success story presentations.

Session 3: TEAM EVALUATION OF PROJECT IMPLEMENTATION

Objectives

At the end of the session, teams should:

1. Have presented the results of their team evaluation of project progress, highlighting the activities completed and the products generated in comparison with their plan.

2. Be able to describe indicators of implementation.

Materials

1. District team project proposal document (from the DTPS planning workshop).

2. District team evaluation report prepared prior to the evaluation workshop.

3. Format for table for the evaluation of project implementation.

Tasks

1. Review the portion of the team's evaluation report that describes project implementation, then on transparencies prepare tables that provide an overview of project progress including:

    - activities completed, as compared to the original plan.

    - products generated, as compared to the original plan.

    - problems encountered, which caused deviation from the original plan.

    - unplanned activities and products.

    - completed activities.

2. Present in plenary (20 minutes maximum per team) the results of the team's review of project progress, first as an overview of planned and actual activities and products, then focused on several carefully selected activities and/or products, problems encountered, and how problems were overcome.

Products

1. Tabular summaries of activities and products, both planned and achieved.

2. Transparencies for plenary presentation.

ANNEX II

Figure 1: **Format for a table for the evaluation of project implementation**

Activity No.	Planned/Unplanned Activity	Scheduled Completion	Actual Completion	Intended product	Actual product
1.1					
1.2					
1.3					
2.1					
2.2					
3.1					
4.1					
4.2					
5.1					
5.2 6.2					

Figure 2: **Example of a completed table for the evaluation of project implementation**

Act. No.	Planned/Unplanned Activity	Scheduled Completion	Actual Completion	Intended Prod.	Actual Product
1.1	Meeting with health personnel to discuss project implementation	11.11.87	End Nov. 1987	To create awareness of the proposed project and gain support	Staff support gained
1.2	Design format for data collection of maternal deaths and ruptured uterus in hospital and community	16.11.87	End Nov. 1987	Format design	Format for data collection
1.3	Orientation of health personnel		Early December 1987	Create awareness on use of format and in-depth follow-up	Awareness created and in-depth follow-up done
1.4	Orientate the CHEs on how to use the format for data collection and how to report maternal deaths	30.11.87	Not done		
2.1	Designing of risk factors register (RFR) hospital and health center	16.11.87	16.11.87	RFR designed monitoring institutional delivery of at risk mothers begun	Done
2.2	Orientation of nurses/midwifes on use of risk factors register and interpretation of risk factors	16.11.87	Early Dec. 87	Create awareness on use of risk factors register	8 health facilities are using risk factors register

CHW: Community health workers

Session 4: TEAM EVALUATION OF SERVICE ACHIEVEMENT AND DIFFICULTY REDUCTION

Objectives

At the end of the session, teams should:

1. Have presented the results of their team evaluation of the effects of their project on the selected service outputs as measured against baseline and target levels.

2. Be able to describe techniques and indicators for evaluating service output, efficiency and quality.

Materials

1. District team project proposal.

2. District team evaluation report.

3. Format for summary of selected service indicators.

Tasks

1. Review the portion of the team's evaluation report that describes service performance, then prepare transparency tables which show the impact of the project on service performance including:

   - trends in selected services, by facility and overall, as measured against

     - baseline levels
     - target levels

   - trends in service difficulties as measured against

     - baseline levels
     - target levels.

2. Present in plenary (20 minutes maximum per team) the results of the team's review of the impact of its project on service performance.

Products

1. Tabular summaries of baseline, targeted, and current levels of indicators for services and products.

2. Transparencies for plenary presentation.

Figure 3: **Format for summary of selected servic e indicators**

District/selected Health Problems	Indicator	Baseline	Target	Achievement
A				
B				
C				
D				

Figure 4: **Example of a summary of selected service indicators from each district**

District/Health Problem	Indicator	Baseline (1987-1988)	Target (1990)	Achievement (1988)
A (*Nutrition*)	- No. of active VHCs*	112/800 (14%)	400/800 (50%)	201/800 (25%)
	- Children < 5 years receiving Vit. A	0	35.153 (67%)	4000 (20%)
	- No. of severely underweight children attending NRU**	104 (3.1%)	743 (20%)	305 (8.8%)
B *(Maternal Mortality)*	- No. of maternal deaths investigated	0	80%	9/15/ (60%)
	- Antenatal coverage	12%	50% (1988)	12%
	- Proportion of high risk pregnancies delivered in hospital	?	100%	9/15/ (60%)
C *(Measles)*	- Clinic attendances (<1 year)	50%	70% (1988)	64% (9 months)
	- Measles immunizations coverage (<1 year)	13,000 (70%)	17,000 (90%)	12,000 (9 months)
D *(Child-spacing)*	- No. of child-spacing acceptors among 15-49 years	2,269 (1.6%)	36% in 1988 10% increase by 1991	20%
E *(Nutrition)*	- Children under 5 years routinely weighed			
	. Chimutu TA	1,752 (17.7%)	5,427 (50%)	695 (6%)
	. Khongoni TA	2,529 (17.8%)	7,819 (50%)	2,632 (17.5%)

* VHC: Village Health Counsellor
** NRU: Nutrition Rehabilitation Unit

Session 5: TEAM EVALUATION OF PROJECT EFFECTIVENESS

Objectives

At the end of the session, teams should:

1. Have presented the results of their evaluation of the health effectiveness and impact of the particular aspect of the service which their project addressed.

2. Be able to describe indicators and methods for evaluating service effectiveness.

Materials

1. District team project proposal.

2. District team's evaluation report.

3. Format for selected indicators table.

Tasks

1. Review the portion of the team evaluation report that describes the results of assessing the project's impact on health indicators.

2. Present in plenary (20 minutes maximum per team) the results of the team's review of the impact of its project on health indicators.

Products

1. Tabular summaries of baseline, projected, objective, and current levels of health indicators.

2. Transparencies for plenary presentation.

Figure 5: **Format for selected indicators**

District	Health Indicator	Baseline	Objective Year	Current Level
A				
B				
C				
D				

Figure 6: **Example of a completed table for the problem of pregnancies too closely spaced**

District	Health Indicator	Baseline 1986-1987	Objective Year	Current Level (1988)
Mulanje	Closely spaced pregnancies (less than 24 months apart)	24% (estimated from 1986 survey)	17% (1991)	27%
Mzimba	Measles morbidity (cases/1000)	44 (revised from 14/1000)	20 (1988) (revised from 8/1000)	26
Salima	No. of children aged 1-4 severely malnourished - preharvest - postharvest	 2950 (9%) 1966 (6%)	 2176 (6%) (1990) 1088 (3%) (1990)	 3796 (11.2%) 2406 (7.1%)
Machinga	Maternal deaths due to ruptured uterus	2	0 (1988)	0 (however there were 2 deaths due to IPH* and PPH**)
Lilongwe	% of under-5 years children who are underweight - Chimutu TA - Khongoni TA	 40% 40%	 20% (1989) 20% (1989)	 16.9% 27.9%

* IPH: Intra-partum hemorrhage
** PPH: Post-partum hemorrhage

Session 6: TEAM SELF APPRAISAL OF WORKING RELATIONSHIPSDURING IMPLEMENTATION

Objective

At the end of the session, teams should have:

1. Shared, in a group discussion among team-members, conducted by a facilitator/moderator (another facilitator records the discussions) their perceptions and judgements on a series of questions about the effects of the DTPS project on their working relationships in the district.

Materials

1. Common list of key questions prepared by facilitators

Tasks

1. Respond freely to questions posed by facilitator, and to remarks of team-mates.

Products

1. A summary of the comments of each team, prepared by the facilitator.

2. A summary of the comments of all the teams, prepared by one facilitator.

Session 7: TEAM ASSESSMENT OF TEAM PERFORMANCE

Objectives

At the end of the session, teams should:

1. Have analyzed and presented how well their district team was able to function as a team in carrying out the planned solution.

2. Be able to identify managerial approaches and mechanisms which are effective in keeping important activities on schedule and in solving problems (administrative, operational, and resource) as they arise.

Materials

1. District team evaluation report.

Tasks

1. Review the portion of the evaluation report that describes district team management in order to prepare a presentation on the team's experience in implementing its planned activities, highlighting:

   - the team's composition and leadership, and how it may have changed over the year

   - how the team maintained communications and coordinated its activities and problems encountered in attempting to do so

   - how the team approached others (staff, agencies, communities) for obtaining support and cooperation in carrying out the plan

   - in general, how successful the team feels its efforts at teamwork have been.

2. One member from each of the teams, sitting on a panel, will make the presentation (10-20 minutes).

3. Plenary discussion to identify common problems in and ideas for improving district team efforts. Methods for better district team management are recommended.

Products

Presentation of the team's experience.

Session 8: PLANNING THE "NEXT STEPS" OF EACH DISTRICT TEAM

Objectives

At the end of the session, teams should have:

1. Reconsidered their implementation plan, and decided what, if any, further extension of their solution effort they intend to carry out over the next year.

Materials

1. District team evaluation report .

2. Implementation plan from project proposal.

Tasks

1. Consider whether the team wishes to carry the work of its solution effort forward into the next year. If so, decide on the activities to be carried out, and how to sequence them.

2. Prepare the results for presentation by one team member in plenary.

Products

Presentation on future activities.

Session 9: EVALUATION OF THE DTPS PROCESS AND OF THE EVALUATION WORKSHOP

Objective

At the end of the session, participants and facilitators, individually and in plenary and panel discussion, should have:

1. Evaluated, how effective they have found district team problem-solving to be as a management strengthening method, and whether the evaluation workshop attained its objectives.

Materials

1. Evaluation questionnaire prepared by facilitators.

Tasks

1. Fill in the evaluation questionnaire (all participants and facilitators).

2. Compile the results (done by a facilitator) for presentation and discussion in plenary. They are then prepared as a brief written report.

3. Complete a panel and plenary discussion.

Products

1. Report of team and facilitator evaluation of the DTPS process and the evaluation workshop.

Figure 7: **Comparison of scores of DTPS planning and evaluation workshops**

		Degree of Success/Effectiveness % of Maximum Score	
	Achievement of session tasks	**Planning Workshop**	**Evaluation Workshop**
1.	Understood the team problem-solving approach	91	99
2.	Became familiar with existing data	86	92
	Identified additional data needs	82	95
3.	To utilize a problem model to identify critical variables	92	87
4.	To identify sources of needed data	87	92
	To design tables for data presentation	85	90
	To plan data collection methods and focus group discussions	85	88
5.	To complete field data collection	87	88
	To complete initial data tabulation	88	85
6.	To analyze field data	88	88
7.	To complete a problem definition and description :		
	. the problem diagram	90	85
	. the quantified statement	86	62
8.	To use design criteria	91	90
	To select critical points for intervention	93	95
	To generate ideas for the problem solution	91	96
9.	To produce a statement of objectives and targets	93	96
10.	To produce a solution description	85	94
11.	To produce an implementation to plan (schedule and responsibilities)	94	95
12.	To choose indicators and methods for monitoring and evaluating the solution	89	94
13.	To create an outline and draft proposal of the solution	84	90
Effectiveness of the conduct of the workshop			
1.	Explanation of session tasks	79	90
2.	Background materials/information	78	85
3.	Participation of team members	81	85
4.	Support by facilitators	82	86
5.	Workshop accommodations	90	92
6.	Living accommodations	92	92
III. General Assessment			
1.	The workshop subject matter was relevant to my work	93	96
2.	The methods applied will be useful in my work	94	96
3.	This style of problem analysis and planning can be used in:		
	Health Centre	64	92
	District Hospital	90	100
	Regional Office	48	84

Achievement of session tasks	Degree of Success/Effectiveness % of Maximum Score	
	Planning Workshop	Evaluation Workshop
Ministry of Health	39	74

Session 10: CLOSURE OF THE EVALUATION WORKSHOP

This session provides an opportunity for senior MOH personnel and representatives of district teams to express their assessments of the DTPS process freely, without formats.

The chairman invites participants to express candid opinions freely. When all opinions have been expressed the evaluation workshop is closed.

NOTES ON EACH SESSION OF THE EVALUATION WORKSHOP

Notes on Session 1: Opening

Duration: about 1½ to 2 hours

1. The Director General of Health Services or his representative makes opening remarks to the district teams, regional staff, DTPS coordinator, other officials, and facilitators.

2. When introducing the participants, note is made of new staff who have joined the district teams and regional staff since the planning workshop.

3. The purposes and objectives of the evaluation workshop are noted, for example:

   Purposes:

   - to enable the district teams to gain evaluation skills through completion of the management cycle of DTPS, i.e. planning ---> implementation ---> evaluation.

   - to evaluate the results of the district teams' efforts to implement their projects, i.e. to answer the following questions: How successfully was the team's project implemented? Which of the planned activities were completed? How many of the intended products were actually produced? What relevant unplanned activities were undertaken/completed?

   - to evaluate the increase in managerial capacity of teams and team members, and hence the effectiveness of the DTPS as a means of strengthening management of primary health care.

   Objectives:

   By end of workshop team members will have:

   - demonstrated the extent to which they as a team had carried out their planned activities during the implementation period, and the extent to which they had produced intended products (i.e. evaluated their project implementation).

   - demonstrated the extent to which their improvement of service had achieved the targets they had set previously, and the extent to which service difficulties had been removed (i.e. evaluated their service achievement).

   - demonstrated the extent to which the project and the improved service had influenced the health problem it was addressing as measured with their chosen indicators (i.e. evaluated project effectiveness).

   - assessed the effectiveness of their team in maintaining their working schedule, managing and controlling its work, attracting staff and resource support for its project, and in overcoming unforeseen problems as they arose (i.e. evaluated district team management).

- assessed, together with Ministry of Health decision-makers, senior officials, facilitators and faculty, the effectiveness of the team problem-solving approach in strengthening individual and team capabilities for improving service performance through better management, and to have made suggestions for the improvement of this approach for future applications in the country.

- found answers to the following questions:

  - How do current problem indicator levels compare with objectives?
  - How do current problem indicator levels compare with base-lines?
  - Did district team performance, teamwork, or management improve? How?
  - What changes were there in district team composition? Leadership?

4. The Evaluation Reports of the teams are distributed. The evaluation workshop programme (see figure 5) and schedule are reviewed. Teams are provided with blank transparencies and markers for making overhead projector presentations of their product for each session.

Notes on session 2: Overview of project and main "success story"

Duration: about 3½ hours
Timing: 10 minutes Briefing
1½ hours Team preparation
20 minutes per team Team presentation
30 minutes Plenary discussion

1. In this session teams prepare a brief resume of the main features of their project, starting with their final definition of the health problem at the planning workshop. For anyone who was not at the planning workshop, or who has forgotten the main lines of any of the team projects, this will provide the background necessary to appreciate the evaluation results to be presented in the subsequent sessions. This overview of the original problem and the solution that was planned is followed by presentation of what each team considers to have been its most important achievement or accomplishment during implementation.

2. This session was added to the original programme in one evaluation workshop to allow teams to share and explain a significant success that they felt they had achieved, wanted to talk about, and found pre-occupying all the while that they were being obliged to work through the systematic expositions of sessions 3-5. In two subsequent evaluation workshops it was successfully used in the opening session, following a brief overview of the team project. Psychologically, this allowed teams to share their pride in a significant success before systematically starting their account of the inevitable multiple deficiencies in what occurred compared to what was planned.

3. Plenary briefing by a facilitator who:

- directs teams to devise a brief (5-10 minute) summary of the main factors influencing their health problem, and the general strategy and main interventions they devised to solve it.

- invites teams to share, in any way they choose, one significant success that they feel they have achieved, and to give their interpretation of how it was done; how did they make it work?

- suggests that each team select for their success story an aspect of their project whose description - in about 5-10 minutes - might benefit other district teams.

- notes that the essential question addressed is, what does the team consider its principal "success story"?

4. Teams, in working groups, prepare an overview of their project. They, then select one aspect of their project which might benefit other teams, and prepare (without a given format) a 10-minute explanation describing the selected achievement: what was done, how the team did it, and what made it work.

5. Team present their overview and success story in plenary, choosing different team members to make the two presentations.

6. Two common themes have emerged from these presentations.

   a. Concentration on the one specific problem has been found to strengthen, not jeopardize, other components of district health services.

b. In most districts, teams have found that they have involved communities more actively than they had been doing before the projects.

Notes on session 3: Team evaluation of project implementation

Duration: about 3 hours

Timing: 10 minutes Briefing
60 minutes Team preparation
20 minutes/team Team presentation
30 minutes Plenary discussion

1. In this session each team describes the activities it carried out and the products it accomplished during the implementation period, and compares these to what it had planned to do in its proposal.

2. Plenary briefing by a facilitator who:

- explains that each team will describe in some detail the activities it carried out since preparing its proposal one year earlier, and will assess project progress by comparing the actual activities against the activity plan, and the products actually generated against those that were scheduled.

- distributes a format for project implementation, showing activities and products achieved versus planned (Figure 2) and explains a completed example (Figure 3).

- clarifies that each team, in order to assess progress, is to compare that portion of its evaluation report which describes project implementation with the implementation schedule in its project proposal - they will do this by preparing and presenting a table and several transparencies to display the comparisons.

- explains that teams are also to describe problems encountered which caused deviation from the plan, and what they did about them; also, any unplanned activities and products, as well as uncompleted activities.

- notes that the questions and discussion of implementation problems that will follow the team presentations should be oriented toward ideas for improving implementation.

- requests teams to comment on whether and how they used the implementation schedule devised in their project proposal document, and to share any methods they developed for facilitating implementation.

- noting that team presentations will be limited to 20 minutes, to be followed by questions, comments and discussion from other teams and workshop participants. advises teams to present in plenary: (1) an overview of all of their planned and actual activities and products; then (2) specific activities and/or products that provide an insight into the progress achieved and the difficulties experienced by the team. Observes that selectivity is particularly important in this session since in it the teams must cover more specific detail than in any of the other sessions. May illustrate this point by noting that the implementation schedule was the longest portion of the district team proposal document, and contained the most indicators.

3. Following the plenary, teams break into their working groups to review their implementation, and to prepare their tables and transparencies.

4. Team presentations in plenary (15-20 minutes per team) followed by 10-20 minutes of questions, answers, and discussion.

5. Teams have to be guided to concentrate first, in this session, on the extent to which they were actually able to carry out the activities and to complete the products that they planned for themselves. They thus describe, using the indicators of implementation which they themselves defined in the planning workshop, the extent to which they were actually able to carry out the project they planned.

6. During the team discussion, the facilitators are liable to have little role other than to see that their team has what it needs to produce clear tables and transparencies, and to help each team condense its presentation into the 20 minutes available. This will mean identifying some of the more important activities and products from the scores of them in the implementation plan, as there will not be time to discuss them all.

7. The chairman of the plenary session should keep the presentations moving briskly. The principal objective of this session is to gain an overview of what was actually done or not done by each team, and how that compared to its plan.

8. If the teams are asked to present to a panel of prestigious persons, it is important that those on the panel do not assume the role of judging each team's accomplishments or shortcomings. The chairman should create a climate in which each team feels that it is forging and presenting its own self-evaluation of its own solution project to an interested and sympathetic audience that includes the Director-General of Health Services and other senior officials.

Notes on session 4: Team evaluation of service achievements and difficulty reduction

Duration:	about 4 hours	
Timing:	10 minutes	Briefing
	2 hours	Team preparation
	20 minutes each team	Team preparation
	30 minutes	Plenary discussion

1. In this session each team describes the changes in services and in the level of difficulties during implementation, compares these to the targets previously set, and evaluates the effects of its project implementation on these changes. The teams demonstrate their ability to describe techniques and indicators for evaluating MCH/FP or primary health care service outputs and efficiency. The plenary discussion should highlight problems encountered and the means used to evaluate service performance and practices in the population, e.g. community surveys, analysis of service statistics, etc.

2. Plenary briefing by a facilitator (about 15-20 minutes) who:

- explains that each team in this session will evaluate and present in 20 minutes the effects of its project on the selected services and the difficulties that it originally identified as critical to its specific health problem, i.e. the extent to which service improvement and difficulty reduction targets were

achieved. Notes that teams should also consider and discuss the effects upon changes in these service and difficulty indicators of influences outside the project.

- clarifies that the team will compare the most recent estimates for service and difficulty indicators in its evaluation report with the targets tabulated in its project document. Recommends that teams use the simple format (Figure 4) to prepare a table and transparency that display the baseline, target and current levels of the relevant service and difficulty indicators. Explains an example (Figure 5) of a completed table. After the team has determined the trend or change in each service and difficulty indicator, it should judge whether this change came about as a result of the team's project activities and products, or whether it was due to other causes.

- notes that the fundamental questions that the teams are attempting to answer in this session are:
  - What achievements were there in improving service indicators?
  - How close to target levels were critical services raised?
  - How much above baseline levels were critical services raised?
  - What achievements were there in ameliorating the difficulties?
  - How do the actual levels of difficulties compare with targets?
  - How do actual difficulty levels compare with baseline levels?

Notes on session 5: Team evaluation of project effectiveness

Duration: about 3½ hours

Timing:	
10 minutes	Briefing
1½ hours	Team preparation
20 minutes a team	Team presentation
30 minutes	Plenary discussion

1. In this session, each team assesses the impact that its project has had to date upon, and describes how it measured change in, the targeted health problem.

2. Plenary briefing by a facilitator who:

- notes that each team in this session will assess the impact its project has had upon its original health problem.

- clarifies that each team is to describe the methods it used to measure the level of each health indicator and then compare the current level of the health problem with both the baseline level and the projected level, to determine whether there has been an improvement. The team will then judge whether the particular health interventions, service improvements, or reductions in difficulties that it achieved through its project, as described in the preceding session, had an impact on these health indicators.

- illustrates how these indicators may be displayed concisely in a table using the simple format provided (Figure 6). The headings for the health problem indicators are: (1) its level at the baseline year (either as originally estimated or as later revised); (2) the objective originally set for it; and (3) its current level. Requests teams to prepare a table and transparency for their 15-minute presentations in plenary.

- illustrates with an example (Figure 7) how the team can judge and interpret project effectiveness in improving health by comparing the achieved level of each health status indicator with the objective set in the project proposal.

- notes the essential question being addressed by the teams in this session is: "How effective was the project in improving the health problem?"

3. In judging whether the improvements in service coverage or quality achieved by their project activities had any impact on the initial health problem, teams must gather, analyze and interpret data. This session calls for use of rates and quantitative manipulation that district personnel may find quite difficult. Some team members may come to understand fully only in this session that the projected level of the health indicator, which they estimated in their project proposal, was intended to be the level the problem would naturally attain at some specified time in the absence of the project. Therefore, facilitators should be available to discuss methodological problems of measurement and to provide epidemiological and biostatistical assistance to their teams during this session. Ideally, such assistance should have been given during follow-up in the field, or at about the time the teams start working on the evaluation of their work.

Notes on session 6: Team self Appraisal of working relationships during implementation

Duration: about 1½ hours
Timing: 45 minutes Group discussion in teams
45 minutes Presentation by a facilitator followed by general discussion

1. Teams meet directly without a plenary. A forum is provided for free-flowing discussion among the members of each team, and a more in-depth insight into their feelings about working relationships and interactions.

2. Facilitators meet before the session to discuss and agree on the main points on which group discussions will focus and then a brief and a carefully worded list of questions which the moderator will use to guide the discussions in line with the expected outputs.

Examples of questions:

- In what way did the project affect working relationships and interactions among the team members?

- What effect did implementation of the project have on the relationships and interactions of the team with community groups, and with nongovernmental organizations?

- In your opinion, did implementation of the project cause you to neglect other activities?

- What were the benefits of this project?

- In what ways did implementation of the project affect contact, support, or cooperation between central, regional, district, and clinic levels?

- During implementation of the project at what period did the team seem to function best?

3. A recorder should assist the moderator, if feasible. The moderator explains that the team members are to discuss freely with each other their responses and feelings as each of a series of questions on interpersonal working relationships inside and outside the team is raised.

4. Team members simply discuss with each other in a quiet room their own thoughts and feelings in response to the questions posed by the moderator. The notes and report are made by the facilitators.

5. To minimize inhibitions to self-expression by team members, someone who is not the group's usual moderator is chosen to facilitate this session.

6. A synthesis of reports is made by one facilitator who then makes a brief presentation in plenary and moderates general discussion.

Notes on session 7: Team assessment of team performance

Duration: about 2½ hours

Timing:	15 minutes	Briefing
	15 minutes/team	Team preparation
	60 minutes	Team presentation
	15 minutes	Plenary discussion

1. In this session team members analyze and present their appraisal of how well they were able to function as a team in carrying out their planned solution to their health problem. They also share any managerial approaches, aids, or mechanisms that they found effective in keeping important activities on schedule or in solving problems that arose.

2. Plenary briefing by a facilitator who:

- refers each team to that portion of its evaluation report which describes district team management.

- notes that each team will be allowed about 45 minutes to prepare for presentation by one of its members, who will sit on a panel, the team's experience in implementing its planned activities, highlighting items listed in Task 1 in the session guide, plus the following:

  • Ideas, approaches, mechanisms, managerial aids or methods found or recommended by the team for keeping important activities on schedule, solving problems as they arise, or improving the management of district team efforts.

- notes the essential questions to be addressed by the teams in this session:

  • What outside support did the team receive?
  • How were activities managed and coordinated?
  • What problems were encountered and how were they resolved?
  • How well did the team work together?
  • What changes in working relationships took place?
  • What changes were made in the strategy?
  • What managerial aids, from the first DTPS planning workshop, were useful?

3. Teams review the district team management section of their evaluation report, discuss their individual views of district team management bearing in mind the issues to be highlighted, and select a spokesperson to present the team's assessment.

4. The chairman of the plenary should see that the discussion identifies common problems in, and ideas for improving, district team efforts. Methods recommended for district team management should be identified.

Notes on session 8: Planning the "next steps" of each district team

Duration: 3½ hours
Timing: 10 minutes Briefing
2 hours Team preparation
60 minutes Team presentation
20 minutes Plenary discussion

1. This session was added to the programme in one evaluation workshop in response to a suggestion by some of the teams who wished to carry their DTPS project forward, and who wanted to use the evaluation workshop as a means of improving their planning for this.

2. The teams were given 2 hours in which to rethink their plan of work, extend their implementation schedule for a further 12 months, and then present their results in plenary for the benefits of discussion and suggestions.

3. Purposely, no guidance is given to the teams other than a request that they indicate the activities they plan to carry out next, and the general sequence in which the activities will be conducted. (Despite this, every team in the past has used the implementation plan format from the planning workshop, as they have found it simple and effective for this purpose.)

Notes on session 9: Evaluation of the DTPS process and of the evaluation workshop

Duration: 1 hour and 15 minutes
Timing: 45 minutes Panel discussion
30 minutes Plenary discussion

1. In this session participants are asked to judge via a questionnaire how effective they have found district team problem-solving to be as a management strengthening method. They also evaluate the DTPS evaluation workshop.

2. The issues addressed include the following. How do those who have been through the DTPS process assess its impact on the growth of their own abilities and on their team's health work in the district? How do they rate DTPS compared to other forms of management training for health workers? How valuable do they think various characteristics of DTPS were? Which sessions of the planning workshop were the most and

least useful? What other topics should have been covered? How has the DTPS year-long process affected management of the district team? What things did they most like, and dislike, about DTPS? What changes in the use of DTPS in their country would they suggest?

3. Before lunch, team members and facilitators fill in the evaluation workshop evaluation questionnaire (see the example in Figure 8) designed by the facilitators. A facilitator analyses the responses during lunch, then presents the results in plenary in conjunction with the panel discussion of session 10.

ANNEX 3

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