Chapter

2

Principles of District Planning

Illustrations

1. The planning model

The generic planning model that follows has eight stages:

1 – 2 Where are you now - **Here**? – Use a **situational analysis** of needs and resources to describe your present situation as it relates to eye health.

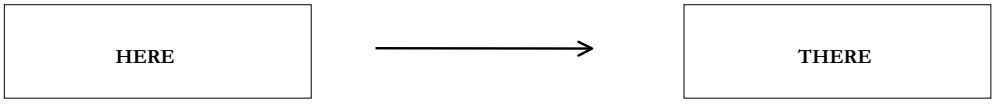
3 – 4 Where do you want to get to - **There**? – Set **aims and objectives** to help you fix targets.

5 – 6 How will you get there? – Decide on the route you will take with a clear **plan, timetable and budget**.

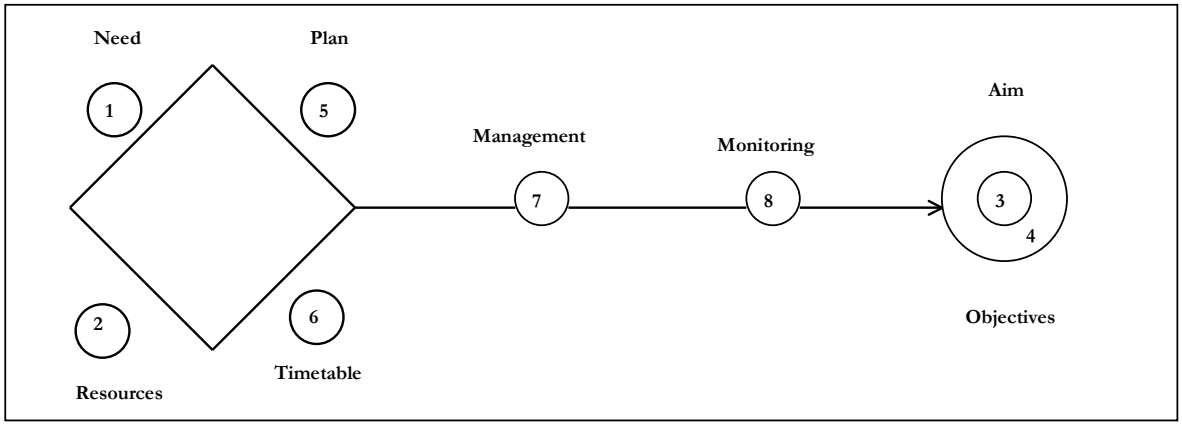
7 Start on the implementation of your plan, carefully **managing resources** – human and financial – to help you reach your targets.

8 How will you know when you arrive? – **Monitor your progress** to ensure the efficient and effective implementation of your district plan. Feedback may influence your targets and resource management. New problems will cause you to adjust your plan in the second year.

Fig. 2.1 The planning model



1 – 2 DECIDING WHERE YOU ARE	=	SITUATIONAL ANALYSIS OF NEEDS AND RESOURCES
3 – 4 DECIDING WHERE YOU WANT TO BE	=	AIM, PRIORITIES, OBJECTIVES
5 – 6 DECIDING HOW TO GET THERE	=	PLAN, TIMETABLE AND BUDGET
7 – 8 GETTING THERE	=	MANAGEMENT OF RESOURCES AND MONITORING



2. Assessing needs

The **NEED** is the gap between the present situation and where you want to reach.

A **NEEDS ASSESSMENT** will help you to define that need.

To define NEED, you should collect information on:

- **Population** – number, density, growth rate, gender, age structure, and distribution in relation to the local geography, cultural and religious norms
- **Population indices** – economic groups, socio-cultural variations, levels of literacy and health problems such as under-5 mortality rates, and measles coverage

This data may be obtained from a local or national census office, the planning unit of the ministries of health or education, or from internet sites giving national population data.

- **Eye diseases and blindness** – estimates of (1) the prevalence and incidence of blindness and low vision in the district based on appropriate levels of visual acuity; (2) the main causes of preventable/treatable blindness and their magnitude.

This data may be available through (1) population-based blindness surveys (best option); (2) rapid assessment techniques used for example in cataract, trachoma and onchocerciasis programmes; (3) extrapolation from disease patterns measured elsewhere but in a similar environment; (4) estimation of magnitude from a reference table or a world blindness prevalence map (the least desirable option).

Detailed maps of the area will be needed.

It is important that all the data collected and generated to help define the need is taken into account.

In brief - it is necessary to identify **the size of the problem, the people most affected and their location.**

3. Assessing resources

RESOURCES are the **personnel, infrastructure and funds** available to tackle the need that has been identified. Questions that should be answered in your assessment include:

- What are the past and present **eye care services** and their **outputs** in the district?
  Collect data related to activities for the prevention and control of blindness over the last five years. Examples will include annual unit totals for: admissions, outpatients, cataract operations, cataract surgeons, IOL implants, surgical outcomes, spectacle provision, and low-vision care. Further data will relate to other key diseases such as trachoma or onchocerciasis. Indicators such as cataract surgical rate (showing output) and cataract surgical coverage (indicating effectiveness) should be calculated. Operations per surgeon, per eye unit and per bed will help to measure the efficiency of the eye care service in the district.
- How developed and functional are the **outreach services**? What are the barriers to access? Do screening and referral outputs meet intended targets?
- What **human** resources in different service categories are available at primary, secondary and tertiary levels of care? How does this compare with WHO recommendations? Are there problems of distribution, recruitment, career structure and retention? What training facilities exist for each category of worker?
- What is the involvement of the **community** in district health care – with regard to planning and implementation? How is this encouraged? What training and support are available? What constraints hinder social mobilisation?

- What **infrastructure** – buildings, equipment and consumables – serves this district? How dependable is it in terms of availability and condition? What is the shortfall in relation to recommendations? Is there wastage with regard to the recommended norms for usage? Are there seasonal variations? What provision exists for standardisation, bulk purchasing, the use of appropriate technology and for repair and maintenance?
- What are the responsibilities of each group in the existing **management system?** How does this system determine and implement policy, particularly with regard to resource utilisation? What data is collected and how is it communicated? What emphasis is placed on increasing output while ensuring quality of outcome?
- What **constraints** are there on optimum resource use and service delivery? Consider human resources, infrastructure and management in your assessment of constraints. How can they be overcome?
- What provision is made in the district **budget** for eye care and blindness prevention? Is the eye care programme integrated horizontally into district health services? What other sources of funding are available?

A review by the **district planning committee** of the surveyed 'Needs and Resources' completes the **SITUATION ANALYSIS** for your district. Constraints and possible solutions should be considered at the review meeting in preparation for agreeing **aims, objectives and strategies** for the **DISTRICT VISION 2020 PLAN**. The underlying purpose of the review is to optimize the use of existing resources and to plan for their development through cost-effective procedures.

District involvement in this discussion should bring **local ownership** to the outcomes and also ensure that the eventual plan is tailored to the district's specific needs.

The review meeting will:

1. agree a **norm for the average workload** for each category of worker for each disease intervention, dividing the available human resources by the estimated magnitude of blindness;
2. estimate the **average output per eye care staff member** per disease intervention, noting underachievement levels, contributory constraints, and proposing remedies;
3. analyse variations, both across the district and month by month, to establish **patterns of resource use** and suggest ways of promoting greater efficiency;
4. calculate and evaluate the present and required **output for facilities and equipment** against present workload, indicating shortfalls, noting constraints and proposing remedies.

Annual questionnaires should be administered to update the assessment of human resources, infrastructure and equipment, and to update the indicators of service productivity and resource usage, noting changes in constraints.

For both human resources and infrastructure, this review will highlight the objectives needed in the **District Plan** - to increase output while securing quality of outcomes, giving priority as necessary to resource expansion and improved efficiency in usage. Seasonal variation as well as inconsistencies across the district will also guide the findings and decisions of this review.

4. Defining the aim

The **AIM** for the district programme will help you to define where you want to be. The aim and objectives should be agreed by all parties on the planning committee at the start. It should be expected that this process will evolve. Wider experience and contact with the problems in the field will bring changing insights and require planning revision during the implementation of the programme.

All parties involved in health care should contribute to the design of the district VISION 2020 programme. These will include: - Health care workers – government, private and NGO
Local administrators
School teachers
Local volunteers

As well as securing an agreed programme, this team concept will help to give ownership, avoid duplication, increase efficiency, and therefore optimise the use of scarce resources.

The **Planning** process should recognise the need to:

- work to **national guidelines** as set out in the **National VISION 2020 5-Year Plan**
- appreciate the **resource limitations** shown by your situation analysis and be realistic in ambition, prioritizing one need at a time and the easiest first
- select disease and location **priorities** carefully, heeding the distribution of need, the availability of resources, and the advantage of securing early positive community reactions to the benefit of the ongoing programme. The key component here is the **bridging strategy** linking the communities in need to the hospital clinical services – concentrating on what can be achieved with a particular disease intervention in an accessible part of the district, rather than setting objectives that will require substantial additional resources. Later amendments can spread the programme to include other areas and diseases.

In addition to the VISION 2020 components necessary to achieve cost-effective disease interventions (as shown in Fig. 1.1), there are four broad themes that should be central to the design of your district programme. These can be summarized as **I SEE – Integrated, Sustainable, Equitable and Excellent.**

- The VISION 2020 approach to community eye care should be **integrated** into district health care services – characterised by wide access, community participation and health promotion.
- Eye care services should be long term and **sustainable** with regard both to financial and personnel resources and to the assurance of continuing demand. External help may be needed to secure this goal in poorer areas.
- Services should be **equitable** – available to both genders and across all of society – not just the better off or those in urban areas - but difficult to achieve with an uneven distribution of resources.
- Care, clinical and non-clinical, should be **excellent** for all to ensure that trust is created, community support is fostered and patients use the services.

The district programme, working to the above guidelines, should combine strategies to achieve **comprehensive eye care**, demonstrating the four components, given on page 3:

- **Promotion of eye health**
- **Prevention of eye disease**
- **Curative intervention**
- **Rehabilitation**

The process of constructing the **district programme** at the planning meeting is summarised in Fig. 2.2. The steps are to:

1. Decide the **objectives** – that should be specific, measurable, achievable, realistic, and time-bound.
2. Define the **priorities** in the context of need and present resources.
3. Agree prioritised **strategies** with set targets that can be monitored to show progress with the objectives.
4. Define the action plan of **activities** and linked sub-activities.

Fig. 2.2 Building the district action plan from the situation analysis (pages 8-11)

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A Gantt Chart is a table of project tasks with a bar chart graphically showing the project schedule, depicting progress through time and enabling both tracking and planning to be maintained (see Appendix AP8.)

5. Specifying objectives

OBJECTIVES for the district VISION 2020 programme are designed to overcome constraints that have been identified in the situation analysis. These **objectives**:

- may relate to **human resource development, infrastructure development and disease control interventions** selected from the five VISION 2020 targeted causes of blindness
- will be achieved through broad activities and narrower sub-activities forming a **strategy** to implement the change
- will be directed at precise **targets**, that have a given completion date and that are measurable as monitoring indicators
- are **realistic** in the time frame and in the wider resource environment.

6. Defining priorities and strategies

Selection of **objectives** and **strategies** may have to be selective in identifying the constraints to be tackled in the early stages of the programme. **PRIORITIES** will have to be agreed by the planning committee and will be guided by such variables as:

- size of health impact in relation to resource demand
- visibility of improved service to enhance public support and patient uptake
- long term service sustainability with regard to people and funds, involving inbuilt planning for cost-saving, income generation and optimisation of resource usage
- degree of community participation
- clear integration of manageable monitoring and evaluation procedures
- emphasis on the improvement of management skills
- ease of integration with the primary health care system (see Table 2.1).

Primary health care (PHC), as formulated by the Alma-Ata Declaration (Sept. 1978) and endorsed by WHO, is a multi-sectored approach to improving health. The close links between primary eye care and PHC can be seen from the list of the main PHC activities shown in the Table 2.1.

Table 2.1 Integration of primary eye care into primary health care

Primary health care	Primary eye care
1. Immunisation	Measles vaccination prevents blindness from measles; rubella vaccination prevents congenital rubella syndrome
2. Better nutrition	Prevents vitamin A deficiency
3. Water and sanitation programmes	Relevant in trachoma control
4. Control of common diseases	Trachoma and onchocerciasis control
5. Delivery of maternal and child health care	Reduce retinopathy of prematurity
6. Health education	Prevention of eye trauma
7. Simple treatment	Treatment of simple eye diseases
8. Essential drugs supply	Availability of tetracycline eye ointment for trachoma and common eye infections; vitamin A capsules for xerophthalmia, ivermectin for onchocerciasis

Primary health care workers are ideally placed to identify blind and visually impaired people in the community. With additional training they can diagnose and refer patients to the appropriate eye care workers and provide basic treatment for simple eye diseases.

A STRATEGY is the total of all the clearly defined **activities** (and sub-activities) needed to achieve an objective. Activities will have clearly defined individual **targets** that indicate progress under the action plan. Strategies too may have to be prioritised. The activities in each strategy will have:

- a sharply defined time schedule
- responsibilities clearly and considerately assigned to identified individuals or post holders
- an even distribution of tasks in the set time, frequently consecutive, rather than overlapping
- training programmes included
- a realistic and pragmatic expectation of resource consumption – a costing
- reliable indicators to monitor achievement and enable an evaluation of the programme

7. Preparing a timetable

The agreed programme to implement the district plan will bring together activities, responsibilities, time schedules, and budget. The timetable can be set out in a Gantt chart (see Appendix Ap8), or, more comprehensively, in detailed action plans (as exemplified in Table 2.2). Experience during implementation will lead this programme to be reviewed and updated on a regular basis. Regular team meetings will lead to better planning.

Table 2.2 Action planning for VISION 2020 at the district level – an example

VISION 2020 ITEM (EXAMPLES)	PRESENT SITUATION TO BE CHANGED	OBJECTIVES TO REACH DESIRED TARGETS	ACTIONS + PERSONS + TARGET DATES	INPUTS – BUDGET NEED + SOURCE	OUTPUT INDICATORS TO MONITOR
Cataract Case Finding					
Cataract Surgery Output					
Cataract Surgery Outcome					
Cataract Surgery Cost					

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8. Preparing a budget

The district programme, integrated within the district PHC service, needs to be accompanied by a carefully planned budget.

EXPENDITURE

1. **Capital** (one off)

   Buildings

   Vehicles

   Equipment (may be externally sourced and therefore not within the local accounting system)

2. **Running** (repeating)

   Salaries (incentives may be difficult to assess)

   Consumables (difficult to assess as most are donations)

   Overheads (including maintenance and repair)

Note

- Consider **all** costs – information on uses of locally generated income can be difficult to research.
- Estimate the amount if an exact figure is not available.
- Running costs should be calculated for a year.
- A 5-10% contingency can be added.

SOURCES OF INCOME – some are not always applicable

- **Service fees**
- **Sales, for example from the optical workshop and the pharmacy**
- **Government, including salaries**
- **Local support**
- **International donors, including donations**

Note

- The goal of financial sustainability requires income to balance or exceed expenditure (see SUSTAINABILITY below).
- Fees should be set at a level that encourages uptake and does not impact negatively on equity.
- Salaries are normally the major expenditure.
- Attempts at cost reduction should always accompany the search for new income generation.
- Government support may be more sustainable than NGO finance.

SUSTAINABILITY

Sustainability can be achieved in a number of ways:

1. **Cost-recovery**, including improved management training and accountability – this may be difficult where the service has been historically free.
2. **Improved service marketing and quality of outcomes**, producing increased awareness and demand.
3. **Team ethos** acquired through a shared acceptance of the need for financial sustainability.

9. Establishing a management structure

This is the first stage in the **IMPLEMENTATION** of the VISION 2020 district programme. The key role of an adopted management structure is to bring together in one place the professional eye care workers, the resources and the community in order to implement the agreed programme.

There are two main questions:

(1). Who will manage the programme?

(2). How will this be done?

(1) **Management personnel**

- A **Management Committee** (the District VISION 2020 Committee) representing the district and the eye health team
- A **Medical Director** and an **Administrator** in the focal hospital with clear job descriptions and appropriate skills - forming an **Executive Committee** that may co-opt other senior staff, for example an experienced MLOP and/or ON.

(2) **Management activities**

- The **Management Committee**, a group of voluntary, community representatives sitting with service professionals in regular meetings, will have agreed responsibilities: making hospital appointments, agreeing budgets, agreeing systems of incentives, receiving reports, and supporting the executive committee.
- The **Executive Committee**, meeting weekly**,** comprising senior hospital employees, will have day to day responsibility for implementing the programme. Its roles will include:
  - **Initiation and realisation of planned programme activities** in accordance with the agreed timetable, supported by resource allocation, the monitoring of progress and the taking of remedial action where targets are being missed. An estimate of realistic individual workloads, knowledge of patterns of present resource use, availability and potential capacity, and a clear appreciation of optimal service standards and targets will be necessary at the start to make this successful.
  - **Regular workshops/meetings** with the whole medical team to discuss tasks and responsibilities and to develop effective lines of communication. Focussed discussion will promote team support for the optimal use of resources, cost containment measures and the creation of community demand through quality of care.
  - **Managing people** – through (1) **encouraging job satisfaction** (clear job descriptions, appropriate skills for the job); (2) **promoting motivation** (consulting staff, shared planning, giving feedback and providing incentives); (3) **enabling participation** on small action-oriented committees, for example to focus on staff concerns, analysis of statistics or patient satisfaction.
  - **Training activities** – on site or through external courses – to fill skill gaps, update existing skills and share experiences with district programme staff elsewhere. Activities will focus in part on community-oriented activities to foster the participation and support of the whole community.
  - **Managing money** – by monthly recording of income against expenditure.
  - **Reporting progress** to District and National VISION 2020 Committees and to funding bodies. An annual report (showing output against targets, human resources, infrastructure and expenditure) will be prepared. It will include targets planned for the next year and the resource implications.
  - **Developing a management information system (MIS)** to facilitate monitoring and evaluation.

- **Securing timely access to consumable supplies.**
- **Promoting demand** through social marketing by ensuring that eye care services are (1) **available** to patients, with respect to distance; (2) **accessible**, regarding transport and opening times; (3) **affordable**; (4) **acceptable** in terms of quality of care and outcomes. It is also necessary to support health promotion campaigns to encourage positive perceptions regarding eye disease treatment and the services available. The strategies adopted will form part of the VISION 2020 district programme and be set out in the plan.

10. Monitoring progress – 'to measure is to know'

The main purposes of **MONITORING AND EVALUATION** of the VISION 2020 district action plan:-

1. To help all stakeholders **track progress** towards the agreed objectives and enable adjustments to be made in the implementation of the programme
2. To motivate staff with **performance feedback**
3. To provide evidence of need for **fund raising**
4. To **raise awareness** in other districts (and other countries) of the successes achieved and problems experienced in a specific district plan.

For the effective monitoring of trends and progress towards the achievement of the agreed objectives, it is necessary to have a set of clear **indicators** – these may need to be monthly, quarterly or annually – whatever is advisable and practical. The setting up of a reliable MIS from the outset will enable a base line to be established and the impact of later interventions to be measured. It is therefore essential that a Monitoring and Evaluation system is agreed and operational from the start of the district programme implementation. Great care should be taken that selected indicators are:

- **valid** – measuring what is intended to be measured;
- **reliable** – even when used by different people at different times;
- **sensitive** – react to changes in the situation or target being measured;
- **specific** – reflect the changes only in the situation or target concerned.

As VISION 2020 targets the reduction and eventual elimination of avoidable blindness, monitoring indicators should focus on:

- the impact on the **burden of blindness** (overall and disease specific) and visual impairment
- performance in prevention and treatment with respect to individual **disease control**
- **human resource development** with respect to the availability of technical skills
- development of the **eye health system** with respect to provision, resources and management.

All records made should be used.

Monitoring will enable the management team to decide whether:

- **objectives and targets are realistic**
- **strategies are effective and efficient**
- **the programme is well managed**

The role of monitoring and evaluation is exemplified in Fig. 2.3.

Fig. 2.3 Example of the planning cycle – school eye screening

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As you begin to plan, there will be a number of assumptions. Planning is a continuously evolving process – as implementation takes place, you learn more about the situation, gain a fuller insight and therefore through evaluating past practices you are able to adjust and improve your planning, strategies and targets.

In any school, the number of spectacles provided for a screening programme may be initially small. As refraction tests proceed, the number of spectacles needed increases and with it the cost of the intervention. This may be resolved through increasing the number of donors of spectacles or by requesting parents to pay (part of) the cost. Subsequent procedures with later peer groups or with children in other schools will be better prepared to expect this resource need to achieve the desired outcomes.

In this example, teachers maintain records of children referred for refraction, those who are wearing spectacles and children's school performance before and after referral. These indicators enable (1) progress to be tracked in reducing one cause of blindness which affects learning and (2) the assessment of procedures for controlling and reversing sight impairment caused by refractive error. Regular monitoring may reveal inconsistent results against an expected norm. Questions can then be asked and procedures can be improved.

Routine internal/external **monitoring of outcomes enables an evaluation of objectives and strategy.** This supports the underlying purpose of approaching the targets of your planning process, maximising the patient number while securing optimal resource usage and outcomes.

The three **case studies** that follow highlight the strategies adopted to optimise VISION 2020 district level eye care in very different regions.