World Health Organization

District Planning Tool for Maternal and Newborn Health Strategy Implementation

A practical tool for strengthening Health Management System

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Department of Making Pregnancy Safer

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Acronyms

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
CBR	Crude birth-rate
CPG	Core Planning Group
DP	District planning
FIGO	International Federation of Gynecologists and Obstetricians
GPG	General Planning Group
HC	Health centre
HIV	Human immunodeficiency virus
HMIS	Health Management Information Systems
HRH	Human resources for health
ICM	International Confederation of Midwives
IMCI	Integrated Management of Childhood Illnesses
MDGs	Millennium Development Goals
M & E	Monitoring and Evaluation
MIP	Malaria in Pregnancy
MMR	Maternal mortality ratio
MNH	Maternal and newborn health
MOH	Ministry of Health
NGO	Non-governmental organization
PMTCT	Prevention of Mother – to – Child Transmission of HIV
PRSP	Poverty Reduction Strategy Paper
STIs	Sexually transmitted infections
SWAp	Sector Wide Approach
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
TBA	Traditional birth attendant
TT	Tetanus toxoid
WHO	World Health Organization

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This tool is based on country experiences and has been prepared to support World Health Organization (WHO) staff assisting countries in district level planning for Maternal and Newborn Health strategy implementation.

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1. Introduction

1.1 The need for district planning tool: MNH plan to make things happen

No issue is more central to global well - being than maternal and perinatal health. Yet every day, 1,600 women and over 5,000 newborn (0 – 28 days) die due to complications, arising from pregnancy, childbirth and postnatal period, which could have been prevented. It is in this context that in 2000, the international community agreed on a vision for the world future which was translated into eight Millennium Development Goals (MDGs) to be achieved by 2015[1].

Effective knowledge and tools exist to help reduce maternal and newborn suffering and death. And experience has shown that available interventions are affordable and can be effectively delivered even in the poorest countries. However, to be able to make a difference, they must reach all the mothers and their babies where and when they need them[2].

To date, in the context of MDG framework, most of the countries with high burden of maternal and newborn mortality and morbidity have developed national strategies / roadmaps towards reduction of maternal and newborn mortality and morbidity. Their specific objectives are to provide skilled care during pregnancy, childbirth, and postnatal period, at all levels of the health care delivery system and to strengthen capacity of Individuals, Families, and Communities to improve MNH. However, as reported in the 2008 Countdown report '…very few countries are making progress reaching women and children with clinical care services, such as skilled care at delivery…postnatal care is an especially important gap in the first week of life when mothers and newborns are at the highest risk'[3]. Most of the countries are currently implementing proposed strategies, but concerns are raised about the slowness of the process as well as the weak translation of proposed strategies / Road Maps objectives and targets into concrete actions at all levels, to be able to effectively reach all beneficiaries.

Countries that have successfully managed to make pregnancy safer have the following three things in common:

- Firstly, policy–makers and health care managers were informed. They were aware that they had a problem, knew that it could be tackled and decided to act upon that information.
- Secondly, they chose an adequate strategy that proved to be the right one: not just promotion of antenatal care, but also skilled care at and after childbirth for all mothers and their newborns, by skilled midwives, nurse or doctors, backed up by hospital care.
- Thirdly, they made sure that access to required services – financial as well as geographical – is guaranteed for the entire population. Where information is lacking and commitment is hesitant, where strategies other than quality facility childbirth care are chosen or where universal access is not achieved, positive results are delayed.

MNH services will be more likely utilized by women in need if they meet the following essential requirements:

- MNH services are essential during pregnancy, childbirth and postnatal period. Women will be more likely to use MNH services if these are accessible, affordable, culturally acceptable and of high quality.
- The most dangerous period for mothers and newborns is around the time of birth. Yet the timing of childbirth is unpredictable and happens at all times of day and night. So, MNH services, to effectively assist childbirth, need to be available 24 hours a day and 7 days a week.
- Even when services are available, some women may not be able to use them. In fact,

some women, due to cultural barriers, do not seek assistance outside their home, because birth is seen as 'life event' to be dealt with inside the family.

- Available evidence suggests that adolescent pregnant women and those with unwanted pregnancies are less likely to use MNH services and to have poor maternal and newborn outcomes.
- Estimates suggest that 40% of all under – five deaths are neonatal deaths, of which many are preventable. Care services for the newborn have been often neglected. More specific attention needs to be given to essential and life saving health care for newborns at district level.
- MNH services may be used as entry point for other essential health services for the mother and her baby, such as: Prevention of neonatal tetanus; Prevention of mother – to – child transmission of HIV/AIDS; Distribution of bed nets to fight against Malaria etc.

The country context may also affect provision and use of MNH services:

- Health sector reforms have been introduced in many countries (e.g. Sector Wider Approach 'SWAp' in African countries such as Malawi, Congo, Rwanda and Zambia etc) to improve efficient use of available resources for health, to increase availability and access to health services, including those for maternal and newborn survival. It is important for health planners and managers to be aware of how key MNH issues can be addressed and integrated into on – going or future reforms in their countries. They should also be able to inform those responsible for health sector reform of bottlenecks relating to access, provision and use of quality MNH services.
- Decentralization. While in many countries, national Ministries of Health make national health policies and coordinate provision of maternal and newborn health services, decentralization requires districts to make planning decisions and to implement MNH activities. As a result, districts now have more responsibility for setting their own priorities and managing their own budgets. Districts are therefore expected to be more accountable to their local populations for the quality of health services provided.
- Need for integration. Countries with high burden of maternal and newborn mortality and morbidity face competing demands for health services and have limited resources. To some extent, more can certainly be achieved by integrating MNH plans with those from other key health programs, such as HIV/AIDS (Prevention of Mother -To - Child Transmission of HIV), Malaria (Malaria in Pregnancy), nutrition, child health etc. A further reason for integrating services is that the number of health personnel available in many countries is currently limited, particularly in rural areas. For management effectiveness in this situation, available staff is required to work in an integrated way. And this integration needs to be adequately planned for and implemented at all levels (service provision, supervision, M&E etc).
- Intersectoral collaboration: To achieve required improvement for all, in maternal and newborn health outcomes, there is need for the health sector to collaborate and coordinate with stakeholders from other sectors (e.g. education, water and sanitation, gender, transport & communication as well as civil society organizations etc) that also have a role to play in MNH at district level.

Empirical evidence has also shown that less than one third of African countries with the highest burden of maternal and newborn mortality and morbidity have district planning process in place. So, for all the above mentioned reasons, there is great need for MNH planning tool that would provide managers and planners, both at national and district levels, with practical tips for analysis, planning and effective implementation of evidence – based MNH essential interventions.

1.2 Purpose of this district planning tool for MNH

Goal: The aim of this tool is to provide national and district health managers / planners with practical resources for planning and implementation of MNH health services towards making pregnancy safer. It is intended to be short and practical for anyone who is responsible for MNH programme management and all stakeholders at district level.

Specific objectives: Users of this tool should be able to:

- ✓ Describe different steps for MNH planning process;
- ✓ Apply appropriate methodology for MNH situation analysis;
- ✓ Apply appropriate techniques for data collection, analysis and use for MNH plan development;
- ✓ Develop action plan for proposed MNH interventions;
- ✓ Develop M&E plan for MNH services at district level.

Expected results: This planning tool should provide necessary tips and skills for health managers / planners to develop plans for effective implementation of national MNH strategy. Additionally, skills acquired should help to use efficiently and effectively available resources and to strengthen management capacity both at national and district levels.

Content: This planning tool (PT - MNH) has 2 sections:

- Section I provides technical overview on prevalence and causes of maternal and newborn deaths and disabilities; and highlights strategic directions for improving maternal and newborn health.
- Section II describes the key 10 steps required for the proposed district planning framework for MNH.

Throughout the document, the reader is directed to other available resources, including WHO tools and guides, which provide more detailed information on various issues addressed.

2. Section I. Context: Why do mothers and babies die and what can be done about it?

2.1. Prevalence of maternal deaths (Maternal mortality ratio - MMR)

Of the estimated total of 358,000 maternal deaths worldwide in 2008, developing countries accounted for 99% (355,000) of these deaths. Nearly three-fifths of the maternal deaths (204,000) occurred in the Sub-Saharan Africa region, followed by South Asia (109,000). Sub-Saharan Africa and South Asia accounted for 87% of global maternal deaths. Among the developing regions, Sub - Saharan Africa had the highest MMR (at 640) in 2008, followed by South Asia (280), Oceania (230), South - Eastern Asia (160), Northern Africa (92), Latin America and the Caribbean (85), Western Asia (68) and Eastern Asia (41)[4].

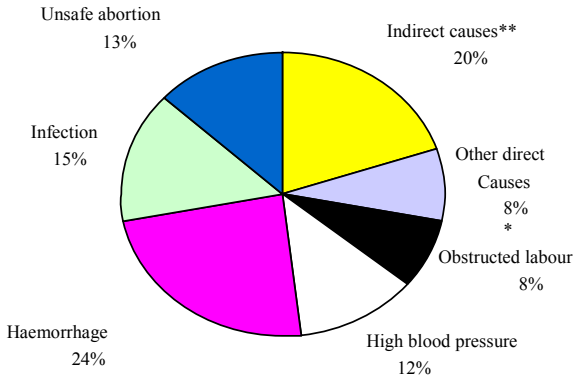
2.2. Causes of maternal deaths and disabilities

Medical causes of maternal deaths: More than 70% of maternal deaths are due to haemorrhage (24%), obstructed labour (8%); eclampsia (12%), sepsis (15%) and unsafe abortion (13%). The remaining deaths are due to either other direct causes (8%) including: ectopic pregnancy, embolism and anesthesia-related causes, or indirect causes (20%). Indirect causes include severe anemia, TB, malaria and HIV/AIDS (particularly in Sub – Saharan Africa).

Figure1. Causes of maternal death worldwide[5]

* Other direct causes include: ectopic pregnancy, embolism, anesthesia-related causes.

** Indirect causes include: anemia, malaria, heart disease



Even if a woman survives childbirth, she may be damaged in different ways. An estimated 300 million women worldwide suffer from ill health and disability caused by complications of pregnancy. Examples of disabilities include problems such as:

- Prolapse of the uterus;
- Obstetric fistula (e.g. vesico-vaginal fistula);
- Secondary infertility as a result of puerperal sepsis.

Some of these problems result in many women being rejected by their families and communities.

2.3. Perinatal deaths

Perinatal mortality rates tend to follow the same geographical patterns as for maternal deaths. In fact, a large proportion of perinatal deaths are related to the conditions of pregnancy and childbirth. Efforts to prevent mortality and disability in mothers will have an equally beneficial effect on the health of babies.

It is estimated that in 2004, there were 133 million live births; 3.7 million of these died in the neonatal period (0 – 28 days). Three million infants were stillborn. 98% of deaths took place in the developing world, where 90% of babies were born. With 40 neonatal deaths per 1000 live births, the risk of neonatal death remains the highest in Africa and South – Central Asia, while the neonatal mortality rate for Latin America and the Caribbean was 13 per 1000 live births[6].

The major causes of neonatal deaths are[7] (The proportions total more than 100% due to rounding):

- Prematurity and low birth weight (29%)
- Severe infections including pneumonia, septicemia, and meningitis (25%)
- Birth asphyxia and birth trauma (23%)
- Neonatal tetanus (2%)
- Congenital abnormalities (8%)
- Diarrhoeal diseases (2%)
- Other causes (11%)

2.4. Social and economic determinants of maternal and Newborn Health.

The links between poverty and poor health have been reported for a long time. "The poorest of the poor, around the world, have the worst health. Those at the bottom of the distribution of global and national wealth, those marginalized and excluded within countries, and countries themselves disadvantaged by historical exploitation and persistent inequity in global institutions of power and policy-making present an urgent moral and practical focus for action"[8].

Poor nutrition, lack of education, inadequate housing and some cultural traditions, can all contribute to poor health.

For women, their low status, combined with poverty, decrease their chances of a successful and healthy pregnancy and childbirth. Low status at family and society levels leads to women having little influence on household decision-making (e.g. whether to use contraceptives or where to give birth). Women may not have access to information and education about when to use health services or new ideas that could spare them from frequent childbearing and save their lives during childbirth. Women and adolescents may not have access to the financial resources necessary for using health services.

The social and economic factors lead to death and disability in two ways:

- For instance, poor nutrition status would make women more likely to become anemic and subsequently develop post – partum hemorrhage as they would be much less tolerant to blood loss.
- Poverty, young age, low status and some cultural traditions restrict women's access to emergency obstetric care (such as cesarean delivery).

Therefore, health managers / planners should be able to identify and address all the social and economic factors that are relevant to their own settings, especially those that affect poor and marginalized women.

It is in this context that other stakeholders, who are involved in education, communication, transportation, gender and water as well as civil society etc have got a role to play in the implementation of maternal and newborn health strategy both at country and district levels.

2.5. Failure of districts to provide required services for women and babies.

For many people, MNH services do not exist or cannot be reached. For example, lack of access to first level or back-up MNH care where major life-saving interventions can be performed is a significant reason why mothers and newborns mostly in rural areas die.

For others, MNH services do exist but are not of the standard quality. Health facilities do not provide the right service when and where needed. This is often the main reason why women do not use services.

Cultural differences between health staff and women can affect women's desire to use MNH services. Also, being a woman, poor, or unmarried / adolescent is often the reason for being discriminated against and may result in abuse and neglect. Also, some women can be stigmatized. For example, a woman attending a health facility for a post abortion complication is be sent to the back of the queue. This is because some staff will suspect she has had an illegal abortion and, with this stigma attached to it, she may then be given poor quality care. Women who expect to be ill treated by health staff will not feel encouraged to use the appropriate services available.

2.6. What can be done to reduce MNH deaths and disabilities? Strategic MNH actions.

The following strategies have proved to be effective in reducing – related MNH deaths and disabilities:

- Giving maternal and newborn health high priority in government policies and providing an enabling environment (leadership/good governance).
- Using cost - effective clinical interventions.
- Providing skilled care and ensuring timely access and universal coverage, through functioning health system.
- Building a continuum of care from home to primary level and referral healthcare facilities.
- Working with women, their partners, their families and communities.

2.6.1 Giving MNH high priority in government policies and providing adequate enabling environment

Political commitment at the highest level of Governments and coordinated response from all concerned sectors are essential for long-term sustainable action to:

- improving the underlying social and economic conditions;
- building required leadership and governance; and
- increasing access to and use of quality maternal and newborn care (A review of country - level financing mechanisms for maternal health found that direct out-of-pocket payments at the point of care reduced utilization of maternal health services in a number of countries and the pooled payment schemes (e.g. insurance) can help increase access[9]).
- Human rights approach would particularly provide an appropriate framework for putting in place laws and policies for promoting MNH and reducing major barriers to MNH care for vulnerable people.

2.6.2 Using cost - effective clinical interventions

At present, clinical interventions that are needed to reduce maternal and newborn deaths and disabilities are well known. In fact, MMR in some countries has been substantially lowered following introduction of these clinical interventions. However, as with many technologies, overuse and inappropriate use of such interventions can also lead to poor quality services and poor health outcomes for mothers and/ or their babies.

It is also known that those interventions are more cost-effective when they are implemented as part of a package: e.g. antenatal care (ANC) package, childbirth package and early and late postnatal package (both for the mother and her baby). Additionally, provision of childbirth - related interventions by skilled birth attendant (SBA), within a continuum of care set up, is most likely to improve significantly MNH outcomes.

The challenge for health managers / planners is to make required interventions and packages available for all women and their babies in line with national policies and strategies.

The following table 1 describes major causes of maternal death and interventions that have proved to be effective in addressing them. Available interventions will benefit the newborn and the mother; but for some newborn conditions, specific measures will be needed. These conditions include infection (tetanus and sepsis), hypothermia and asphyxia.

Table1. Major causes of maternal death and key interventions to effectively prevent or treat them

Direct causes of maternal death	Cost - effective clinical interventions
Bleeding after delivery (24%)	Active management of the 3rd stage of labour; Detect & Treat anemia in pregnancy; Skilled attendant at birth: prevent/treat bleeding with correct medicines e.g. oxytocin, replace fluid loss by IV drip and transfusion if severe.
Infection after childbirth (15%)	Skilled attendant at birth: clean practices. Antibiotic if infection arises
Unsafe abortion (13%)	Skilled attendant: give antibiotics, empty uterus, replace fluids if needed, counsel & provide family planning/STI prevention. Access to safe abortion where not against the law.
High blood pressure, most dangerous when severe (eclampsia) (12%)	Detect high blood pressure in pregnancy; refer to doctor or hospital. Treat convulsions with appropriate anticonvulsive medicine (MgSO4). Refer unconscious woman for expert urgent assistance.
Other direct obstetric causes (8%)	Refer ectopic pregnancy for operation

Table3. Major causes of stillbirths and key interventions to effectively prevent them

Causes of stillbirths	Clinical interventions
Birth asphyxia and trauma (40%)	Skilled attendant at birth. Effective management of maternal obstetric complications.
Other known causes (pregnancy complications, maternal diseases, malaria, malformations) (25%)	Maternal care during pregnancy. Presumptive treatment for endemic diseases, effective management of pregnancy complications.
Congenital syphilis (8%)	Maternal syphilis screening and treatment of positive cases.
Unknown cases (27%)	

Source: Adapted from Newborn Health policy and planning Framework, WHO[10]

2.6.3 Providing skilled care, ensuring timely access and universal coverage, through a functioning health system.

Managers at all levels of the health system are expected to strengthen human resources for health in the district to ensure that staff with the required skills are available in sufficient numbers and are deployed in most appropriate places. It is also essential that staff have full access to enabling environment for them to effectively do their job.

Skilled care provision during pregnancy, childbirth and postnatal period is a critical intervention for improving MNH outcomes. The person providing the skilled care is known as skilled attendant.

Box 1: Definition of skilled birth attendant

A skilled attendant is defined as "an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns"[11].

Evidence shows that the best intrapartum-care strategy is likely to be one in which women routinely choose to deliver in a health centre, with midwives as the main providers, but with other attendants working with them in a team. Such care is referred to as first level care. At back-up (referral) level a mix of skilled staff are required to provide emergency obstetric care when complications arise during pregnancy, childbirth and postpartum period. Health care professionals that are trained and skilled to conduct surgery, anesthesia as well as skilled attendants for specific newborn health issues are needed.

The advantages of facility-based deliveries both from a technical perspective and from systematic analysis of mothers' experiences are many. They enable teamwork, so that skilled health personnel can attend far more births than it would be possible in home deliveries and make higher coverage possible. They also enable non-professionals, such as assistants and auxiliaries, to help making care more cost-effective. This allows a single midwife to attend up to 175 to 220 deliveries per year with faster improvement of coverage, compared to about 50 deliveries or less per year for a single-handed midwife visiting mothers at home with lower coverage.

Health managers & planners must investigate whether the attitude and prejudice of health staff are affecting use of services. Talking with users and non-users and conducting case reviews and audits will provide valuable information about the quality of services that are delivered.

However, providing quality skilled care is not enough if women and their newborns are unable to access it. The entire population and particularly its poorest section must have access to first level and back-up care.

To achieve MNH goals, Governments have to build strong partnerships with all stakeholders to mobilize required financial resources and to strengthen different components of the national health system.

2.6.4 Building adequate MNH continuum of care.

Most women have a healthy, normal pregnancy, childbirth and physiological postnatal period. Those women are expected not only to benefit from support from within their families and communities, but also to receive health services at the first level of care – the primary care level.

However, due to complications, some women and newborns will require specific treatment at a higher level. In many cases it is not possible to detect in advance who among women or babies will face complications. Only careful monitoring and appropriate interventions during pregnancy, childbirth and postnatal period can help in preventing and managing many of these complications that would otherwise result in death and disability.

Therefore it is essential that all women have access to quality care by a skilled attendant who knows when to refer women to a higher level when life-threatening complications arise. Thus continuum of care is needed with skilled care from the woman's home to the first level of care and to the back-up level if needed.

Household and community level: The continuum of care starts at household level with self-care and prevention.

A woman's ability to provide self-care to herself and baby depends on her level of education, how well off she and her family are, amenities in the community, cultural norms and her social position within the family and the community.

Box 2. The concept of continuum of care[13]

All women should have the highest attainable standard of health, through the best possible care before and during pregnancy, childbirth and postpartum period. This continuum of care encompasses the life – cycle of the woman, from adolescence through to the birth of her own child. Additionally, it includes all levels of the health system from the household to the first and a higher – level referral service site, as appropriate for the needs of each woman or newborn.

The skilled attendant is expected to serve as a link between health services and household/community level. She/he may do this through direct contact with women and their families or through trained community health workers.

Box 3. E.g. Self-care provision for MNH

Adequate nutrition

Adequate rest

A plan for birth

Warmth for the baby

Good hygiene for mother and baby

Support for breastfeeding

First level MNH care

Although women may have contact with MNH services at family and community level, the first level care is the first point of health service delivery. These services may be provided at a health centre (or at a health post depending upon the country context). The minimum level of services to be provided at this level (Emergency Obstetric Care) includes:

- ANC (all women);
- Skilled care during labour and birth (all women);
- Postpartum care (all women);
- Essential newborn care (all newborn babies);
- Essential first line life-saving skills (women and newborns in need);
- PMTCT;
- Family planning;
- Referral for back-up care (women and newborns in need).

Back-up level (referral level)

A limited number of women and newborns with problems requiring more complex care will need to be referred to a higher level of MNH services (e.g. caesarean section for prolonged labour or hysterectomy for uterine bleeding), blood transfusion and intensive care (e.g. Eclampsia). Back-up services also include non-emergency interventions (e.g. treatment of Congenital Syphilis). Some newborn babies may also need referral to specialist care that provides intensive care (e.g. treatment of neonatal Tetanus or Meningitis). Back-up is ideally provided in a hospital where doctors - specialists, skilled general practitioners or mid-level technicians with appropriate obstetric or neonatal skills - can deal with mothers or babies whose problems are too complex for first-level providers (Comprehensive Emergency Obstetric Care both for the mother and the newborn).

For all levels, the required staff, equipment, medicines, facilities, transport and communication system must be available 24 hours a day, and 7 days a week.

MNH services are expected to be equitably distributed so that women can reach them in time when and where needed.

Underpinning all services provided are four key principles. Services should be:

- Affordable – all women can afford to use available services;
- Acceptable – services that are welcoming, confidential and accommodate beneficiaries' culture;
- Accessible – are within easy reach and available at convenient times;
- Professional – provided care is based on known evidence of what is effective and of good quality.

Districts must ensure that health centres and district hospitals are linked by functional referral mechanisms and adequately organized so as to ensure a continuum of care. It is also crucial that collaboration is effective between different services (e.g. family planning, antenatal care, HIV/AIDS, etc.). This collaboration/integration is a key factor for women to receive appropriate care when and where needed.

Health teams have overall responsibility for planning and providing good quality services through continuum of care; but support of many other services and groups is essential. For instance, a woman living with HIV who has to attend ANC clinic, needs integrated care from both MNH and HIV services for herself and her baby to reduce the risk for HIV transmission to the baby.

2.6.5. Working with women, their partners, their families and communities:

Women and their partners, families and the wider community can make an important contribution to improving maternal and newborn health. At household level, families can ensure that pregnant women have sufficient and quality food, sufficient rest and facilities for good hygiene. Household members would also support the mother in caring for the baby, particularly for exclusive breastfeeding. In addition, survival of mothers and babies depend on household members if they are able to recognize and respond to danger signs during pregnancy, childbirth and postnatal period. Community support is often needed, particularly for referral purpose.

Box 4. Sri Lanka's Success in Reducing Maternal Mortality[14]

It is widely recognized that Sri Lanka successfully reduced its maternal mortality at a time when its GNP was relatively low. Among the important factors which contributed to this success was the political commitment to provide health and education services free of charge, particularly to remote and disadvantaged communities. The 1930s to the 1950s saw an expansion of maternal health care with a well developed system of primary, secondary, and tertiary care units. District analysis of MMR for periods in the 1960s, 1970s, and 1980s found that the greatest reductions were found in the areas that had higher MMR in the 1960s thus suggesting that services in poorer districts in the country have the greatest impact.

2.7. National Public Health Planning Framework

For the last two decades, most of the developing countries have embarked on economic reforms, in the context of Poverty Reduction Strategy Programme with the assistance of the World Bank. Those are essentially: Medium Term Expenditure Framework (MTEF) & Sector - Wide Approaches (SWAp) and have to be taken into account as far as public health planning is concerned.

MTEF: According to the World Bank's Public Expenditure Management Handbook (1998a: 46), "The MTEF consists of top down resource envelope, a bottom - up estimation of the current and medium - term costs of existing policy and, ultimately, the matching of these costs with available resources… in the context of the annual budget process[15]."

As the Handbook suggests, "Key to increasing predictability and strengthening the links between policy, planning and budgeting is an effective forum at the centre of government and associated institutional mechanisms that facilitate the making and enforcement of strategic resource allocation decisions". The three pillars of an MTEF are: projections of aggregate resource envelope, cost estimates of sector programme and a political-administrative process that integrates the two[16].

SWAp: Sector - wide approaches (in the form of programme aid) have been promoted by the World Bank since 1980s. Derived from sector investment programmes or sector expenditure programmes, SWAps are instruments through which to deliver agreed-on health policies and to manage aid and domestic resources in a rationalized and optimal way. What makes SWAps attractive is that they are perceived as being able to strengthen governments' ability to oversee the entire health sector, develop policies and plans, allocate and manage resources.

MTEF & SWAp entail significant implications on health planning[17]:

- They propose that donors will 'give up the selection of which projects to finance in exchange for a voice in the process of developing sector policy and allocating resources.'[18]
- They are organized around a negotiated programme of work, and will only succeed if there is sufficient commitment to shared goals both from the government and key players in the donor community.
- They are implemented over the medium to long term, thus reinforcing the requirements for long time horizons, continuity and commitment.
- They aspire to the use of national systems for managing resources.

3. Section II: District planning framework for MNH

3.1 District planning process for MNH

3.1.1 Who should get involved? 'Participatory approach'.

The planning process is expected to be more effective if a wide range of stakeholders are involved in the planning process. This is known as "participatory approach". Stakeholders will need to have a common understanding of MNH key issues, to share institutional goals and expectations. Potential stakeholders should include:

- Policy makers (e.g. politicians and decision makers) to ensure political commitment and consistency with government vision and national health policy & strategic plan.
- Health managers (e.g. health managers/planners and administrators) to ensure strong leadership for provision of maternal and newborn care at all levels.
- Health professionals (medical & paramedical) and other technical workers, both from public and private sectors as key players for provision of MNH quality care.
- Community representatives, including women, are key stakeholders, as far as needs assessment is concerned. They can also suggest how MNH services could be provided and what barriers must be addressed for optimal access and coverage.
- Civil society /Non-governmental organizations (NGOs) from health related sectors. Civil society / NGOs, in many parts of the world, are known to play an important role in providing MNH related services at community level, that effectively complement MNH services provided by the public & private sectors, in the context of continuum of care.
- Academic/research institutions: health sciences teaching & research institutions have a role to play in capacity building process (pre and in – service training) as well as MNH related research for better understanding of existing issues and adequate design of evidence – based interventions.
- Representatives of other sectors (e.g. finance, gender, education, transport, communication sectors etc). Their optimal contribution should be provided if effective universal coverage is to be achieved.
- Development partners for their critical role in resource mobilization and technical support for MNH agenda at global, national and district levels.

The proposed participatory approach is likely to allow for most accurate community needs assessment. It should also allow for designing appropriate MNH strategic actions. In this context, stakeholders are also likely to have sense of ownership of planned services and therefore to be ready to provide required support for effective implementation of district MNH plan.

3.1.2. How to lead district planning process: Establish a core team.

Strong leadership and adequate organizational skills are critical for effective and transparent planning process. The leading role for the planning process should be played by the head of the District Management Team.

The following are key specific points that would be useful for the planning group to adequately organize the work:

- Identify a core group of about 6 – 12 people. This group will be referred to as the 'Core Planning Group' (CPG). The CPG would normally include 2 - 3 health planners or MNH managers. Other CPG members would be active representatives of stakeholders.

Key tasks for CPG members would be the following:

- To select a chairperson who will provide technical leadership for the whole planning process;
- To identify 2 CPG members who have the capacity to write a draft plan;
- To design methodology to be used (literature review; key informants interviews; focus group discussion etc);
- To identify key stakeholders (including community representatives) and partners who will be consulted for inputs along the planning process. These people could be called 'Stakeholders Planning Group';
- To define timeline as well as roles and responsibilities for actors who will be involved in the planning process.
- To collect required data;
- To analyze data;
- To develop draft MNH plan;
- To present draft MNH plan to stakeholders planning group members for inputs and comments;
- To write the final MNH plan.

- Members of 'Stakeholders planning group' would have the following tasks:
  - To give any relevant information about MNH community needs and priorities to be addressed, particularly for vulnerable groups.
  - To provide inputs on how MNH quality service could be improved;
  - To provide inputs on potential community participation for a more effective MNH quality service;
  - To provide inputs on potential contribution from other stakeholders in general and development partners in particular;
  - To provide inputs / comments about draft MNH plan.

- Both planning groups all together will have the responsibility of reaching consensus on goals, priorities, objectives, activities / services, expected outcomes and budget to be included in the final MNH plan, which will then be collectively adopted by all stakeholders.

3.2 Key steps for MNH planning process

To ensure effective implementation of interventions aimed at making pregnancy safer, adequate planning is a critical step. In some countries, the proposed planning process is carried out at national level. In countries with decentralized health services, districts are responsible for setting up specific objectives, deciding on priorities, designing activities and making staffing and budget decisions while complying with national policies, strategies and standards of care. Following a planning process through logical steps makes it more likely that the plan will be implemented, based on community needs and local context and will address MNH priorities.

Below, is the description of 1 - 10 step planning cycle that leads to the development of MNH plan.

3.2.1 Step 1: MNH situation analysis

Rationale

The planning cycle starts with a situation analysis focusing on relevant MNH-related policies, services, human, material and financial resources, as well as governance. With this information, managers & planners can then decide how to ensure MNH quality services, to make MNH programme improvements and to achieve objectives and goals.

The purpose of MNH situation analysis as initial planning step is to assess the status of national & district MNH strategy/programme implementation. This assessment is expected to help in identifying strengths and weaknesses as well as possible solutions. Its output is also essential for priority setting.

Goal and Objectives:

- Goal: To identify gaps between current MNH status and targets (at national and district levels).
- Objectives:
  - To describe maternal and newborn health status (trend analysis).
  - To identify policy strengths and weaknesses with regard to MNH programme.
  - To describe MNH programmatic issues (resources, access, quality, etc) and identify related gaps.
  - To make relevant recommendations for addressing identified gaps.

Methodology for MNH situation analysis includes:

- Literature review; trends analysis of MNH statistics (national surveys; DHS; MICS; WHO MPS country profiles etc)
- Key informants interviews (MOH officials; MNH Programme managers; MNH providers; Development partners & community members).
- Define sample size (facilities to be assessed).
- dentify sources of data: (i) policy statements, publications, technical reports, health statistics; National census report etc; (ii) HMIS; Country MNH profile; (iii) National surveys: DHS, MICS, Maternal mortality survey reports etc.
- Generic questionnaire for data collection (see annex 2)
- Observation protocol (specific items such as maternity ward etc).
- SWOT analysis.
- Health system impact assessment tool[19].
- The following discussion points would help the planning group to define community needs and priorities:
  - Trends of maternal mortality ratio, newborn mortality & stillbirth rates.
  - Major causes of maternal and newborn deaths
  - Do women and newborns have access to the services of MNH minimum essential package - antenatal care, intra-partum (birth) care, basic emergency (first level care) and comprehensive (back-up care) obstetric and neonatal care, routine postnatal & neonatal care, and family planning – according to national standards?
  - Trends of national coverage targets for MNH services?
  - Distribution of MNH services in relation to population needs?
  - How do MNH services meet minimum quality standards (infrastructure; equipment)?
  - Are MNH facilities fully staffed (skilled birth attendants)? What are other key issues related to human resources for MNH in the country? (Policy, regulation and planning; competencies; management and performance improvement; labour market; education, training and research etc).
  - Are current laws and regulations posing barriers for women and their newborns to access quality care (equity & gender perspectives)?
  - Financial gaps for MNH programme implementation.
  - Governance issues.

- At what extent is the community participating in the national MNH strategy implementation? Community attitudes, problems and potential resources must be determined as their evaluation is essential to the success of MNH programme.

SWOT (Strengths, weaknesses, opportunities & threats) Analysis: SWOT profile

In the context of MNH situation analysis, it is always useful to conduct SWOT analysis, a powerful technique that helps identifying specific programme's strengths & weaknesses and understanding opportunities and threats, during implementation of MNH plan. The SWOT profile would therefore help focus on activities into areas with comparative advantage in terms of strengths & opportunities. By focusing on key factors affecting MNH strategy implementation, now and in the future, the SWOT analysis provides a clear basis for examining its performance and prospects as well as guidance for effective implementation of the proposed plan (see Annex B-3, page 54).

Box 5. Key components of MNH situation analysis

- Brief description of demographic and socio – economic characteristics of the population at national and district levels, focusing on women and children;
- Description of the national MNH strategy context (National health strategic plan; National road map towards reducing maternal and newborn mortality; other health related strategic plans etc);
- Epidemiological background based on latest data for maternal and perinatal mortality and their trends over time at national and district levels (including affected populations, geographical distribution, socio – economic related differences etc); as well as data on access to skilled birth attendant and to caesarean delivery; coverage levels of essential MNH services.
- Brief description of the national health system (at district level, both public and private sectors as well as community component), with special emphasis on maternity services;
- Brief description of human resources for MNH issues & gaps;
- Brief description of programmatic and financial gaps & needs;
- Community participation;
- Based on careful analysis, highlight strengths, weaknesses, opportunities and threats for MNH programme at district level;
- Conclusion: Summary of MNH key issues and recommendations focusing on potential priorities and solutions.

NB. The above-proposed methodology is a summary of 'the Short Programme Review' tool for MNH (SPR). This tool applies a participatory process to measure progress of MNH programmes to achieve MDGs, with the following objectives: assess MNH Status and intervention coverage; identify weak MNH activity areas that result in low MNH intervention coverage; identify and propose practical next steps for program action[20].

3.2.2 Step 2: Analyse causes of identified MNH problems

The MNH Plan should be designed to address district priority problems. To do this, managers / planners will need to have a good understanding of the route causes of existing problems. This would help planning teams identify appropriate strategies and activities specifically aimed at solving MNH problems. As the root cause might not be obvious, a 'cause - and - effect analysis' will be used to generate hypotheses about possible causes of problems by asking planning group members to list all the possible causes and effects for the identified problem. This analysis technique organizes a large amount of information by showing links between events and their potential and actual causes[21].

There are two ways to graphically organize ideas for a cause - and - effect analysis: (a) Fishbone diagram, which is organized by category; and (b) Tree diagram which highlights the chain of causes.

The Tree diagram will be used for MNH planning process. It displays the layers of causes, looking in - depth for the root causes (See details in Box 6).

Box 6. Problem tree: Technique for cause analysis of health problems

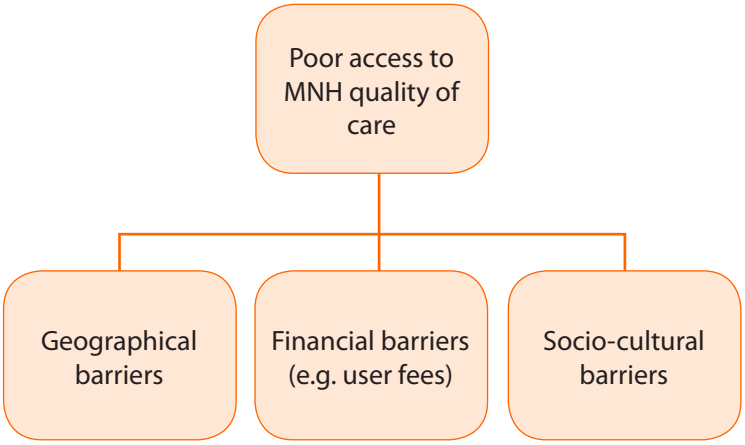
The problem tree displays identified problems in a hierarchical order. This is accomplished by identifying determinants of core problems.

Next, problems that directly cause the core problem are positioned above other causes and direct below the core problem.

Problem tree is constructed using the prioritization matrix. Here are guidelines for problem tree development through 7 steps :

- Step 1: Brainstorming: Identify major problems in the undesired situation (choose one core problem).
- Step 2: Write a short statement about the core problem, that explains the choice of the core problem.
- Step 3: list causes of the core problem. Try to establish direct relationships and be as specific as possible. Quantify the identified core problems: Leading cause of death / morbidity.
- Step 4: List effects of the core problem: note any quantifiable data
- Step 5: complete the problem tree: make sure that the causes leading directly to the core problem as in hierarchical order.
- Step 6: Examine and finalize the problem tree and verify its validity.
- Step 7: Presentation of problem tree

Box 7. Tree diagram (MNH quality of care)



3.2.3. Step 3: Select priority problems

Based on situation analysis/Short Programme Review findings, the planning group will have found many problems and many causes for each of the problems. In the context of limited resources, it would not be possible to address all of the identified problems, even if additional funds for MNH programmes are successfully mobilized. Therefore high priority issues must be selected based on standard criteria. It is important that such criteria are agreed upon in transparent manner and communicated to all stakeholders. E.g. is HIV transmission from mother-to-child a priority problem in your country? In Zimbabwe, HIV/AIDS is the major cause of maternal mortality (25%)[22]. So Fighting HIV in Pregnancy should be considered a priority for MNH in Zimbabwe on that basis.

The following are standard criteria for priority health problems selection:

- Prevalence / Incidence: How frequent is the problem?
- Severity: How severe is the problem? What is likely to happen if the problem is not solved? (Will people die, or will they only suffer minor discomfort?).
- Feasible solution:
  - For health problems, feasibility can be assessed by considering the following factors:
    - → Are medical techniques available to allow for the health problem to be managed?
    - → Could these techniques be provided in the country?
    - → Would these techniques be acceptable to the people suffering from the health problems to be selected (e.g. culturally acceptable)?
  - For health service problems, feasibility can be assessed by considering the following items:
    - → Is the solution to the problem consistent with national policy and local priorities?
    - → How much it would cost to solve the problem – and if sufficient funding is available;
    - → Are there adequate numbers of health workers to implement the solution? Do they have adequate skills to implement the solution? Can training be provided?
    - → Timeline (How long would it take to implement the solution?).

There may be other country specific criteria to be considered. For instance, economic effect of existing problems might be an important criterion for the community. So, district planning group members should be able to assess selected problems based on proposed criteria. The planning group will have to determine the scale to be used in rating the options against each criterion.

E.g. If the options were to be rated on the two criteria of consistency with adequate numbers of health workers and cost, each on a scale of 1 (least desirable) to 5 (most desirable). The total value provided by all district planning group members for each option (by adding the ranking for each criterion) would be the basis for defining priority problems.

In some cases, priority problems might have been identified at national level and included in the National Health Sector Strategic Plan. District teams are therefore expected to adopt those that are relevant to their setting.

3.2.4. Step 4: Setting goals

A goal is a broad statement of the overall outcome(s) that the proposed plan is expected to achieve. For instance, the United Nations have published eight Millennium Development Goals to be achieved by 2015. Goal 5 is "to improve maternal health".

The goal(s) will be used in later steps of the planning process to decide what activities are to be carried out for MNH plan implementation. The goal(s) will provide direction and coherence to the whole of district MNH plan. MNH goals relate to women and newborns 'health issues, wellbeing and to the type / package of services to be provided.

Usually there are only a few goals, or perhaps only one goal. To set the goal(s), managers /planners have

Box 8. Examples of District MNH goals

Machakos District (Kenya, 2009): 'To Improve maternal and neonatal health'[23].

Kibaha District Council (Tanzania, 2009): 'To improve maternal, neonatal and child health services in Kibaha district council'[24].

to consider not only selected priority problems but also national policies. MNH goal(s) are expected to be consistent with national health policy.

3.2.5. Step 5: Develop strategies and set objectives

A strategy is a broad approach that has to be followed to achieve a goal. Available evidence has shown that the four essential pillars supporting strategies for improving maternal and newborn health are as follows: (i) Family planning and access to other reproductive health services; (ii) Skilled care during pregnancy and delivery, including (iii) Emergency Obstetric Care for maternal and newborn complications and (iv) Postnatal Care for mother and baby.

Objectives are more detailed statements that show how goals will be reached. Like goals, they describe planned outcomes that result from implemented activities – they are not activities themselves.

Box 9: 'SMART'. Required criteria for a clearly stated objective

- Specific: identifies concrete events or actions that will take place.
- Measurable: quantifies the amount of resources, activity, or change to be expended and achieved.
- Appropriate: logically relates to the overall problem statement and desired effects of the program.
- Realistic: Provides a realistic dimension that can be achieved with available resources and plans for implementation.
- Time-based: specifies expected time for the objective to be achieved.

They may essentially relate to health issues of mothers and newborns and to MNH services that will be provided in terms of coverage, use, or quality. The SMART approach is useful when developing objectives.

There are three main reasons for setting objectives.

- First, they define in a clear and precise way what the plan is designed to achieve.
- Second, the objectives largely determine what key activities should take place during plan implementation.
- Third, objectives provide required guidance for managers / planners to apply appropriate monitoring and evaluation tools.

Once priority health or health service problems have been agreed upon and specific objectives set, next step is for managers / planners to select the most relevant activities to achieve objectives and targets (expected outcomes). These activities will dependent on available resources (both human & financial) as well as specific context.

Box 10. Examples of district objectives for MNH

Bungoma District(Kenya, 2009):

- To increase the percentage of assisted deliveries by skilled attendants in the district from 42% (2008) to 52 %(2010).
- To Increase the number of facilities offering PMTCT services in the district from 12 (2008) to 18 (2010).
- To increase the number of Nursing staff in district facilities from 164 (2008) to 264 (2010).

Mpanda District Council (Tanzania, 2009):

- To increase number of pregnant mothers delivered at health facility level from 54% to 64% by June 2011.
- To increase number of skilled personal at health facilities from 30% to 45% by June 2011.
- To increase number of health facilities providing CEmoC from 1 to 4 by June 2011.
- To increase number of delivered mothers who will be seeking for postnatal care from 2% to 20% by June 2011.

3.2.6. Step 6: Select activities to strengthen MNH services

In this MNH planning tool, it is recommended that proposed programme implementation be based on health system strengthening (HSS) approach that is most likely to lead to better health outcomes through improvements in access, quality and efficiency. Key MNH activities[26] will therefore focus on the following six HSS components, depending on available resources. Priority should be given to key activities aimed at filling up identified gaps. Here are some examples:

- MNH service delivery:
  - Update district MNH norms and standards;
  - Provide ANC & FP outreach services;
  - Setting up of quality assurance mechanism;
  - Supervision of district maternity services;
  - Strengthening of referral and counter - referral system (transportation & communication);
  - Integration of prevention of mother - to - child transmission of HIV (PMTCT) activities into MNH services;
  - Maternal death audits at facility level;
  - Strengthening of linkages between health facilities / services and communities (women's groups; men) to support Quality Facility Childbirth;

- MNH workforce:
  - In-service training on IMPAC guidelines: Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC); Managing Complications in Pregnancy and Childbirth (MCPC); Managing Newborn Problems(MNP);
  - Setting up of deployment criteria, retention and motivation mechanisms;
  - Implement performance - based contracts (Pay for Performance scheme);
  - Improve quality of district training institutions for health professionals;
  - Support MNH - related continuing medical education at district level;

- Health financing:
  - Establish / implement / support exemption/reduced price mechanisms (community – based health insurance prepayment scheme) for poor section of the population to cover expenditures for MNH services.
  - Develop district grant proposal for MNH;
- Equipment, medicines and supplies:
  - Conduct district needs assessment for pharmaceutical management with focus on MNH medicines (availability, quality, rational use, distribution etc);
  - Provide required commodities;
  - Establish/Strengthen district blood bank facility;
  - Purchase required equipment and supplies for maternity care;
  - Set up / strengthen maintenance system etc.
- Monitoring & evaluation:
  - In-training service in M&E for maternity service providers;
  - Organize data collection, analysis & dissemination of district MNH data (both quantitative & qualitative) from various reports / studies / surveys;
  - Establish vital registration system;
  - MNH short programme review; Update service availability mapping;
  - Conduct operational research addressing specific MNH issues (e.g. MNH services utilization rate; effectiveness and efficiency of community – based health insurance scheme; MNH service access barriers; MNH service client satisfaction etc).
- Leadership/Governance. 'WHO has recommended that one of the primary roles of a Ministry of Health is to develop health sector policy, with the aims of improving health system performance and promoting the health of the people (WHO 2000)'[27]. This role could be fulfilled through the following activities, among others:
  - Address equity issues through subsidies for poor people to have access to MNH services;
  - Hold regular coordination meetings with stakeholders and other sectors (e.g. Civil Society organizations) to facilitate intersectoral synergies and transparent decision - making process etc.
  - Promote best MNH practices.

All of the above activities are provided as examples that could be applied for district planning. In this activity development process, efforts should be made by managers / planners not only to be creative when designing MNH activities, but also to constantly focus on marginal / underserved populations (such as poor, widows, adolescent mothers particularly from rural areas and suburbs) for their effective access and use of MNH services as they are most vulnerable to MNH conditions.

3.2.7. Step 7: Resource needs estimate for MNH activities

MNH managers / planners should be able to provide resource needs estimate for proposed activities based on the following two main components:

(i) MNH interventions related costs: these are composed of MNH interventions unit costs (assigned to MNH interventions, based on inputs required for their implementation) and coverage rate (number of users); e.g. The cost of ANC package = ANC visit unit cost (based on required inputs such as human resources, medical devices, pharmaceuticals & facilities) multiply by ANC coverage rate (number of ANC users / clients).

(ii) MNH Program costs: these are additional costs required for effective implementation of MNH plan. They are related to the following program activities, namely: in – service training, supervision, M&E activities etc. A generic costing framework could be used for program costs (see example of costing checklist in annex 4).

The WHO MPS-iHTP resource planning tool can be used to provide resource needs estimate for the package of MNH services and clinical interventions, both at district and national levels [28].

In decentralized settings, it would very useful if district mangers / planners could come up with estimates of required resources to provide essential MNH care. This would be crucial when advocating for universal coverage.

At this stage, the planning core group should be able to design a draft work plan which is a tabular form encompassing the following key items:

- Goal;
- Objectives;
- Expected outcomes (Targets);
- Description of all proposed activities;
- Required inputs for activity implementation;
- Timeline;
- Responsible unit;
- Resource needs estimate (by activity & total).

3.2.8. Step 8: MNH action plan

The action plan is basically a table designed to show important MNH milestones (i.e. when important activities are expected to be completed) to allow for monitoring of programme implementation.

A Gantt chart is a simple aid used to develop action plan and for monitoring of programme/project activities. It allows for presentation of activities in logical sequence and illustrates dependencies that exist between different activities. For each activity, starting and closing dates are mentioned, using a horizontal bar, with the duration on the graph. It also helps lay out visibility of tasks that need to be carried out; it provides basis for scheduling completion of tasks: it helps plan allocation of resources necessary to complete activities and identify the critical path for the program in order to meet the expected completion date.

It utilizes a grid table with time in weeks or months with major activities and steps and linked to identifying who is responsible for reporting and completion.

Fig.2 Example of Gantt chart.

Goal 1:													
		2009											
Object.	Activities	J	F	M	A	M	J	J	A	S	O	N	D
Obj 1	Acti 1.1	■	■	■									
	Acti 1.2	■	■	■	■	■							
	Acti 1.3			■	■	■	■	■					
	Acti 1.4				■	■	■	■	■				
	Acti 1.5		■	■	■	■	■	■	■	■			
Obj 2	Acti 2.1			■	■	■	■	■	■	■	■		
	Acti 2.2	■	■	■	■	■	■	■	■				
	Acti 2.3			■	■	■	■	■	■	■	■	■	■
	Acti 2.4			■	■	■	■	■	■	■	■	■	■

3.2.9. Step 9: Monitoring and evaluation plan

Basic concepts of monitoring and evaluation

Monitoring is a process of comparison, across populations or geographical areas, to highlight differentials or to detect changes over time (to measure progress) between reality and goals.[29]

Evaluation is the systematic acquisition and assessment of information to provide useful feedback about some object (health project / programme etc). It is a set of activities and data collection that allows accurate understanding of the way the programme is or is not working, what factors affect program activities and targets.

Types of Evaluation: There are many different types of evaluation, depending on the object being evaluated and the purpose of the evaluation. Perhaps the most important basic distinction in evaluation types is that between formative and summative evaluation.

- Formative evaluations strengthen or improve the object being evaluated, by examining the delivery of the program, the quality of its implementation, and the assessment of the organizational context, personnel, procedures, inputs.
- Summative evaluations, in contrast, examine the effects or outcomes of some object. They summarize it by describing what happens subsequent to delivery of the program; assessing whether the object can be said to have caused the outcome; determining the overall impact of the causal factor beyond only the immediate target outcomes; and, estimating the relative costs associated with the object.

Monitoring and Evaluation are two sides of a measurement coin. They together provide data and perspective necessary to guide strategic planning, to design and implement programme/project and to rationally allocate resources.

Evaluation analyses the extent to which changes in key variables or outcomes can be attributed to the interventions undertaken by the programme/project. It requires careful analysis of qualitative or quantitative data to provide a critical understanding of the multiple factors affecting the outcome. Evaluation can thus suggest more comprehensive ways to increase effectiveness.

The following table describes the concepts of monitoring and evaluation

Table 4. Concepts of monitoring and evaluation

Monitoring	Evaluation
Focuses on activities that are done – when, how many, where, at what cost, how well.	Focuses on the impact of the activities – did the activities achieve the planned objectives & targets?
Data is collected during the time when the plan is being implemented. Monitoring is continuous during the whole of the implementation period.	Data is often collected before the start of the implementation period. This allows comparisons to be made between the situations before and after implementation. Data is also collected at, or soon after, the end of the implementation period.
Monitoring is very helpful in identifying problems so that corrective actions can be taken during implementation period. It helps to improve the quality of MNH services.	Evaluation is useful in finding out the impact of MNH services at the end of a period of time. This information is useful for planning the next program of activities and for informing other stakeholders about what can be achieved.

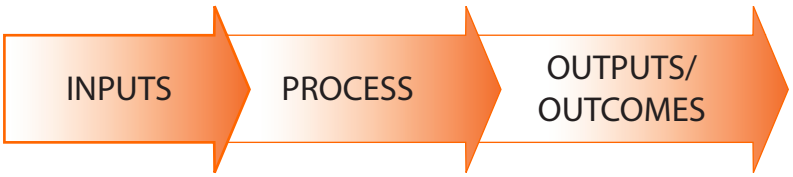
MNH indicators

Indicators are markers of health status, service provision or resource availability, designed to enable the monitoring of service performance or programme goals. In some cases, indicators are measurements that have the power to summarize, represent or reflect certain aspects of the health of persons in a defined population. In other cases, they may simply serve as indirect or proxy measurements for information that is lacking.[30]

Indicators are summary statistics used to measure progress. In general, managers/planners use specific indicators for each phase of MNH program implementation cycle (inputs, process, output and outcome):

- Inputs: core program ingredients that enable services to be delivered (e.g. human/financial resources, physical facilities, equipment, etc.).
- Process: multiple activities carried out to achieve program objectives (e.g. in –service training based on IMPAC guidelines).
- Outputs: results of MNH activities at the program level (e.g. utilization rate of MNH services).
- Outcome: changes measured at population level (e.g. Coverage rate of skilled birth attendant at birth).
- Impact: anticipated end results of a program (e.g. reduction of maternal mortality).

Figure 3: Conceptual model of healthcare system [31]: Implementation levels of M&E plan



E.g. MNH indicators:

Inputs indicators:

- Adequate MNH policy in place;
- Adequate human resources availability;
- Availability of required health facilities (e.g. 1 basic emergency obstetric care for 100,000 people);
- MNH norms & standards availability;
- Equipment, essential drugs availability;

Process indicators:

- Functioning reporting system;
- Attendance rate of staff in training;
- Regularity of supervision;
- Functioning of community health committees;
- Staff work load;
- Utilization (outpatient /inpatient);
- Appropriateness of referrals.

Output indicators:

- Skilled attendant at birth coverage
- Skill level of MNH staff

Outcome indicators:

- Maternal mortality Ratio (MMR)
- Neonatal mortality rate
- Maternal lifetime risk

Decisions from the planning group need to be made in relation with the following elements for the proposed indicators:

- How many times in a year the proposed indicator should be calculated?
- How much the indicator is expected to increase or decrease according to the objective (targets)?
- Whether to break down data by categories of special interest for analysis, e.g. different geographic areas, household wealth status, ethnic groups, and facilities.

Box 11. Example: Monitoring skilled attendant at birth indicator

OBJECTIVE: X proportion of births should be attended by a skilled attendant, in a given period of time.

INDICATOR: Proportion of births attended by a skilled attendant =

$$\frac{\text{Number of births in the district attended by skilled attendants in a given period of time}}{\text{The total number of live births in the district for the same period}}$$

CALCULATION: The numerator (top line) can be obtained by taking all health system records of births. Then decide whether the person attending each birth was "skilled" or not. Then add up all births which have been attended by a "skilled person".

The denominator (bottom line) can be obtained from census data. In some cases, it may need to be estimated, because some births may take place at home and/or not be registered. An estimate can be made by applying local crude birth rates (number of births = crude birth rate X population/100). If no reliable crude birth rate is available, a survey of births in the community would be needed.

PROBLEMS: There is need to have a clear definition of "skilled attendant". How can the local number of births be estimated? Are there migrations involving pregnant women? Will that affect the total number of assumed births?

USING THE INDICATOR:

The indicator could be calculated every 3 or 6 months over a period of 2 or more years. A bar chart showing the proportion every 3 or 6 months would show whether the proportion has increased as planned.

If progress is not satisfactory, district managers would have to explore the reasons for the poor progress and consider appropriate actions to reach the target. It would be useful to analyze trends of the proposed indicator to look for differences (e.g. urban versus rural; among socio – economic categories / quintiles) with regard to equity. Comparison accross districts could also be useful.

National estimates are more appropriate for determining Maternal/Neonatal mortality levels, in countries with no birth & death registration systems in place.

Box 12. Example: Shortlist of indicators for district monitoring of Reproductive Health.

1. Antenatal care coverage
2. Births attended by skilled health personnel
3. Availability of basic essential obstetric care
4. Availability of comprehensive essential obstetric care
5. Prevalence of low birth weight
6. Contraceptive prevalence
7. Prevalence of positive syphilis serology in pregnant women
8. Prevalence of anemia in women
9. Percentage of obstetric and gynaecological admissions owing to abortion
10. Reported prevalence of women with genital mutilation
11. Reported incidence of urethritis in men
12. Prevalence of HIV infection in pregnant women
13. Knowledge of HIV-related preventive practices.

Sources of data for M&E

With regard to M&E, MNH programmes are provided with data from various sources. These are:

Health management Information System (HMIS): Monitoring and evaluation both use data collected and analyzed through national HMIS[32]. So, there are likely to be records of patients attending health facilities; diagnoses made and treatments provided; financial data; records of staff employed; medicines and supplies; infrastructure and available equipment etc.

Health surveys & studies/Operational research: In several countries, some of the data may not be so easily available or accurate for many reasons. For instance, vital registration may not be thorough; data related to MNH quality care may not be regularly collected. In such cases, special tools will be needed to obtain the necessary data. Tools that are often used include key informants' interviews; patients exit interviews; focus group discussions; population - based surveys / studies; country profiles etc.

Both monitoring and evaluation can involve local community participation (particularly women). Such participation can encourage local people to become involved in MNH issues, to be informed and to provide information about the extent of MNH service improvements at community level[33].

M&E plan

Both monitoring and evaluation should be planned at the same time as MNH plan is being prepared. And for this, the following key elements are needed:

- A list of programme / project objectives;
- A statement of all indicators that will be used for evaluating impact of MNH services at the end of implementation period;
- A list of indicators for which data will be collected in the baseline survey;
- A list of activities to be carried out;
- Tools for data collection; sources of required data
- Action plan that shows when all monitoring or evaluation activities will take place;
- Who will be responsible for preparing monitoring and evaluation tools, data collection or processing, preparing reports, and disseminating results.
- Resource needs estimate for monitoring and evaluation activities.

3.2.10. Step 10: MNH plan approval and Advocacy

Planning group members all together need to agree on the final version of the MNH plan for its approval. They may also decide to prepare a - two pager summary of the plan, with the purpose of:

- Informing the local community about the proposed MNH plan for their support;
- Championing the cause of improved MNH services amongst local authorities, development partners and the Ministry of Health;
- Informing other services and sectors;

This summary should highlight key points of the plan and would include:

- Major causes of maternal and newborn death and disability;
- Set goals, objectives, expected outcomes & key activities;
- Major strategies to be implemented for the planning period;
- Total resource needs estimate, financial gaps and potential sources of funding;
- Relationship / synergies of the plan with other ongoing programmes.

Box 13: Example of district plan outline for MNH

- Table of contents
- Acronyms and Abbreviations
- Acknowledgements
- Executive summary
- Introduction
- Overview of national MNH policies, programme & services
- Assessment of MNH current situation / MNH priorities
- Goals
- Objectives & targets
- Activities/interventions (Work plan)
- Estimate budget
- Plan of action (Gantt chart)
- Monitoring & evaluation plan
- Risks (possible constraints which might affect planned activities and outcomes)
- Financial gap analysis & funding strategy.

Once the plan is approved, it is important that the plan is made known to a wider audience. There are various ways of doing this – by sending the plan or the summary to interested and concerned people, by holding meetings in the community and by using available media (radio, newspapers and TV) to disseminate the plan to the general population.

The DPT - MNH must be integrated not only into the national health strategic plan (e.g. taking account of human resources plan, health financing), but also into the national development vision & strategy. To achieve this, a wider consultation is of great importance. At this stage, the planning group will also have to identify potential funding sources, based on the proposed budget and financial gap analysis.

Managers / planners can assist in bringing to the attention of national policy makers the existing financial barriers that prevent women and newborns from accessing healthcare, as well as consequences of their prevailing low budgets for MNH at district and facility levels. Local funds may be available from sources such as NGOs, religious groups, major employers / private sector and external donors. The local community itself can be a source of funds for specific items, such as referral system etc.

Health sector reforms, sector wide approach programs (SWAp) and introduction of other financing mechanisms should also be monitored to ensure that, although they are expected to strengthen maternal and newborn health for all, they do not disadvantage the poor and other vulnerable groups.

4 Conclusion

The aim of this guide is to provide health managers / planners with guidance and practical tool for district planning and implementation of MNH programme, towards making pregnancy safer and accelerated reduction of maternal and newborn morbidity and mortality in priority countries.

The proposed planning process is expected to be more effective with active involvement of a wide range of stakeholders. This is known as "participatory approach". Stakeholders will need to have a common understanding of MNH key issues, to share national vision, goals and aspirations to be able to develop an adequate district MNH plan, based on community needs and local context. Thus, following a – 10 step process, planning group members will come up with MNH priorities, specific objectives, activities and required human & financial resources, while complying with national policies, strategies and standards of care.

PT-MNH is based on health system strengthening (HSS) approach that is most likely to lead to better health outcomes through improvements in access, quality and efficiency.

Managers / planners should ensure that the DPT - MNH is integrated into the national development vision & strategy as well as national health strategic plan.

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Annex A
Manual for Orientation workshop facilitator

1. Workshop preparation

1.1 Introduction

The aim of this 'District Planning tool' is to provide national and district health managers / planners with practical resources for planning and implementation of MNH health services towards making pregnancy safer. It is intended to be short and practical for anyone who is responsible for MNH programme management and all stakeholders at district level.

1.2 Objectives

This workshop is designed as an in-service training orientation for district health managers/planners who are involved in antenatal, childbirth, postpartum and newborn care services.

At the end of the workshop, participants should be able to:

- Improved their skills in health planning;
- Increased their knowledge of "best practices" in maternal and child health care; and
- Raised their awareness of the importance of improving maternal and newborn health.

1.3 Expected result

This district planning tool should provide necessary skills and tips for health managers / planners to develop plans for effective implementation of national MNH strategy. Additionally, skills acquired should help to use efficiently and effectively available resources and to strengthen management capacity at district level.

1.4 Target audience

This orientation workshop is primarily intended for DHMT members who are responsible for MNH care services in the district.

The people who might contribute to the planning process could include:

- District Maternal & Child Health (MCH) manager.
- Head of Obstetrics & Gynecology department/District hospital;
- District midwifery supervisor;
- Midwives & nurses from district hospital & health centres;
- Planning coordinator in the district health office;
- Representatives from NGOs/FBOs/CSOs or donor agencies;
- Community representatives.

1.5 Orientation approach

This course adopts a participatory and interactive approach and is designed to maximize involvement of all participants. Participants will work through the sections with the aid of facilitators and will learn through a combination of individual reading sessions, group discussions, facilitator led drills in groups.

1.6 Facilitation techniques

A. How to give Pre- and Post-test

Explain to participants that the purpose of pre-test is to give facilitators a sense of baseline knowledge of the group, and it is not an examination. Allow 30 minutes for the test of approximately 10 questions (Multiple choice & short questions).

Do not discuss answers to the questions when the test is finished as the same test will be given as post-test, but explain that all materials will be covered in the course. At least two persons should score the test the same day it is given so that facilitators can gear the training to the level of knowledge of participants. You can discuss the answers at the end of the course, after the post-test.

B. How to conduct a drill

- Explain the procedures for doing the drill. Tell participants:
  - This is not a test. The drill is an opportunity for participants to practice recalling the information that they have learnt and will need to use when addressing planning issues.
  - You call on individual participants one at a time to answer questions. You usually call on them in order, going around the table. If a participant cannot answer, go to the next person and ask the question again.
  - Participants should wait to be called on and should be prepared to answer as quickly as they can. This will help keep the drill lively.
  - Remain friendly and create a non-judgmental environment that facilitates participation of trainees.
- Allow participants to review the text for a few minutes before the drill begins. Tell the participants they may refer to the text during the drill, but they should try to answer the question without reading.
- Start the drill by asking the first question. Call on a particular participant to provide the answer. He/she should answer as quickly as he/she can. Then ask the next question and call on another participant for answer. If a participant gives an incorrect answer, ask the next participant if he/she can answer.
- Keeps the drill moving at a rapid pace.
- The drill ends when all the participants have had an opportunity to answer and when you feel the participants are answering with confidence.

C. How to provide individual feedback

When participants are working, facilitators should:

- Be available, interested and ready to help.
- Watch participants as they work and offer individual help if someone looks troubled or is not writing answers or turning pages.
- Encourage questions and requests for help.
- If important issues or questions arise individually, make a note to discuss later with the entire group.
- If a question arises and you feel unable to answer adequately, obtain assistance as soon as possible from another facilitator.

Written exercises can also be read aloud and discussed in the group.

D. Reading

When the facilitator manual says participants should read part of the participant's manual, you can have participants read silently on their own, or ask for a volunteer to read a section loudly. The method you choose depends on factors such as level of education of the group as a whole, differing levels within the group, their understanding of the language, and group preference. Before you start, make sure everyone is on the same page. If participants are reading aloud, make sure they all get chances to read during the course. You may also choose a mixture of silent reading and reading aloud.

Explanations should be short and to the point, using a flip chart and/or referring to the manual. Occasionally, when you need to move quickly, you may consider presenting certain materials as a short, interactive lecture, rather than having participants read through a number of pages themselves.

1.7 Instructional materials, supplies, venue, timetable

A. Materials for participants

Each participant will need the following instructional materials to work through the training. You can use a checklist to plan your course.

Steps in preparing course materials:

- Calculate numbers needed, always adding a few extra copies.
- Arrange for printing, photocopying and delivery of materials before training begins in order to allow time to correct any errors.
- Check each item for accuracy when finished.

B. Checklist of instructional materials

Items required for training (E.g.)	Number needed for participant/Facilitator	Ready
1. District planning tool for maternal and newborn health strategy implementation.		
2. IMPAC guidelines		

C. List of required supplies and equipment

Supplies needed for each facilitator and participant during the course:

- Name tag and holder or adhesive tape (works well to write names on) or alternatively can use name cards;
- Folder to organize manuals;
- Notebook/stationery; ball point pen; pencil & eraser; CD.
- Supplies needed for each small group/classroom: Flip charts.

D. Venue

Classes should ideally be for 15 to 25 participants. If there are more participants, make a second group and plan for extra rooms accordingly.

E. Dates and scheduling

The workshop coordinator, in consultation with the DHMT, is responsible for setting workshop dates which should be based on the district planning cycle. The MNH district plan produced during the workshop will have to be reconciled with other program plans and integrated into an overall district health plan. Depending on the district, this probably means that the workshop should be completed at least one month before the district health plan is due.

For effective learning process, it is proposed to conduct a -3 day orientation workshop, with approximate duration of each step as shown in the following table:

Approximate duration of planning steps

Step	Name	Approximate duration
	Introduction	1 hour
1	Assess current situation and identify problems.	3 hours
2	Analyse causes of problems.	2 hours
3	Select priority problems.	1 hour
4	Set goals.	2 hours
5	Develop strategies and set objectives.	1 hour
6	Plan activities.	4 hours
7	Estimate resource needs	2 hours
8	Develop action plan.	3 hours
8	Develop monitoring and evaluation plan	3 hours
10	MNH plan approval and advocacy	Variable

1.8 Roles & responsibilities

- Workshop Coordinator: A coordinator should be designated by the district director at least two months before the workshop to organize the planning process. The coordinator may be a member of the DHMT or someone outside the team. He or she should have communication skills, knowledge of health services in the district, including stakeholders and its specific context. Before the workshop starts, the coordinator should ensure that the following tasks are completed:
  - Selection of participants
  - Informing participants about the orientation workshop, its objectives & schedule;
  - Arrangements for the venue;
  - Other administrative & logistic arrangements
  - Compilation of required materials.
- Participants - Before the workshop. All participants should :
  - Read background materials recommended by the coordinator;
  - Compile any relevant district data that might be useful for planning exercise;
- Participants - During the workshop. All participants are equally responsible for:
  - Producing a draft plan by the end of the workshop;
  - Sharing information and experience, listening to others, and cooperating in problem solving will help to ensure involvement and ownership of the plan by all participants.
- Participants - After the workshop. At the end of the workshop, members of the planning team should have a good draft of a maternal and newborn health plan for the district, but more work is probably needed before the plan can be adopted and implemented. These include:
  - Checking and completing budget figures, if necessary.
  - Completing the plan after key stakeholders who did not participate in the development of the draft have reviewed it.
  - Integrating it with the district health plan.

2. District Planning process for MNH: from planning to action

The diagram below shows how each step in the planning process leads to the next. You will be following this process, from planning to action, throughout this workshop.

THE PLANNING PROCESS

Steps	Tasks	Products
1. MNH situation analysis	Study current maternal and newborn health status and maternal and newborn health services in district. Identify possible problems.	Summary of maternal and newborn health status. Summary of maternal and newborn service delivery. Description of possible problems. Map of health facilities, services offered, and location of personnel in district.
2. Analyse causes of identified problems.	Investigate possible causes of problems identified in Step 1.	Description of causes of problems.
3. Select priority problems.	Identify maternal and newborn health care problems that should be addressed as high priorities during this planning period.	Selection of priority problems.
4. Set goals.	Develop district goals for reduction of maternal and neonatal mortality and morbidity and stillbirths.	Statement of district goals.
5. Develop strategies and set objectives	Design strategies for meeting goals. Set objectives for strategies.	Description of strategies, objectives to be reached, targets and approximate time needed to implement it.
6. Plan activities	Decide what the DHMT should do to implement the strategies. Decide what other key stakeholders will do to implement or assist with implementation of the strategies.	Selected key activities and responsible units.
7. Estimate required resources for MNH activities	Estimate the cost of selected activities and assess the availability of funding.	Estimated resource needs and funding gaps and sources.
8. Develop MNH action plan	Put together goal, objectives, strategies, activities and resources needs.	Action plan showing activities, responsibilities, schedule, estimated resource needs and funding sources.
9. Develop a monitoring plan	Decide what the DHMT should do to monitor implementation of the plan and progress towards achieving district objectives.	A monitoring plan.

The Planning process

Steps	Tasks	Products
10. MNH plan approval and advocacy	Compile the products of previous steps. Prepare a first draft. Decide how to fill any gaps in the plan, and how to integrate the plan into the general district health plan. Prepare for district approval process.	Draft maternal and newborn health plan; Advocacy materials.

Step 1: MNH Situation Analysis

Read the overview and guidelines for this step

Overview

Main tasks

- Review district data for completeness, accuracy, and timeliness.
- Analyse the status of maternal and newborn health.
- Analyse the access, use, and quality of maternal and newborn health care services.
- Complete a health service map of your district.
- Develop a list of major problems.

Required materials

- District data compiled before the workshop
- National, provincial, and district goals, objectives, and targets for maternal and newborn health
- Latest district health plans
- Reports, evaluations, and other documents that assess the strengths and weaknesses of district maternal and newborn health services
- District map – large scale, can be hand drawn

Approximate time to complete step 1: 4 hours

Expected deliverables:

- Amended data sheets
- A district map showing location of maternal and newborn health facilities, services offered, personnel and, if available, mortality and morbidity by catchment area
- A list of maternal and newborn health problems in the district.

Guidance for completing task

Review district data for completeness, accuracy, and timeliness.

With the rest of the planning team, review each data sheet compiled by the workshop coordinator before the workshop. Check for:

- Completeness: Do all facilities and health care providers report?

- Accuracy: Do diagnoses, registrations, and other data appear to be accurate?
- Timeliness: Are the data recent? How recently were they collected?

Identify the data that you suspect are incomplete, inaccurate, or out-dated.

If members of the planning team have brought more complete, accurate, or timely data, amend the data sheets accordingly.

Analyze the status of maternal and newborn health in your district.

Use the data sheets on Maternal and Newborn Health Status to identify areas in which mortality and morbidity may be high. List problems for mothers and newborns separately.

Analyze issues of access, use, and quality for maternal and newborn health services in your district.

Use data sheets on Access, Use, and Quality of health services to identify areas in which problems may be indicated. Compare the actual situation shown on the data sheets with district, provincial or national goals and objectives. If they have not been set, compare your district's performance with global targets. Make different lists for access, use, and quality problems.

Complete a health service map of your district.

Make a map of your district.

Use data sheet on available facilities and MNH services as a reference, mark on the map the location of every health facility (health post, health centre, hospital, - both public and private) that provides maternal and newborn health services. Use different colors to show different types of facility.

Use the data sheet on available professional MNH service providers; make a list of providers (by type and number) in each health facility or village. Attach these lists at the appropriate locations on the map.

If you have data on maternal and newborn mortality and morbidity by village or health facility catchment area, mark these on the map too.

- When you have completed the map, identify which:
- Populations are not currently reached by health services;
- Maternal and newborn services are not, but should be, offered at facilities;
- Facilities have gaps in staffing; and
- Locations where maternal and newborn mortality and morbidity occur.

Develop a list of major problems and rank them by importance

You now have several lists of problems – maternal and newborn health status and access, use, and quality of services. You also have a map showing where services and personnel are located.

Before deciding what the major problems are, discuss:

- Are maternal and newborn mortality or morbidity rates or stillbirth rates higher than national (or WHO) targets?
- What are the major causes of complications for mothers and infants?
- Do women and newborns in the district have access to the seven interventions - antenatal care, delivery care, basic and comprehensive essential obstetric care, postpartum care, newborn care, and family planning – according to national standards and targets?
- Does coverage for key interventions meet national targets?
- Does each of the key interventions meet minimum standards of quality?
- Are all facilities fully staffed according to national standards?

Also discuss whether the team has the data needed to identify the causes of problems. You will probably find that there are gaps in the data but that you have enough to continue planning. In Step 6, you can decide what data you will need in the future, how and from whom it will be collected and analyzed, when, and by whom.

From all of the problems that you have listed, select the five that you think are most important and rank these in order, listing the problem that is most important as number 1.

Step 2: Analyse Causes of identified Problems

Read the overview and guidance for this step

Overview

Main task

Identify causes of identified problems.

Required materials

- List of maternal and newborn health problems.
- Approximately 30 postcard-sized cards, or 15 pieces of A4 paper cut in half, or three or four sheets of flip chart paper and coloured pens

Approximate time to complete step 2: 2 hours

Expected deliverables:

- Diagrams tracing the probable causes of major maternal and newborn health problems.
- Short narrative description of major problems and their causes.

Guidance for completing tasks

Identify possible causes of the problems identified in Step 1.

Begin with the first problem and identify all possible causes for the problem in your district. Then analyse each cause, to identify its root causes, both clinical and service-related causes.

List the problems on flipchart paper or construct a problem diagram. Annex 1 provides step-by-step instructions for developing a problem diagram and gives examples of two types of these diagrams.

Problems that are not analysed at this time should be reviewed in the next planning cycle. If data are not available, unreliable, or very old, the data themselves may be one of the major problems for your district.

Identify the most critical causes in contributing to maternal and newborn deaths, disability and stillbirths.

When you have considered all of the causes that might have led to the problems and correctly linked causes and effects, use a coloured pen to highlight the causes that are most directly related to the problem in your district.

Select the major problems that you have identified and their most important causes and describe these on a worksheet.

Step 3: Select Priority Problems

Read the overview and guidance for this step

Overview

Main tasks

- Select criteria to be used for setting priorities.
- Identify maternal and newborn health care problems that should be given priority during planning exercise and problems that should be left to the next planning period.

Required materials

- Description of maternal and newborn health problems and their causes.
- Documents describing national and district priorities for health and development.

Approximate time to complete step 3: 1 hour

Expected deliverables:
A description of priority problems for current and future planning exercises.

Guidance for completing tasks

Decide what criteria to be used for setting priorities.

The criteria below will help district team set MNH priorities.

Prevalence: How common is a problem?

Consequences: What is likely to happen if the problem is not solved? (Will the problem continue, get worse, or solve itself?)

Population affected: Who is most affected by the problem and who is most likely to benefit by its solution? Where do the affected people live? What are their social and economic characteristics?

Political commitment: Has the community or the government identified this problem as a high priority? Is the community or government or both providing support to solve the problem?

Feasibility of solution: Are human and financial resources available to solve the problem? Can it be solved without negatively affecting other district health services?

Timeliness: How important is it that the problem be solved in the next planning period, or can proposed action be postponed?

Review the list and add any other criteria that you think are important for your district. Additional criteria may include, for example, effect of problem on economic well-being, and might be seen in documents discussing national or district priorities for health and development.

Assess problems according to selected criteria.

List identified problems.

Give each problem a score from 1 to 3 (3 being the highest) for each criterion. Add the scores for each problem for a total.

Reconsider the list of problems and revise as necessary.

Problems with the highest total scores should be priority problems.

Decide which problems should be addressed in the current planning exercise.

Step 4: Set Goals

Read the overview and guidance for this step

Overview

Main tasks

Set goals for reduction of maternal and newborn deaths, stillbirths, and major pregnancy-related complications.

Required materials

- National strategy for reducing maternal and newborn mortality & morbidity.
- Data on MNH status.
- List of priority MNH problems.

Approximate time to complete the step: 2 hours

Expected deliverables:

A statement of goals addressing priority problems of maternal and newborn health in the district.

Guidance for completing tasks

Make sure priority problems selected in Step 3 address national and district goals.

Review national and district maternal and newborn health goals. Assess how proposed solutions for priority problems are likely to lead to the achievement of national and district goals.

Write goal(s) for each priority problem.

For each priority problem to be addressed in the current planning period, define a goal that describes what reductions in mortality or disability are expected to be achieved by solving the problem.

Examples of goals relating to the reduction of maternal & newborn mortality and morbidity

The following example is provided for reference only. District goals should relate specifically to the district situation.

Reduce, by 30% in the district, the number of maternal deaths due to post-partum hemorrhage.

Write a district goal for each priority problem identified in Step 3. Name the causes addressed (e.g., Eclampsia); completion date and amount of change that is expected to be achieved should be realistic. Use the health status data reviewed in Step 1 to enable you to set realistic targets.

Step 5: Developing Strategies and Set Objectives

Read the overview and guidance for this step

Overview

Main tasks

Identify strategies that are most likely to help achieve the defined goals.

Set objectives to be achieved for reaching the goals.

Required materials

- The most recent district health plan
- Reports, evaluations, and other documents assessing strengths and weaknesses of current strategies.
- National standards for access, use, and quality of maternal and newborn services.
- Map, demographic data, and data on services in district.
- Flip chart paper and pens, white board, or chalk board.

Approximate time to complete the step: 2 hours

Expected deliverables:

For each goal, selected strategy and SMART objectives are defined (including selection criteria).

Guidance for completing tasks

Assess district strategies described in previous plans and reports on their implementation.

Review the most recent district plans for maternal and child health care. What strategies are described in those plans?

Review reports, evaluations and other documents assessing strengths and weaknesses of current district strategies. What strategies are, or appear to be, working? What strategies are not working? Why?

Develop a list of possible strategies for achieving each objective.

Select one goal for the current planning period from Worksheet 4.1 and write it on flipchart paper or chalkboard. Brainstorm as many strategies as you can for reaching this goal.

Example of Strategies

Promote quality facility childbirth for reducing maternal mortality.

Offer PMTCT services to all women coming for ANC visits in high burden settings.

Discuss what is needed to implement each strategy, including resource and time requirements and number and skills of health workers needed.

Decide what criteria to be used for selecting strategies.

The criteria described below should help decide which strategies are most likely to be successful. Add criteria as agreed by the team.

Impact: What impact is proposed strategy likely to have in solving the problem? What additional benefits might be produced? What effect, if any, might the strategy have on other health services?

Consistency: Is the strategy consistent with existing district and national goals, objectives, plans, and activities?

Evidence-based: What is the evidence that the strategy actually works?

Acceptability: Will the strategy be acceptable to key stakeholders who are not represented at the planning workshop? Such as national and provincial government officials and people in local communities?

Feasibility: Are both human and financial resources available to implement the solution, or can they be mobilised?

Timeliness: How much time is needed to implement the proposed strategy?

Assess each strategy according to the criteria.

Give each strategy a score from 1 to 3 (3 being the highest) for each criterion. Sum up the scores for each strategy. Select the strategies that will best meet each goal.

Set one or more objectives for each strategy.

Objectives are needed to provide direction and purpose to managers, staff, and others and to monitor progress and achievement. To be useful, objectives should be SMART. That is, they are:

Specific: They are clear and unambiguous. They tell everyone exactly what is expected, when, and at what level.

Measurable: They include numbers or percentages to indicate how much improvement is expected. Use district, national, or WHO standards to help decide what measurements are to be used.

Achievable: They are realistic and can be met by district staff without reducing quality standards.

Relevant: They are consistent with and related to national goals and priorities.

Time bound: They have a specific beginning and end date.

Examples of SMART objectives

These examples of SMART objectives are provided for reference only. Teams must construct their own objectives for their plans.

Coverage of postnatal visits by skilled attendants will increase by n % by the year X.

90% of all women in high-risk areas will have received protective doses of tetanus toxoid (TT2+) by the end of Y year.

Step 6: Plan Activities

Read the overview and guidance for this step

Overview

Main tasks

1. Decide what activities need to be carried out to be able to achieve defined objectives.
2. For each activity, schedule timelines, decide who will be responsible and expected outputs.

Required materials

- Most recent district maternal and newborn health plan and budget
- Data on existing maternal and newborn services, including number and location of personnel.

Approximate time to complete the step: 4 hours

Expected deliverables:

A work plan with key activities for reaching each objective.

Guidance for completing tasks

Describe major activities to be carried out for effective implementation of identified strategies.

Describe each strategy and objective; identify the agency that will be responsible for implementing the strategy. If the lead agency is private, the government agency in charge of coordinating the input of the lead agency should also be named. Note: If non-government representatives in the workshop agree to implement specific strategies, e.g., an emergency transport system for women with delivery complications, they should make an action plan and take it back to their organizations for approval.

Brainstorm on activities that might be needed to implement strategies, and select the most important ones. Which of the brainstormed activities are absolutely necessary to achieve selected objectives? Which activities can the district and its partners implement?

Define timeline for key activities (start and completion dates for each activity).

Decide who will be responsible for completing each activity, including NGOs, teaching institutions, and other partners who agree to take responsibility for specific activities.

Identify expected output for each activity.

An output may be an event, such a meeting, or a product, such as a report, training manual, or formal commitment of support from the community. The process of describing an output will help decide which activities are really necessary. Outputs will be used to monitor implementation of the proposed plan.

Step 7: Resources Needs Estimate for MNH Activities

Read the overview and guidance for this step

Overview

Main tasks

1. For each activity, estimate needed financial resources and
2. Identify funding gaps and sources.

Required materials

- Most recent district maternal and newborn health plan and budget;
- District financial reports for previous fiscal years;
- The draft work plan;
- Recent catalogues for prices of drugs, supplies, and equipment.

Approximate time to complete the step: 2 hours

Expected deliverables:

Needed financial resources (with source of funding) for reaching each objective.

Guidance for completing tasks

Estimate needed resources for implementing each activity.

Use recent district budgets, expenditures and catalogues to help estimate needed financial resources for each activity.

Use the costing checklist to ensure all key items are included.

Identify funding gaps and sources.

Identify the likely source of required funds and estimate funding gaps for all activities. The government may pay the total cost of some activities, but the cost of others may be shared among government and private sources or paid entirely by private sources. For example, the government may cover personnel salaries and benefits, while supplies, drugs, and training materials may be covered by non-governmental organizations, multi-lateral or bilateral partners, or other donors.

Example of costing checklist

	Item	Capital costs	Recurrent costs
1	Personnel	Training – initial Building of staff accommodation	Salaries, benefits (e.g. housing allowance, hardship - remote area allowance, education allowance for children, etc.) pensions, refresher training
2	Medicines, medical supplies and equipment	Blood bank, purchase of large new medical equipment	Disposable and non-disposable medical supplies, equipment and medicines for in-patient/ out-patient clinics
3.	Non medical equipment and furnishings	Chairs, beds, desks, etc.	Maintenance, replacement, depreciation, small equipment items
4	Transport and travel	Ambulances, new vehicles	Maintenance, replacement, fuel
5	Communications	Radio, telephone, cell phones	Maintenance and operating costs
6	Buildings and grounds	Construction costs, including building of laboratory, operating theatres, etc. Land purchase	Maintenance, rent, taxes, depreciation
7	Energy panels, electricity connection	Generator, solar panels	Oil and electricity
8	Water and sanitation, waste disposal	Installation and building costs	Maintenance
9	Food equipment	Kitchen	Food costs for staff and patients
10	Housekeeping	Equipment and buildings (see 1 and 2)	Housekeeping supplies
11	General administration	Computers, typewriters,	Stationery, record system software, and maintenance
12	Advocacy		

Adapted from: Green A (1999) An Introduction to Health Planning in Developing Countries, 2nd Edition, Oxford University Press, pp 318 reprinted 2001, and the World Health Report 2005 - Section on costing the scaling up of MNH care coverage.

Step 8: Define MNH Action Plan

The action plan is basically a table designed to show important MNH milestones (i.e. when important activities are expected to be completed) to allow for monitoring of programme implementation.

Read the overview and guidance for this step

Overview

Main tasks

1. For each activity, estimate starting and closing dates.
2. Design Gantt chart.

Required materials

- The draft work plan

Approximate time to complete the step: 3 hours

Expected deliverables:

Gantt chart

Guidance for completing tasks

A Gantt chart is a simple aid used to develop action plan and for monitoring of programme/project activities. It allows for presentation of activities in logical sequence and illustrates dependencies that exist between different activities. For each activity, starting and closing dates are mentioned, using a horizontal bar, with the duration on the graph. It also helps lay out visibility of tasks that need to be carried out; it provides basis for scheduling completion of tasks.

Make a calendar or Gantt chart that shows when major activities are scheduled to occur and what the deadlines for outputs are.

Goal 1:

		2012											
Object.	Activities	J	F	M	A	M	J	J	A	S	O	N	D
Obj 1	Acti 1.1												
	Acti 1.2												
	Acti 1.3												
Obj 2	Acti 2.1												
	Acti 2.2												
	Acti 2.3												
	Acti 2.4												

Step 9: Developing a Monitoring Plan

Read the overview and guidance for this step

Overview

Main tasks

1. Decide how the district health management team will monitor:
    - Implementation of the plan
    - Progress towards achievement of objectives
    - Progress towards achievement of goals
2. Develop a plan for monitoring progress towards achievement of objectives.

Required materials

- A list of programme / project objectives;
- A statement of all indicators that will be used for evaluating impact of MNH services at the end of implementation period;
- A list of indicators for which data will be collected in the baseline survey;
- A list of activities to be carried out;
- Tools for data collection; sources of required data
- Action plan that shows when all monitoring or evaluation activities will take place;
- Who will be responsible for preparing monitoring and evaluation tools, data collection or processing, preparing reports, and disseminating results?
- Resource needs estimate for monitoring and evaluation activities.

Approximate time to complete the step: 3 hours

Expected deliverables:

1. A plan for monitoring progress towards achievement of objectives, including baseline values, targets and timeline.

Guidance for completing tasks

1. Develop schedule for monitoring plan implementation.
    - Districts should monitor their plans to make sure they are doing what has been planned and they are able to make needed corrections as soon as problems arise. The aspects to monitor include:
        - Activities. Is every activity implemented? If not, why not? What can be done to improve plan implementation (or should the plan be changed)?
        - Dates. Have activities begun and been completed as planned? If not, why not? What can be done to get back on schedule?
        - Person or office responsible. Are people or offices named in the plan doing their jobs? If not, why not? Should someone else be given responsibility?
        - Costs. Are expenditures matching estimated costs? If nothing has been spent on an activity, what is the problem? If the actual costs are higher than the estimated budget, what can be done to limit spending and how will additional cost be paid for?
        - Funding. Have funds been allocated and released as planned?

- Expected outputs. Are events taking place and materials being produced on time and is their quality adequate? If not, why not? What can be done to improve production of outputs?

2. Develop a plan for monitoring progress towards objectives.
   - Review the objectives on Worksheet 5.2. Are the objectives still SMART? If not, revise them and for each objective, decide the following: (See Worksheet 7.2 for an example.)
     - Measurement: The number or amount that you are aiming for.
     - Baseline: The current status. (See data analysed in Step 1: Assess Situation and Analyze Problems.)
     - Targets: What is expected to be achieved for reaching each objective. Targets are interim objectives and should also be SMART.
     - Schedule: The dates on which each target and objective should be reached.
     - Sources of data: Documents from which appropriate data is extracted.
3. Set targets for measuring progress towards achievement of objectives / goals.
   - For each goal, set targets to be reached for achieving objectives and goals.

Step 10: Developing a Monitoring Plan

Read the overview and guidance for this step

Overview

Main tasks

1. Planning group members all together need to agree on the final version of the MNH plan for its approval. They may also decide to prepare a - two pager summary of the plan, with the purpose of:
   - Informing the local community about the proposed MNH plan for their support;
   - Championing the cause of improved MNH services among local authorities, development partners and the Ministry of Health;
   - Informing other services and sectors;
2. Develop a plan for monitoring progress towards achievement of objectives.

Required materials

- A list of programme / project objectives;
- A statement of all indicators that will be used for evaluating impact of MNH services at the end of implementation period;
- A list of indicators for which data will be collected in the baseline survey;
- A list of activities to be carried out;
- Tools for data collection; sources of required data
- Action plan that shows when all monitoring or evaluation activities will take place;
- Who will be responsible for preparing monitoring and evaluation tools, data collection or processing, preparing reports, and disseminating results?
- Resource needs estimate for monitoring and evaluation activities.

Approximate time to complete the step: variable

Expected deliverables:

1. A first draft of district plan for maternal and newborn health, which can be reviewed by other stakeholders who have not been participated in the planning process.

Guidance for completing tasks

1. Write a draft plan

   Discuss and come to an agreement on what needs to be included in the plan. Prepare an outline. If there is no standard layout, consider using the steps of this workshop as your table of contents, including:

   - Assessment of the current situation
   - Problem analysis
   - Identification of priority problems
   - District goals for making pregnancy safer
   - Strategies and objectives
   - Action plans
   - Plan for monitoring

2. Prepare an executive summary.
   - Prepare a one- or two-page executive summary that highlights the main points of your plan.
3. Plan for next steps

   Here are some key issues to consider as next steps:
   - How to complete the plan.
   - How to gain support for the plan.
   - How to use the plan to back up funding proposals.
   - How to link up with other services, such as malaria, TB, or HIV/AIDS.

Annex B

B-1: Summary of DPT - MNH steps

Step	Tasks	Products
1. Assess current situation and identify problems.	Assess current maternal and newborn health status and maternal and newborn health services in district. This includes review of existing and relevant reports, plans and policies. Identify MNH problems.	Summary of maternal and newborn health status. Summary of maternal and newborn service delivery. Description of possible problems. Map of health facilities, services offered, and location of personnel in district.
2. Analyze causes of MNH problems	Investigate possible causes of problems identified in Step 1 and most affected groups.	Description of causes of problems and most affected groups.
3. Select priority problems	Identify maternal and newborn health care problems that should be addressed as high priorities during this planning process.	Selection of priority problems and groups.
4. Set MNH goals	Develop district goals for reduction of maternal and perinatal mortality and disability.	Statement of district MNH goals.
5. Develop strategies and set objectives	Design strategies Set objectives	Description of strategies to be applied and objectives to be achieved
6. Plan and cost activities	Decide what activities are needed to implement strategies and meet objectives. Decide what other stakeholders will do to implement or assist with implementation of the strategies.	Action plan showing activities, responsibilities, possible partners schedule, (GANNT chart)
Cost MNH plan	Estimate cost of activities	Budget of MNH plan
Develop MNH action plan	Define timeline for proposed activities	Gantt chart
Develop a monitoring and evaluation plan	Decide what is needed to monitor implementation of MNH plan and progress towards achieving objectives. Decide what indicators to be used for M&E	A plan for monitoring, including list of core indicators.
Approve & disseminate MNH plan	Decide how to fill any gaps in the plan, how to conduct the review process, and how to integrate the plan into the general district health plan. Finalize the plan Advocate for getting the plan approved and for getting the budget.	Final approved plan published; Budget approved; Plan dissemination launched

B-2: Situation analysis: proposed generic questionnaire for data collection at district level

A. General information			
Items	Value	Source	Comments
A1. Total population			
A2. Population sex distribution			
A3. Population age distribution			
A4. Life expectancy			
A5. GNI			
A6. Literacy rate (total; sex distribution)			

B. Selected MNH indicators			
Items	Value	Source	Comments
B1. Maternal mortality ratio (trend analysis)			
B2. Newborn mortality rate (trend analysis)			
B3. ANC utilization rate (at least one visit; 4 visits)			
B4. SBA utilization rate (total; rural versus urban; by wealth quintile)			
B5. Percentage of deliveries at facility level (total; rural versus urban; by wealth quintile)			
B6. CS rate (total; rural versus urban; by wealth quintile)			
B7. Postnatal services utilization rate (48 hours) (total; rural versus urban; by wealth quintile)			
B8. Percentage of home deliveries			
B9. Low birth weight			
B10. Contraceptive prevalence rate			
B11. Percentage of children born to HIV+ mothers			

C. MNH service delivery			
C1. Availability of Basic & Comprehensive Essential Obstetric Care			
Items	Value	Source	Comments
C1.1 BEOC facility			
C1.2 CEOC facility			
C1.3. Percentage of facilities with basic newborn health services			
C2. Quality improvement activities			
Items	Value	Source	Comments
C2.1 Integrated ANC package provided on daily basis?			
C2.2 Childbirth services 24/7?			
C2.3 PMTCT interventions integrated into MNCH services?			
C2.4 Use of partograph?			
C2.5 Maternal death review?			
C2.6 Perinatal death review?			

D. Health system component			
Items	Value	Source	Comments
D1. Existence of national MNH strategy (road map…);			
D2. Health workforce density?			
D3. Percentage of MNH facilities supervised according to standards?			
D4. Percentage of facilities that have all tracer medicines and commodities in stock (specific MNH medicines: Oxytocin, Magnesium sulfate; PMTCT etc…)			
D5. User fees or health insurance scheme for MNH services?			
D6. The ratio (& distribution) of RH/ maternal health expenditure as a proportion of THE.			
D6. Percentage of births registered?			
D7. Community participation in the management of district health services?			

B-3: SWOT analysis framework

	Positive	Negative
Internal	Strengths	Weaknesses
	What are our advantages?	What could we improve?
	What are we doing well?	What are we doing poorly?
	What relevant resources do we have?	What should we avoid?
	What do others see as our strengths?	
External	Opportunities	Threats
	Where are opportunities favourable to our goals?	What obstacles do we face?
	What are interesting trends we are aware of and could be responsive to?	What are our competitors doing?
		Are the requirements for what we offer changing?
		Could any of our weaknesses threaten the aim of our organizations?

B-4: Example of costing checklist

	Item	Capital costs	Recurrent costs
1	Personnel	Training – initial Building of staff accommodation	Salaries, benefits (e.g. housing allowance, hardship - remote area allowance, education allowance for children, etc.) pensions, refresher training
2	Medicines, medical supplies and equipment	Blood bank, purchase of large new medical equipment	Disposable and non-disposable medical supplies, equipment and medicines for in-patient/ out-patient clinics
3.	Non medical equipment and furnishings	Chairs, beds, desks, etc.	Maintenance, replacement, depreciation, small equipment items
4	Transport and travel	Ambulances, new vehicles	Maintenance, replacement, fuel
5	Communications	Radio, telephone, cell phones	Maintenance and operating costs
6	Buildings and grounds	Construction costs, including building of laboratory, operating theatres, etc. Land purchase	Maintenance, rent, taxes, depreciation
7	Energy panels, electricity connection	Generator, solar panels	Oil and electricity
8	Water and sanitation, waste disposal	Installation and building costs	Maintenance
9	Food equipment	Kitchen	Food costs for staff and patients
10	Housekeeping	Equipment and buildings (see 1 and 2)	Housekeeping supplies
11	General administration	Computers, typewriters,	Stationery, record system software, and maintenance
12	Advocacy		

Adapted from: Green A (1999) An Introduction to Health Planning in Developing Countries, 2nd Edition, Oxford University Press, pp 318 reprinted 2001, and the World Health Report 2005 - Section on costing the scaling up of MNH care coverage.

B-5. Shortlist of indicators for global monitoring of Reproductive Health

1	Antenatal care coverage
2	Births attended by skilled health personnel
3	Availability of basic essential obstetric care
4	Availability of comprehensive essential obstetric care
5	Maternal mortality ratio
6	Perinatal mortality rate
7	Prevalence of low birth weight
8	Contraceptive prevalence
9	Total fertility rate
10	Prevalence of positive syphilis serology in pregnant women
11	Prevalence of anaemia in women
12	Percentage of obstetric and gynaecological admissions owing to abortion
13	Reported prevalence of women with genital mutilation
14	Prevalence of infertility in women
15	Reported incidence of urethritis in men
16	Prevalence of HIV infection in pregnant women
17	Knowledge of HIV-related preventive practices

Glossary

Glossary for health planning

1. Benchmark: A standard, or point of reference, against which things can be compared, assessed, measured or judged. Benchmarking is the process of comparing performance against that of others in an effort to identify areas of improvement.

2. Capacity assessment: A structured and analytical process whereby the various dimensions of capacity are assessed within a broader context of systems, as well as evaluated for specific entities and individuals within these systems.

3. Capacity development: The process by which individuals, groups and organizations, institutions and countries develop, enhance and organize their systems, resources and knowledge; all reflected in their abilities, individually and collectively, to perform functions, solve problems and achieve objectives.

4. Civil society organizations: The multitude of associations around which society voluntarily organizes itself and which represent a wide range of interests and ties. These can include community-based organizations, indigenous peoples' organizations and nongovernment organizations.

5. Country assistance strategies/plans: A generic term for documents setting out the planned programme of assistance provided by a donor to a country, usually for a set period (often 3-4 years). They address how to achieve the MDGs. Produced usually in consultation with governments, business, civil society and others within the country.

6. Cumulative effects/impacts: Incremental impact of an action when added to other past, present or reasonably foreseeable actions regardless of what agency or person undertakes such actions. Cumulative impact can result from individually minor but collectively significant actions taking place over a period of time.

7. Decision makers: Policy-making, planning and decision-making systems vary and the meaning depends greatly on national or agency circumstances and procedures. A decision maker may be: i) an official responsible for broad-scale or sectoral development plans or ii) an elected Councilor or Minister. Within donor agencies, a decision maker may be i) the Head of bilateral assistance in HQ; ii) the country manager/director and iii) the sectoral team leader in the agency with overall responsibility for delivering the product deriving from use of the instrument in Box 4.1; or iv) development co-operation advisors in embassies, etc.

8. Development Policy Lending: A World Bank instrument focusing on issues such as governance, public sector management and reform of social sectors – such as health and education (see WB OP 8.60 and structural adjustment).

9. Direct Budget Support (DBS): Development agencies increasingly provide financial support to macro-level policies and to government budgets to assist the recipient through a programme of policy and institutional reform and implementation that promote growth and achieve sustainable reductions in poverty. The support may include a mix of general budget support and policy and institutional actions (including economy-wide reforms such as tax reforms, privatization, decentralization and trade liberalization).

10. Direct Budget Support Agreements are the formal DBS instruments negotiated between the development agency and recipient government.

11. Good governance: Governance is the exercise of political, economic and administrative authority necessary to manage a nation's affairs. Good governance is characterized by participation, transparency, accountability, rule of law, effectiveness, equity, etc.

12. Harmonisation: Of aid procedures aims to reduce unnecessary burden on recipient countries and enhancement of development effectiveness and efficiency of aid by reduction of transaction cost of aid procedures among donors and recipient countries. Many bilateral and multilateral donors have international discussions about harmonisation of aid procedures and are engaged in harmonisation work.

13. Indicator: A signal that reveals progress (or lack thereof) towards objectives, and provides a means of measuring what actually happens against what has been planned in terms of quantity, quality and timeliness.

14. Millennium Development Goals: Eight international development goals for 2015, adopted by the international community (UN Millennium Declaration, September 2000). The IMF, World Bank and OECD have endorsed the MDGs.

15. National Sustainable Development Strategies (NSDS): Called for in Agenda 21 and the Implementation Plan of the 2000 World Summit on Sustainable Development. The DAC defines NSDS as "a co-ordinated set of participatory and continuously improving processes of analysis, debate, capacity-strengthening, planning and investment which integrates the economic, social and environmental objectives of society, seeking trade-offs where this is not possible". Implementing an NSDS would most likely consist of using promising, existing processes (e.g. PRSP) as entry points, and strengthening them in terms of key NSDS principles in the DAC policy guidance).

16. National ownership: The effective exercise of a government's authority over development policies and activities, including those that rely – entirely or partially – on external resources. For governments, this means articulating the national development agenda and establishing authoritative policies and strategies. For donors, it means aligning their programmes on government policies and building on government systems and processes to manage and coordinate aid rather than creating parallel systems to meet donor requirements.

17. Policies, Plans and Programmes (PPP): Have different meanings in different countries according to the political and institutional context. Here these terms are used generically.

    Policies are broad statements of intent that reflect and focus the political agenda of a government and initiate a decision cycle.

    They are given substance and effect in *plans* and *programmes* (schemes or sets of usually linked actions designed to achieve a purpose). This involves identifying options to achieve policy objectives and setting out how, when and where specific actions will be conducted.

18. Policy Reform: A process in which changes are made to the formal "rules of the game"– including laws, regulations and institutions – to address a problem or achieve a goal Usually involves a complex political process, particularly when it is perceived that the reform redistributes economic, political, or social power.

19. Poverty Reductions Strategies/Papers: Prepared by a country government with the World Bank, International Monetary Fund and civil society and development partners. Describe the country's macroeconomic, structural and social policies and programmes over a three-year or longer horizon to promote broad-based growth and reduce poverty, as well as associated external financing needs and sources (www.imf.org/external/np/prsp/prsp.asp).

20. Sectoral strategy: A policy framework, for the long- and/ or medium-term, which has been adopted by a government as a plan of action for a particular area of the economy or society.

21. Sector Wide Approach (SWAps) (Or Sector investment programmes): All significant donor funding support a single, comprehensive sector policy and independent programme, consistent with a sound macro-economic framework, under government leadership. Donor support for a SWAp can take any form – project aid, technical assistance or budget support – although there should be a commitment to progressive reliance on government procedures to disburse and account for all funds as these procedures are strengthened.

22. Stakeholder: Those who may be interested in, potentially affected by, or influence the implementation of a PPP. In the context of an SEA applied to development co-operation, stakeholders may include: i) internal staff (environment and non-environment) in donor agency and other departments in the donor country, ii) the partner country government, iii) other donor agencies, iv) NGOs, and v) civil society.

23. Structural Adjustment Programmes: A World Bank instrument prevalent in the 1980s that focused on correcting the major macroeconomic distortions hindering development. Replaced by Development Policy Lending in 2004. Tiering: Addressing issues and impacts at appropriate decision-making levels (e.g. from the policy to project levels).

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