# District team problem solving guidelines for maternal and child health, family planning and other public health services

## Preface

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

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

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

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

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

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

(* report available on request)

This guideline is written in an effort to share the accumulated experience from these applications and to encourage other countries to engage in action management learning-by-doing through district team problem-solving. Section 2 of this guideline presents the DTPS and its implementation and would be of first interest to decision-makers. Section 3 provides guidance on the steps to follow for organizers of DTPS workshops. Section 4 deals with practical aspects of DTPS workshops and their actual conduct and is of prime interest to both organizers and facilitators.

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

## 1. PURPOSE OF THE GUIDELINES

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

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

The guidelines describe:

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

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

## 2. WHAT IS DISTRICT TEAM PROBLEM-SOLVING?

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

- conducting their own analysis of one high priority public health problem, for example in MCH or FP in their district
- devising and then implementing their own solution to this problem over a one-year period
- conducting and presenting the results of their own evaluation of their implementation (progress, constraints, service improvements, and health impact)
- developing the ability to gather and use data
- developing good team-work and improved managerial skills.

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

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

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

Teams learn a "bottom line" approach. Their efforts are focused on health outcomes or end-results with the aim of achieving a better health status of the population. They plan to improve the delivery and utilization of the critical services that will produce this. The "problem" they analyze and attack is some unacceptable MCH/FP (or other public health) condition that is important to the Ministry of Health (MOH), to the district team, and the community. Their challenge is to reduce this specific health problem over a relatively short period of time.

As part of the DTPS process, teams will:

- systematically analyze a problem
- identify principal causes and locally feasible solutions within the national policy and programme framework
- plan and put into operation the team's implementation activities within a realistic time frame
- decide how they will monitor and evaluate both their efforts to implement and the success of their envisioned solution
- present all this clearly and briefly within a coherent action plan (or team project proposal)
- learn to listen to and to use all members during the one-year DTPS period, thus to function as a real team (often for

the first time), and to develop team spirit.

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

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

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

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

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

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

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

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

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

- A sizeable group of individuals (5-7) from each district are trained together. They continue as a team that has learned to work together, a mutual support group. Usually, they are emotionally involved in their commonly designed plan. In contrast, individual trainees returning to the workplace after normal management training frequently find that colleagues and superiors do not understand their new language or concepts, and do not appreciate or encourage the changes they may try to initiate. The isolated trainee usually lacks the confidence to convince uninitiated colleagues, or the spirit to undertake the difficult task of changing health service routines.
- A feasible solution to a real problem, with a detailed workplan document, is in hand, ready for implementation by the end of the planning workshop. Trainees in conventional management courses commonly learn "useful" management techniques by applying them to hypothetical, simplified problems, or to problems in other health services. However, they usually experience difficulty, upon return, in actually applying these techniques to the complex problems of their own services. Typically, they do not find enough time and support to make effective use of the management techniques they have learned.
- Before the planning workshop is over, central decision-makers and regional support staff actively listen to, discuss, and approve each district team's problem analysis and solution proposal. Trainees of conventional management courses often doubt that their superiors, including mid-level supervisors, understand their view of the problem or the changes they would like to undertake. They are, therefore, unsure of support, and fearful of misunderstanding and opposition. Proposals developed are often left awaiting future review.
- At the outset, teams know that they must present their own evaluation of their effort in about a year at an evaluation workshop. This further motivates each team to sustain action and to monitor its results. Most management training efforts lack such a follow-up mechanism or any evaluation of actual health improvements achieved.

### 2.3 Who participates in DTPS?

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

The district medical (or health) officer and the chief district nursing officer should always be included. The choice of other

team participants should be made by the district medical officer in consultation with provincial and central officials supporting the DTPS exercise.

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

### 2.4 Who facilitates DTPS and what is their role?

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

- managers and central level staff of national health programmes, where relevant, e.g. director of family health services, manager of the expanded programme on immunization, etc.
- regional or provincial health personnel
- health personnel with special, relevant expertise, e.g. statistician, epidemiologist, nutritionist, demographer, experts in clinical fields, etc., as needed
- staff of relevant training institutions, e.g. public health Institute, national training centre, community medicine faculty of a collaborating university, etc.
- staff of support agencies (e.g. WHO, UNFPA and UNICEF)

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

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

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

### 2.5 What kinds of problems can be addressed through DTPS?

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

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

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

### 2.6 How is implementation achieved and facilitated?

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

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

difference in services and health status.

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

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

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

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

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

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

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

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

## 3. HOW TO SET UP A DTPS PROCESS THAT WORKS

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

- are initially challenged by high-level Ministry of Health (MOH) superiors to devise ways to ameliorate one public health problem in the population for which they are responsible; to present 9-10 days later their proposed solutions to the MOH decision-makers in an effort to obtain approval to go ahead with their planned activities; to proceed to implement their action plans, if given the "go-ahead"; then, 10-12 months later, to present their own evaluation of their results to the same officials.
- are driven hard to accomplish pre-specified team tasks, generating products on paper using specific, simple formats, all in limited periods of time.
- are assisted by central, regional and sometimes by external facilitators. Facilitators must spend most of their time listening, continuously resisting the temptation to take over. They must avoid interventions, however well intentioned, that will deprive the team members of a sense of ownership of the defined problem and of the solution.
- are obliged to work through their tasks together interactively (with only the most minimal guidance from facilitators) which usually leads to the development of good morale, group functioning, communication, and coordination (i.e., team-work).
- receive almost no lectures or didactic instruction, but learn through doing what is required.
- produce creditable solution proposals, in the form of typed action plan documents which they present and defend on the last day of the planning workshop.
- devise their solution strategies assuming that no additional resources are available and thereby develop the capacity to make better use of existing resources.
- actively explore the potential for intersectoral and community collaboration, and the particular functions that need to be integrated within government services, wherever these are found to be necessary to improve the public health

problem being analyzed.

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

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

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

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

- selecting, in consultation with other health officials, the four districts to participate in DTPS
- either selecting/approving the priority health problem to be assigned to each district, or providing criteria for selection of these problems in the districts
- guiding the selection of district team members
- appointing a staff member to be in charge of coordinating DTPS and bringing together a group of appropriate facilitators
- attending the opening of the planning workshop to challenge teams with the assignment to develop solutions within available district resources for a specific health problem, and then on the last day, listening to the presentation of team proposals in order to approve their implementation
- attending one or two of the three days of the evaluation workshop to listen to and discuss each team's evaluation of its results.

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

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

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

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

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

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

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

- senior programme managers drawn from the programmes associated with the problems being addressed (e.g. from MCH, FP, immunization, nutrition, etc.)
- trainers from an institution that may become responsible for the subsequent application of DTPS on a continuing basis - an institute or faculty of public health, a department of a medical school, etc.
- staff already experienced in the planning and conduct of DTPS; these may be staff from neighbouring countries, WHO staff, or consultants who have applied the process before.

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

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

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

### 3.3 Step 3: Select districts and teams

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

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

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

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

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

### 3.4 Step 4: Select important district health problems

The public health problems selected should be those that are known to be particularly important in the district to which they are assigned. They may be diseases which are excessively prevalent or virulent, or about which there have been public or political complaints. In one country, for example, these turned out to be high maternal mortality in one district, close mean birth intervals in a second, high immunization drop-out in a third, and poor nutrition status of children aged under five years in the fourth. In another country, the same problem (maternal mortality) was assigned to all the district teams.

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

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

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

It is notable that in the past, where the initial problems were selected by central Ministry authorities, all the district teams ultimately agreed that the problem assigned to them was of high priority. Generally, however, the teams found it necessary to redefine, within the broad problem assigned, a particular, more limited aspect which the team felt was both important

and which it could influence using its limited resources and time available. For example, one district was assigned by the DGHS the broad problem of "poor management of high-risk pregnancies". However, the team finally defined its project objective as "to reduce maternal deaths due to post-partum haemorrhage".

The alternatives for selection of district health problems are:

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

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

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

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

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

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

- Planning workshop - 9-10 consecutive days during which all teams work in one location to analyze their problem (including some field data collection), design a solution, and plan its implementation and evaluation. A proposal is prepared and presented to decision-makers for approval.
- Implementation period - about one year (10-12 months) in which all teams are functioning within their services while implementing their planned solution. Towards the end of this period the teams will conduct the evaluation of their solution according to the evaluation framework they prepared in the planning workshop.
- Evaluation workshop - 3 days during which decision-makers and all the teams hear the results of each team's evaluation. Sometimes the next phase of implementation is prepared at this workshop.

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

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

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

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

### 3.6 In summary

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

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

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

at the district level:

- DTPS must be supported by a high-level champion in the MOH. Once the approach is adopted various roles must be performed by provincial and district authorities as well as by involved training institutions.
- The MOH should identify an appropriate training institution to provide facilitation for DTPS implementation and to assist in the development of a core group of facilitators.
- The DTPS coordinator and the core group of facilitators should receive an in-depth briefing in the theory and practice of DTPS, with a thorough review of the process of DTPS, its learning methods and content. However, real understanding of the methodology by facilitators is achieved only after active participation in DTPS application.
- As soon as problems and teams have been selected, team members should be briefed on DTPS, provided with guidance materials, and helped to gather available documents and information on the selected problems before coming to the workshop. The availability at the beginning of routinely collected information is very important for team progress in the planning workshop.

# 4. HOW TO CONDUCT EACH PHASE OF DTPS

Effective use of DTPS to improve management of an ongoing health services system requires different kinds of efforts over the five phases, or periods, shown in Figures 1a and 1b. There are the three core periods of the DTPS process during which the teams plan, implement and then evaluate their solution. These are preceded by an initial setting-up period in which the central MOH must make preparations for the DTPS process. Finally, during follow-up, the MOH determines whether and how DTPS will be extended and institutionalized in the health services system.

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

- Phase 1. Setting-up period (about 1-2 months), in which the MOH makes preparations to assure that the prerequisites for successful application of DTPS (see section 3) are in place.
- Phase 2. The planning workshop (9-11 days) in which selected district personnel come together as a team by preparing an action plan for their solution to a priority health problem (see section 4.1, 4.2 and Annex 1).
- Phase 3. Implementation (10-12 months) by the team of its action plan in its district plus its monitoring and evaluation of this effort (see section 4.3).
- Phase 4. The evaluation workshop (3 days) at which the district team presents its own assessment of its progress and success in dealing with its problem, and its evaluation of the relevance of the DTPS process for improving management at district level (see sections 4.4 and 4.5, and Annex 2).
- Phase 5. Assessment of and follow-up by the Ministry of Health on the experience, skills, progress, team morale and methods generated by completion of the one-year cycle of the DTPS process (see section 4.6).

## 4.1 Preparing for the planning workshop

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

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

The planning workshop guides groups of district health workers to function as teams while they systematically work their way through the steps needed to develop their own feasible and effective solutions to real health problems. To achieve this, each team completes a series of carefully sequenced and pre-specified tasks, which are introduced and clarified by facilitators. The teams are informed clearly about what they must do and produce in each session, and are shown examples of successful products. It is necessary to clearly state the objectives of the workshop (planning phase). An example of objectives for the planning phase is shown in Figure 2. The sessions, tasks, and major products of the planning workshop are sequenced as shown in Figure 3.

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

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

#### 4.1.2 The structure of a typical workshop session:

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

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

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

#### 4.1.3 Workshop syllabus and session guide

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

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

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

Planning Workshop syllabus contents

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