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INDEXED

WORKING GUIDELINES FOR
 COUNTRY HEALTH PROGRAMMING



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1. Purpose and definition of Country Health Programming

Country Health Programming (CHP) is a management process for the use of Member countries of WHO in achieving the social target set by the World Health Assembly in 1977 - "health for all by the year 2000", that is, the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.¹ As stated in the Declaration of Alma-Ata, "Primary health care is the key to attaining this target as part of development in the spirit of social justice". The joint UNICEF/WHO report to the Alma-Ata Conference on Primary Health Care in 1978 stressed the importance of country health programming in planning for primary health care:

" Planning for primary health care has to be carried out in communities as well as at intermediate and at central levels. The ministry of health or its equivalent is responsible for formulating national health policy, including primary health care policy, and the for promoting its adoption by the government. Such policies are more likely to be effective if they form part of overall development policies, thus reflecting the social and economic goals of the government. Strategies have to be devised to translate policies into practice; a useful process for this purpose has come to be known as country health programming which consists essentially of assessing the country's health problems in their socioeconomic context, identifying areas susceptible to change and formulating priority programmes to induce such change.² "

CHP offers a managerially sound yet pragmatic approach to the national health planning and programming process. As a method, first and foremost, CHP is a thinking tool for making various choices: choices regarding the policies, the priorities, the possible strategies, the appropriate technologies and resources. CHP is much more than a methodology; it is a continuing process for national planning, programming and management of the implementation. It includes:

- policy formulation and definition of priorities;
- the preparation of programmes to give effect to these priorities;
- the selective identification of relevant technologies and the managerial support required;
- the preferential allocation of budgets, and
- the integration of the different programmes within the overall health system.

It also makes provision for monitoring and evaluation of operations and of their impact with a view to improving existing plans or preparing new ones as required, as part of a continuing cycle.

¹ Resolution WHA30.43, WHO Handbook of resolutions and decisions, vol. II, 3rd ed., 1979, p. 3

² Primary Health Care, Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Geneva, WHO, 1978, p. 54.

2. The policy implications of CHP

Policy is the statement of general principles against which an organization carries out its planning and action. Most constitutions define the obligation of the government towards the health of the people. More specific policy statements amplify the general statement of the constitution. Specific policies, either formal or informal, provide a set of guiding principles within which a country's health system operates. A national health policy is an expression of goals for improving the health situation, the priorities among these goals and the main direction for attaining them. A satisfactory health programme can hardly be produced in a political vacuum or in the absence of government policy directives. In this connexion, it is imperative to ensure that there is adequate consideration of policy matters at every stage and step of CHP.

Generally there are two important implications of policy - technical and political. If the CHP process cannot incorporate both of these aspects, it will run a serious risk of failure, evidenced by non-participation of the policy-makers in the planning process, rejection of the CHP product, or non-compliance with any revision or technical innovation derived from the programming and pre-implementation stages. More seriously, the whole CHP process can be easily treated as a mere intellectual exercise and its product completely ignored by the policy and decision-makers. It might be wise, therefore, to maintain the viability of the CHP process by carefully verifying all policy elements and promoting them throughout the formulation and implementation stages. Once the policy-level decide to initiate a particular policy, it would be worth while to examine, by using CHP, the implications of implementing each alternative being considered, so as to ascertain whether the policy would be carried through and what might be the degree of impact. In this way, CHP may become one of the country's mechanisms for generating health policy, by promoting continual interchange between the technical planning and policy formulation processes.

It is also important that once the plan is developed, the same principles that guide CHP should be used in, or at least communicated to, the other agencies such as the budget bureau of the finance ministry, economic and development board and other agencies concerned. Seeking the advice of the budget bureau staff right from the beginning, is essential. That a policy has been put into effect should be measurable in visible changes produced in the formal budget and resource allocation.

3. The basic principles of CHP

Both the CHP working procedures and the working arrangements suggested for undertaking them are derived from a set of basic principles which are outlined below:

3.1 The broad base participation

The fact that health status is influenced by various social, economic, demographic and cultural factors, implies that for many of the health programmes to be undertaken it may be necessary to act simultaneously at different intervention levels and in several sectors. As a programme implies a series of interrelated actions aimed at attaining defined objectives, the interventions in some health areas have to be programmed within and outside the usual boundaries of the health administration so as to include other sectors as necessary. Hence, the working arrangements of CHP place much emphasis on participation. Depending on the country, several types of participation may be advocated: multidisciplinary participation, because of the interdependence of various health disciplines; multisectoral participation, because of the complementary relationship of the health and related sectors; the participation of different levels, that is from policy-making to the executing level; and the participation of various interest groups - the community, consumer representatives and the health professions, because of their various commitments and interests in health.

3.2 "Management by objectives"

This concept provides the methodological base for both programme formulation and implementation. Accordingly, a programme must be tailored towards achieving explicit objectives. The logic which permeates the CHP procedures is, therefore, that objectives must determine the choice of strategies and of programme activities, and the latter should determine the choice of material and human resources. When setting objectives and defining the programme's purpose, account is taken not only of the available epidemiological, social and health system data, but also the country's overall long-term goals as expressed in its development policies as well as in its social and health policies. Obviously, health programmes must be consonant with the country's general policies and must in principle be part of its socio-economic development plan.

3.3 The scope of the programme

CHP working procedures focus on the development of programmes in priority areas. Where a commitment exists to the social target of "Health for all by the year 2000", CHP will lead to the identification of the priority areas that must be developed for this target to be achieved. In different national situations, problem areas will be defined in different terms. In some the focus may be on particular target population groups or geographical areas that heretofore have been deprived of organized health care; in others, it may be on particular components of primary health care that have not been adequately developed; and in still others, it may focus on the reorientation of the health system required before the primary health care approach can be implemented.

In the past, in some situations, the scope of programme formulation has been confined to only one aspect of the many priority problems that face national governments, e.g. vertical programmes like malaria control or family planning programmes of national scope. In the future, with the growing focus on the global commitment to "health for all", the scope of CHP will by definition encompass all national health goals within a long-term perspective. This general frame, labelled "the master plan" is what Stage Two of the present CHP guidelines aims at producing. The master plan will indicate the priority sequence for working out programme entities as part of a common policy and strategy framework. It may, for example, indicate in which parts of the country attention will initially be focussed, what efforts will be undertaken to strengthen the support to be provided to primary health care, what manpower development programmes will be undertaken to meet the manpower requirements at the different levels of the health system, what mechanisms will be established to reinforce intersectoral cooperation, etc.

3.4 Repetitive sketching

The use of step-by-step guidelines implies a linear logic along which the group and subgroup discussions will be conducted. The outputs of one step will be needed to start the following steps. Nevertheless, in reality the work is "back-and-forth". For instance, a recommendation made during an early stage can be challenged during the later steps, and amended accordingly. Such back-and-forth adjustments are often necessary.

3.5 CHP as a continuing process

Repetitive sketching of various programmes also occurs over time, and each sketch is brought into sharper focus as implementation proceeds. While the long-term master plan specifies the broad areas of activities for the years ahead, increasingly detailed plans of action are drafted for the implementation of programmes timed for the near future. An even closer look is taken for specifying the activity schedule, budget, etc., for the annual or biennial period about to start. A widely held view is that, while long-term plans are determined at the country's policy making level, short-term plans are elaborated in more detail by those responsible for execution, including those

at the peripheral levels. While it is true that detailed plans of action must be in consonance with the master plan, it is also true that the programmes elaborated in some detail, and even more so, the experience of their implementation - their evaluation - are of help in updating the master plan.

3.6 Feasibility of the programme

The identification of constraints in and obstacles to carrying out the programme activities is recommended at Stage 3 of the present working guidelines. Nevertheless, the notion of feasibility must permeate all phases of the process, including the initial setting of priorities and definition of policies and strategies. Constraint analysis is undertaken with the aim of identifying the administrative and managerial support requirements of the programme and recommending the necessary developments in the organizational structure.

4. Organization of programme formulation

4.1 Practical arrangements

The usual starting point for CHP could be a government decision to assign a core group to the task of formulating national health programmes. In many countries the existing legislation provides for this type of planning focus. The group should be composed of about 15 individuals who have easy access to policy making levels, access to depositories of information and knowledge and contacts with various ministries, community and other interest groups. Although they may, as a team, be considered a multidisciplinary group, their essential role is to coordinate the work among various elements consulted every day, lead the discussions and record the conclusions and the recommendations.

There is no prerequisite to undertaking the health programme formulation work. The preparation of the necessary data is undertaken with a view to using information that is already available. Nevertheless some permanent mechanisms may become necessary when CHP evolves as a continuing cycle of programme implementation, evaluation and reformulation. The CHP working group will require clear terms of reference from the government, i.e., according to each case, from the health ministry, the national planning agency or the intersectoral coordinating body. The terms of reference will permit the CHP core group to have permanent working relationships with other groups and institutions described hereunder:

- (a) The decisions-makers, including high-level officials of the ministry of health and senior representatives of other relevant sectors. This group may take the form of a steering committee which will sponsor and direct the CHP work at regular intervals and will involve other policy makers as necessary.
- (b) Health workers, teachers and specialists with the best available information, knowledge and experience as regards a wide range of health and social disciplines. Some of the steps described below also imply making the best use of available administrative and legal expertise, as well as all relevant information sources.
- (c) National community and professional interest groups and agencies with social and health interests, as relevant.

The administration which formally sponsors and supports the CHP work, will have to coordinate the contacts among the various bodies mentioned above, in order that the CHP group can secure appropriate directives, information and expertise as the work progresses.

As already pointed out, the contribution of various institutions is of great importance: for example, the national planning board may well provide the policy inputs needed for CHP; medical and health schools can provide the knowledge required; health workers can provide their experience; and various associations or persons may well reflect the aspirations of different categories of health consumers or communities and health service providers.

Practical working accommodation is of importance for the efficiency of the CHP group. Support staff such as demographers, budget and finance officers, personnel and supply officers must be made available when the work requires them. The same is true of adequate administrative support.

While it is important that working arrangements be prepared with utmost care, there might be an initial resistance to working in multidisciplinary and multisectoral groups. Nevertheless the effective applications of CHP procedures will in the long run create bridges between the several levels, sectors and disciplines through the mechanisms created for joint work.

4.2 Alternative arrangements

The preceding paragraph suggests arrangements that are customary for a centralized planning approach. While such an approach may be appropriate at the beginning of the process, it may not be so as the work progresses. Once a broad national policy framework is defined and some health strategies are determined, the work may continue at the regional and provincial levels in a decentralized setting. Nevertheless, irrespective of the setting, the logic and sequence of CHP working procedures remain basically the same.

One alternative would be to assign members of the core group to work with the health representatives of the various provinces in producing their health programmes.

Another, perhaps more practical alternative, would be for the core group to work jointly with the representatives of one province to produce a health programme, which could then be adapted and used by other provinces.

Finally, a decentralized approach from the outset can be recommended in countries where community representation is well defined through political mechanisms. This method has the obvious advantage of allowing for regional difference in problems and priorities. For the national administration it poses the problem of balancing the need for uniformity of resources and optimal action against the need for diversity and local autonomy.

The type of arrangement most suitable for the country must be discussed before the work is started and must be included in the terms of reference.

5. Procedural stages in the CHP process

The following section of these guidelines suggests steps for carrying out CHP. Care must be exercised to adopt these guidelines to various country needs and to local procedures. The guidelines cover three main stages in the formulation of a programme:

Stage 1 (Steps 1-2): Preparation for CHP. In this stage the past and present situations are described. A health information document is prepared through collation and tabulation of the available data and their analysis. The terms of reference for the CHP working group are drawn up and administrative arrangements undertaken to facilitate team work.

Stage 2 (Steps 3-12): At this stage a comprehensive "master plan" is drawn up. This plan sets long term goals and health objectives, defines health strategies and selects priority programmes which are defined within their broad features.

Stage 3 (Steps 13-20): Formulation of the implementation plan for the programme whose execution is first priority. This stage entails consolidation of programme activities and resources required following a detailed analysis of constraints. These specifications aim at producing the capital and recurrent cost estimates of the programme and a schedule for its development. Stage 3 is a continuous activity as each priority programme will have to be formulated or re-formulated and revised in turn through evaluation and feedback.

The stage of programme implementation cannot be presented in the form of procedures. Nevertheless, some basic provisions in terms of programme management, monitoring and evaluation of implementation will be suggested as essential elements of the continuous cycle of CHP.

5.1 Time considerations

Although the long-term master plan is meant to cover a span of twenty years, this period will naturally be split in 5 to 7 year health programmes depending on the government's planning cycle. These, in turn, are divided into yearly implementation plans (or operational schedules) detailed and revised before each financial year. It may be reasonable to complete the health programme implementation plans a year ahead of the corresponding financial year; this, in order to find the necessary funds and adjust resource provisions of the national budget.

Stage 1 of CHP can usually be carried out in a few weeks. Also depending on the circumstances, Stage 2 may be completed over a few months, although it may be necessary to make allowances for policy decisions. Stage 3 will only be undertaken for those programmes whose execution is the earliest in the programme priority sequence.

STAGE I : PREPARATION FOR CHP

Step 1 : Terms of reference and policy directions to the CHP Group

The practical way for the CHP process to begin is by a government decision to assign a core group of persons to this task. In many countries the legislation provides directives on planning and organizing the health system. In any case, the terms of reference for the CHP Group should indicate the government's policy on areas of primary concern and the expected output of the CHP process. There might be specific mention of the budgetary provisions for health development. The terms of reference should also include a preliminary schedule for the CHP work and the assignment of tasks and responsibilities within the CHP Group.

It is essential that the members of the CHP Group should be fully aware of the country's political orientation and long-term social and developmental priorities. If the Group's terms of reference do not provide sufficient policy directions, time should be taken to clarify social and health policy issues which remain unstated. It is of the utmost importance for the CHP Group to know the government's current and long-term position and policies on critical questions such as:

- (1) long-term demographic questions;
- (2) particular social groups (rural population, children and mothers, working women, workers' health, adolescents, school health and the elderly);
- (3) development of particular regions;

- (4) development sectors of priority (housing, agriculture, food production and marketing, irrigation, water supply, electricity supply, road building, education, industrial production, etc.);
- (5) community development (collective solidarity, local initiative and responsibility);
- (6) environmental questions (urbanization, waste disposal, water safety);
- (7) health resources (immigration and emigration of health personnel, private practice, health and social insurance, drug production and importation);
- (8) pattern of distribution of health services, population without access to essential services;
- (9) state organization administration and finance (decentralization, budgetary ceilings, professional associations, unions); and
- (10) regional and international health action and inter-country cooperation.

All policy issues may not have been clarified at the initiation of CHP. Nevertheless, at given points in time during the CHP process, when making choices among various alternatives, the policy-makers will have to make these policies gradually explicit in order to permit the master plan to be placed in the proper political and socioeconomic context.

The list of critical policies and, where relevant, the texts relating to them should form part of the health information document which is to be prepared and reviewed before programme formulation is started.

Step 2 : Preparation of the health information document

Data should be assembled by a small support team drawn from such disciplines as medicine, statistics, demography and economics, who should be familiar with the country situation and with existing data sources.

Data collection must be selective and relevant to the needs of the CHP process. A reasonable amount of carefully selected information is worth far more than a mass of data collected without reference to purpose. For instance, the use of national average figures could be very deceiving as they may conceal serious differences in the morbidity pattern and uneven distribution of health services. Such differences must be highlighted as they are essential in establishing health priorities.

Data collection must also be made within a reasonable time. The launching of special surveys for data collection should be avoided. Nevertheless, special attention should be paid to the conclusions of social and health surveys undertaken in recent years. Information already available should be used and judgements made on the suitability of those resources of various government and non-government agencies which collect, process, store and use information relevant to health.

Data assembled for CHP should favour, to the extent possible, the review and analysis of:

- the country's health and social development policies
- demographic features and forecasts
- the economic and social situation as related to health
- the health status of the population
- the existing health service facilities and their coverage of the population, including health resources located in various sectors and agencies
- the existing health manpower situation

- the health budget and expenditure, with a breakdown giving the unit cost of various health services
- general environmental, nutritional, housing, family planning
- health system problems; and other specialized information as deemed necessary and justified by specific purposes.

The categories of information that might be used in CHP are suggested in more detail in the reference list given in Annex 1.

After basic information is compiled and structured, the Group should draft a brief information document outlining the existing health situation and, where related, the general development situation of the country. The document should not consist simply of statistical tables; it should attempt to synthesize data, ~~comment~~ on the present situation and review the country's policy and priorities as expressed in the socioeconomic development plans.

During the drafting of the CHP document, it will be possible to refer to the information document in order to avoid repetition. Although it is an important information source, the document will not be the only source available to the CHP Group. As the work progresses, large numbers of persons consulted will provide additional and more specific data.

STAGE 2 : MASTER PLAN

Step 3 : Definition of priority health problems¹

The CHP Group should review collectively the present situation. The Group should satisfy itself that the information document prepared is based upon all the relevant information available, that the analysis reflects, with reasonable accuracy, the current situation and trends with regard to health and the health services and that both health policies and health aspects of the national development plan are featured.

In most instances the Group's attention may concentrate on problems of great concern requiring immediate attention; nevertheless, enough time should be given to defining possible future evolution of problems. The review of health problems should not be limited to diseases only; it should encompass deficiencies in the living conditions of communities or of particular age groups and deficiencies in the social and physical environment which affect health status. In addition to health problems, population growth and its dynamics as reflected on family and community resources, or problems in relation to the distribution and use of essential commodities, water and food, and some harmful commodities, will be listed if they are felt to be a cause for concern.

The Group must ensure that priority selection is carried out with as little bias as possible; it should consult representatives of the policy-makers, consumers, providers and other interested groups.

The process of identifying health problems of concern² may call for a methodical approach such as the determination of a set of criteria for selection of priorities (one such set of criteria could be drawn from Annex 2).

¹ In this context the term health problems implies disease, disability or discomfort, temporary or permanent.

² In this context the term concern implies dissatisfaction with the existing service system and/or because of the absence of services, as felt by consumers and providers.

Specific shortcomings in the provision of health services - administrative problems, shortage of resources and other difficulties - are not listed as health problems, since they will be diagnosed later as "constraints" and dealt with accordingly. Nevertheless, the possibility of listing health service problems in conjunction with health priority problems should not be excluded. If service problems - such as lack of coverage and manpower - are selected as priorities without due consideration being given to health problems the likelihood is that the existing services will be extended and perpetuated, irrespective of their relevance to the problems.

The Group should then describe health problems and attempt to expose their relationship with other problems in their particular environment - physical, social, cultural, economic and other. Problem definition may be facilitated by the use of diagrams showing the interlinkages among problems. The material should be consolidated to avoid overlapping and duplication. Finally, medium- and long-term projections of problems should be attempted based on past trends and intelligent guesses.

Once priority problems have been defined the next question is: what is being done, or what has been done so far, to solve them? If the priorities are newly recognized, it is possible that nothing is being done. However, it is important to ascertain how other sectors are contributing, perhaps indirectly, to solutions, and whether the problems are solved at individual or community level.

When the priority problems selected are currently being tackled, the Group will require additional data on activities and interventions under way in these areas, and the resources - physical, human and budgetary - currently devoted to the solution of these priority problems. This description is used later in recommending changes in the present system.

Step 4 : Setting health goals and objectives¹

Having selected and defined health priorities the CHP Group should set some long-term goals and objectives. Overall policy statements on long term goals such as "health for all" and health objectives must be, to the extent possible, quantified and made explicit with regard to "what" is to be achieved, "when" and "where". "For whom" may also have to be specified if particular age groups or risk groups are singled out.

The long-term health goals and medium-term objectives should obviously be consistent with the social model projected by the national policy organs for the coming decades. The CHP deliberations offer the setting for such a long-term reflection at high echelons. As questions regarding long-term goals and policy directions are raised, critical policy issues not tackled before will need to be discussed at the highest level and cleared.

Step 5 : Definition of health strategies

For each consistent group of health goals and objectives health strategies should be defined.

Strategy implies broad lines of action towards defined objective(s). For instance

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Throughout this document, the terms goal, objective and target are used with the following meanings: Goal : a purpose to be achieved over a long period of time, usually non-quantified, without a time limit. Objective : a medium-term purpose to be achieved over a given time period, often quantified. Operational target : a short-term purpose, always quantified and dated. These terms form a hierarchy: goal is used for broad policy and social aspirations; objectives imply the desired impacts on health status, and targets correspond to the operational level, to health interventions, and to developmental activities.

tackling the problem of a high infant mortality rate may require one or more of the following lines of action: providing safe water supply and food, services for vaccination, health education and other maternal and child health services. Strategy choice implies choosing one action line from among others. It also implies any desired mixture of the available range of interventions - technical (i.e. preventive, curative, educational, research, etc.), managerial and others. When these are being defined, it should be realized that later on, during the programming phase, they will be broken down into a set of activities and resources. The feasibility of these activities and the required resources will be discussed against a systematically produced list of constraints and obstacles. It is therefore necessary, from this early stage to define the most relevant and feasible strategies - by attempting to indicate present and potential obstacles. Attempts should be made at projecting their evolution within specified time frames. The concordance between the health strategies proposed and the sets of other development strategies contemplated by other sectors must also be taken into account at this stage. This critical aspect will require joint working sessions with representatives of relevant sectors.

Step 6 : Selection of priority health programmes

During this step the Group should define the health systems of the future. Broad strategies defined during the previous step must be broken down into more explicit entities, i.e. programmes which are sets of interrelated services and operations intended to achieve specified objectives. The programme boundaries, their scope and breadth depend much on the policies and strategies defined. An integrated strategy will generate one national programme such as "primary health care". In order to arrive at an implementation plan, this integrated programme must be broken down into manageable components. In large countries this could be done by province, starting with geographical entities or population groups of first priority, according to the objectives already defined.

In a rather different context the short term strategy might be the solving of a given set of problems by means of an intensive mass campaign. These seemingly distinct entities just mentioned must be projected in time so that their integration with other components will form the basis of the health system as visualized in the long term.

After the selection of priority programmes, the programming work should proceed only for those areas of immediate concern. When a programme's priority sequence is due after two years or more, its detailed formulation can be delayed. The master plan which will be produced at the end of this stage should include a list of programmes by location and content and a long-term timetable for their formulation and implementation. When the government's long-term indicative investments in health, social and developmental sectors are made explicit as a result of CHP work, the investments can be scheduled according to the priority given to the programmes.

Step 7 : Preparation for programme formulation

The previous step selected the priority areas for conducting programme formulation work. For this to be meaningful the participation of persons who are close to the peripheral health level is indispensable. It should involve both those who implement key programmes and community representatives. The former group could include province or district health officers, heads of various health services or representatives of other sectors, e.g. education, agriculture, or public works in the provinces where the health programme - often multisectoral - is due to be developed. Various health disciplines and teaching staff may need to be represented at various points in time of the formulation, therefore the available expertise will be invited to take part in the work. The same applies to various managers, such as supply, budget and personnel officers.

This step should therefore serve to identify the additional support staff to the CHP work, to brief them on the procedures being followed and to inform them on the work performed so far so that they can provide appropriate inputs from their respective fields of expertise.

Step 8 : Identification of the health activities of the programme

This step aims at recommending the essential health activities of the programme and at defining briefly their technology content. The programme must be described first in functional terms, that is, in terms of programme performance, before any attempt is made to recommend facilities and resources. The starting-point is the set of priority health problems already defined in Step 3. By reviewing these problems and their intersectoral implications, the CHP Group can determine the various health activities - health service activities as well as any intersectoral health activities - necessary for combined action, bearing in mind that this combined action stems from the strategies broadly defined in Step 5. The programme activities listed will often include interventions, techniques and procedures recommended for combat priority health problems. They may include diagnostic, curative, preventive or rehabilitative interventions and ancillary procedures as relevant to the problems. Alternatively, they may comprise educative, informative, social and other health-related interventions. Here again, the CHP Group should be able to call on any expertise needed and ask for specific information on any appropriate question. Both the specialists and the peripheral health workers should be made aware that the technical procedures recommended must be of a standard kind that is applicable to most of the consumers most of the time. Furthermore, they should be relevant to the most common aspects of the problem rather than to unusual variations of it. Costly and impractical technologies should be excluded.

This step should be completed with an attempt to quantify the critical activities - what will be done and how much of it. Thus, operational targets are set for programme operation such as number of vaccinations, number of school children screened, tons of weaning food produced, etc. In this task the Group should use as a basis of estimation the quantified health objectives and strategic goals set in previous steps, as well as the problem density figures and estimates. It will not be necessary to include the various managerial and supportive activities in detail at this stage as many of these will be identified later.

The procedure outlined in this step applies both to the formulation of a new programme and to the re-design of an existing one. While for a new programme it is necessary to identify all essential activities, this is not so for an ongoing programme. The re-design of an existing programme implies the review of the health activities as they are currently applied, and alterations are recommended only in activities which need change.

Step 9 : Identification of development activities of the programme

Not all programme activities directly affect the population's health or improve its social and physical environment. Some activities are aimed at improving the effectiveness and efficiency of the health and health-related systems and at maintaining their performance at a level likely to accomplish the targets set for them. These indirect activities, aimed at developing the system's potential, are usually intensive but time-limited interventions as opposed to direct health activities which are mostly performed on a routine basis. Development activities include the building of new facilities or improving existing ones, procuring and installing equipment, establishing or changing working procedures, designing a new training programme, specific investigations or issuing new legislation. The same could be said about the work of other sectors, such as building irrigation schemes, fisheries, baby food plants, sewage and community development schemes. The identification of development activities is made easy when the type and intensity of health activities have been identified in the previous step, including those undertaken by other sectors. Health activities and development activities should be grouped separately as far as possible, as this grouping may later help in computing the recurrent and investment budget needs.

Step 10 : Conversion of programme activities into resource requirements

All the programme activities identified in Steps 8 and 9 are now to be converted to resource requirements; human, physical and other. Once the resource categories are specified, their amounts are estimated taking into account the health objectives and strategic targets, including the coverage targets set earlier.

The assessment of the manpower needs of the programme requires special attention and calls for the work of a sub-group which comprises trainers, personnel officers and members of the civil service and finance commission responsible for authorization of staff positions. Throughout its work this group should be concerned with policies and strategies affecting national staff in general, and health staff in particular.

Standard health activities identified earlier (Step 8) must be the basis for specifying various categories of personnel needed. The reorientation of the available personnel towards new health objectives as well as the use of local and traditional human potential are issues to be considered at the decision-making level.

The programme development rate is likely to put a heavy demand on the current health manpower training functions and may require capital investments in this area. Consequently, any resource development activity resulting from the programme needs will have to be listed with programme development activities. (Step 9.)

In the case of ongoing programmes, particular attention should be given to specifying resources that are different from those currently used.

All the resources identified must be projected over the time-frame of the programme. Future projections of manpower must make provision for personnel migration and depletion rates and other factors as relevant.

Step 11 : Estimated cost of the programme

Using the outputs of the previous step, an attempt is made to estimate the costs of the essential resources identified as necessary for the new or existing programmes. It is often necessary to make use of both unit (or standard) costs when available, and the estimates of experienced staff. It may be appropriate to make a distinction between the costs which can be met locally and those which are required from municipal, regional and national budgets. The support of staff belonging to supply, budget or finance units will be needed during this step.

Step 12 : Preparation of the master plan document

The work performed so far should permit the elaboration of medium- and long-term prospects for the national health system. The master plan which can now be derived from the material prepared through these steps should comprise the following:

- the national policy orientation for health
- the priority health problems and the justification for the long-term goals and health objectives selected
- a description of the strategies advocated and their rationale
- a brief description of the health system which is recommended to be developed in the long term
- the programme areas proposed, the order of priority among these programme entities and a long-term timetable for their implementation
- an indicative budget for programmes whose launching is recommended now, and gross budgetary estimates for programme entities phased out for the future
- the various intersectoral, legislative and social implications of the programme, and the expected short, medium and long-term benefits.

The draft master plan should be revised at high government echelons. Depending on the health problem under consideration and the features of the programme discussed, this level will comprise the ministry of health and high ranking officials of various interested sectors. In most instances the state planning agency and the finance ministry will be involved. An official mandate must be obtained for proceeding further with the plan of action and implementation schedule for the programme components to be launched in the immediate future.

In some cases the necessary mandate is not obtained until the preliminary draft is amended in order to fit the requirements and consolidate alternative proposals from different participating regions and agencies. Adjustments may be required in order to synchronize and integrate the health programme with other development programmes that are contemplated or under way in various sectors.

The master plan may be updated each time a significant change occurs in the policies and whenever the experience of programme implementation - the result of periodic evaluation - warrants a change.

The master plan must be considered as the government's long-term investment plan in the health sector, and proper allocations should be effected accordingly in the yearly and medium-term budgets.

The generation of resources earlier than expected may expedite launching of new programmes on the waiting list, and vice-versa.

From this step onwards the programming work will continue for programme areas whose implementation is due in the immediate future and for which development funds have been secured.

STAGE 3 : PLAN OF IMPLEMENTATION

Step 13 : Feasibility of the programme: constraint analysis

The analysis of constraints is undertaken in this step in a systematic way although, as stated earlier, it should be implicit in all previous steps.

The feasibility of all action recommended so far must now be critically questioned. The programme's standard health activities as well as the programme's developmental "build-up" activities should be systematically reviewed and the obstacles to their implementation identified. Constraints are all kinds of obstacles, current or potential; they include political, institutional, legislative, social, cultural, ecological and financial limitations and impediments. Some constraints may be so serious that certain programme components may have to be abandoned and the programme adjusted accordingly. Other constraints are removable, in which case the remedies must be listed as part of the programme's activities.

The many proposals for preventing and/or removing constraints, generated during this step, will then be properly structured. As this is done, the managerial, procedural, legislative and other support requirements of the programme will gradually emerge. The information required in order to run the programme is of such importance that the information system should be given special attention during this stage. The same can be said for manpower training, logistics and maintenance systems, as well as specific investigative and research activities. These are all supportive areas where both developmental and routine support activities are expected to take place. Activities of a supportive nature should not be formulated in detail before the priority health programmes have been properly defined. Support programmes should be formulated concurrently with the health programmes in order to serve their requirements.

Financial resource limitations are the leading constraints in many countries. As the costing of programme activities has been done in earlier steps, those activities requiring resources that are costly to obtain and the maintenance of which is fraught with obstacles should be critically reviewed and they should be replaced if possible by appropriate technology and low-cost solutions involving the maximum use of the human and physical resources available within the community. Alternative sources of financing at community level and other sectors can be considered at this stage, as well as voluntary sources and cooperating agencies. Constraint analysis helps in the screening of proposed programme activities and selection of the most relevant and practical ones. If a given strategy largely implies activities which are irrelevant or beset by obstacles, this strategy will be revised. Through the same process current policies may be questioned and amended accordingly.

Step 14 : Organization and management of the programme

The output of the preceding step is a list of various remedies and solutions recommended to prevent or overcome the present and potential obstacles to programme activities. The list of remedies suggested should be logically structured so as to define the managerial and support systems necessary to back up programmes' health activities. These may include improvement in the organizational pattern, procedural changes in the administration, function and task attributions among levels of execution, the development of a logistics system for the health services, repair and maintenance of equipment, the reporting and information services, personnel management, etc.

A critical requirement of this step is the identification of focal points responsible for developmental programme activities; their functions must be made explicit and the tasks facilitated through appropriate delegation of authority. It could be argued that development activities, being limited in time, can be tackled by the existing administration dealing with the programme area. In particular cases, nevertheless, when development activities require coordinated efforts in several administrations - such as building and maintaining maternal and child health facilities, installing a weaning-food factory, revising the school training programmes - the suggestion may be to assign each component of the programme to a different administration. In such a case, a focal point for programme management should be designated to monitor and coordinate the programme.

To ensure the continuity of the CHP process, it is important that those who have been instrumental in the formulation work should also be concerned with monitoring, assessment and reorientation work and be given a position mid-way between implementation and decision-making, with easy access to both. In the same vein, programme managers and their staff may have to coordinate various activities falling under different government sectors and other agencies. In this respect, the establishment of an inter-agency "Health Development Centre" is warranted to ensure the scope and the continuity of the CHP process (see Annex 3).

Step 15 : Programme budgeting

Based on the outputs of Step 13, the Group prepares consolidated cost figures for various programme components, then works jointly with finance and budget staff to draft a programme budget proposal. The fact that the programme's standard health activities have been identified in some detail will provide the basis and justification for establishing the "recurrent budget", whereas the activities of a developmental nature will help in structuring the capital or "investment budget" for the programme. If, due to finance policy, a ceiling is set for the health sector's budget which is incompatible with estimated costs, this is a serious constraint to the programme. Ways must be found of diversifying the sources of health funds, including greater use of resources of the other sectors involved. It may be useful at this stage to indicate what elements of the proposed programme would be suitable for external funding.

While drafting the recurrent cost components of the programme budget, the working group must attempt to make future projections of the resources needed. Realistic budgetary projections require that some predictable factors be taken into account, such as the average

life-span of various facilities, amortization rates for various non-expendable equipment and supply, emigration rates and student depletion rates for different categories of health manpower. These projections should also take into account inflationary rates and policies on regular increments in manpower salaries, since the latter are a most important component of health expenditure. Care should be taken not to propose capital investments which could lead to maintenance costs that are unsustainable for the future recurrent budgets.

As programme budgets are computed with more precision, it becomes imperative to adjust the tentative budgetary estimates of the master plan.

At this stage the financial projections should be prepared with the assistance of budget officers, in a format that can easily be incorporated into the national budget. It is essential that funds for priority programmes be easily identified in the various chapters of the national and regional budgets. Along with programming, budgeting is necessarily a continuous process. The updating of yearly budget allocations should be in line with the programme reviews and evaluation done at regular intervals.

Step 16 : Establishment of programme schedule

Programme activities consolidated after constraint analysis should now be put into time sequence. As some programmes comprise large numbers of activities, it may be necessary to group these activities according to their time of performance. The Group must decide which activities are critical for the programme, and establish end-targets and intermediary targets (milestones). For managerial as well as budgetary reasons, it is important to pay particular attention to scheduling the programme's "developmental" activities. The scheduling work helps to reveal time constraints which may have been overlooked before. Consequently, some activities may have to be speeded up while others are slowed down in order to achieve a synchronized development.

Step 17 : Programme assessment and evaluation¹

Throughout these guidelines, emphasis is placed on setting policy goals and priorities, health objectives and operational targets. Although these concepts are interrelated in a hierarchy², each one of them refers to a different time-frame and also needs a different set of measurement indices. The setting of a schedule and identification of milestones and targets for "development" activities allows the short-term monitoring and assessment of the state of development of the programme.

Developmental milestones include such targets as expansion of training centres and changing the training curricula, and are quite distinct from the programme's health interventions which require programme delivery indicators, such as the number of school-children screened, fed, or vaccinated, or pregnancies attended.

Assessment of the impact of these health activities on the health of the community requires a longer time-frame and a set of epidemiological and social indicators (e.g. infant mortality rates, life expectancy, etc.). For the sake of consistency it would be desirable that the same indicators used for setting health objectives be used when evaluating the

¹ It is specified here as a "step", while in fact, evaluation permeates through all steps of the CHP process. For further details see seminar document CHP/IRS/79.6: "Provisional Guidelines for Evaluation in Country Health Programming (CHP)", 10 October 1979.

² See footnote on Step 4, page 11.

programme's health impacts.

The information system recommended for the programme, including the reporting forms, should allow easy monitoring of health interventions and their impact. On the other hand, the programme's development activities can easily be monitored through the implementation schedule drawn for this purpose.

Assessment and evaluation must be carried out at regular intervals and as required. Yearly reviews of the progress with decision-makers, key implementors and community representatives must become a regular feature. This may be done before the start of the financial year to update the budgetary provisions for the forthcoming period. Evaluation of the programme and appropriate amendments may be needed before the new cycle of the national development plan is launched. The generation of essential information necessary for the day-to-day monitoring and long-term evaluation of the programme should be a vital component of CHP through its successive cyclic process.

Step 18 : Consolidation of various programme proposals

As implied above, any CHP formulation effort can produce one or more programme with different breadth and scope. Programming can be more or less detailed; it can cover the entirety of the health area, or an important component of it. This will depend on many factors such as the extent of problems, the size of the population to be covered and the size of the provinces and of the country. When two or more programme entities have been formulated, they must be reviewed simultaneously, as many common features will allow interlinkage among them. The combination of various activities and the joint use of common resources are likely to save considerable funds and efforts. Examples are a common purchase, storage and distribution system, an integrated information system, an integrated training programme, and coordinated public information and health education schemes.

Step 19 : Preparation of the programme document

As work progresses and different aspects are drafted, it is necessary for a small editorial group to cross-check the various elements of the programme document.

The programme should comprise the master plan or should include a succinct reference to it, summarizing the policy and strategy base of the programme.

The implementation schedule, the investment budget and the recurrent budget should appear in the body of the report. Excess detail can be avoided by relegating supportive data to annexes.

The preliminary draft of the document should be reviewed with key executives and implementers and, following its completion, it must be submitted to the higher authorities for approval and financial clearance.

It has been stated earlier that the process of CHP is an instrument for policy makers to make important choices; equally, the programme document can be a valuable working tool for those charged with authority over its execution. Nevertheless, whatever the level of detail and precision of the document, it should be realized that each and every detail cannot be predicted. The implementers must find more ample possibilities to complement and amend the programme elements according to local needs and possibilities provided that the central aim of the programme is maintained. In this context flexibility should mean the interpretation of the programme by those local and peripheral level workers who are responsible for implementing it in an efficient and effective way.

As an illustration, Annex 4 provides the table of content of an actual programme document.

Step 20 : Preparation for programme development

The roles of various participants in the programme development must be mutually understood. The lower-level staff must understand what is expected from them by their immediate and higher-level supervisors. The programme's managers should know the area of their responsibility and respective authority. A role and task distribution must be established through the review of the implementation schedule. This schedule should be detailed and amended as necessary by local executives. In a large programme, it would be necessary to create a coordinative focus to monitor and synchronize simultaneous activities performed in several administrations and various sectors and locations. Provision should be made for rapid communication and appropriate reporting, which are of great importance.

Depending on their nature, some resources may have to be procured by central stores whereas others will be available locally. On the basis of the programme's resource list, respective responsibilities should be clarified and purchasing and spending authorities should be delegated accordingly.

The community representatives should be identified in places of key importance for the programme, and their role in motivating and conducting various community activities and efforts should be clarified in mutual role-sharing sessions. The administration's part in these efforts should be made clear. When the area to be covered is very large and includes hundreds of communities, an extensive public information campaign might be necessary to motivate the populations and obtain their support. Meetings with the representatives of the communities and of the administration should be held periodically to assess the progress made and agree on corrective and supportive measures. As experience builds up, the lessons learned will be incorporated into the master plan and implementation plan.

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Basic Information Requirements for CHP

A Suggested Reference List

Not all information categories carry the same weight and importance. Depending on the circumstances and subject to the availability of data, relevancy must be the rule when selecting data for the information document.

1. Policy data

The relevant information on policy and legislation should be collected in such a manner as to provide information needed for (a) national development policies and plans, and (b) national health policies. This information will be used in all steps of the CHP process.

2. Demographic data and forecasts

Relevant demographic data and vital statistics should include:

- (a) the age structure of the population by sex
- (b) urban/rural distribution
- (c) birth rate
- (d) crude death rate
- (e) infant mortality rate
- (f) other consolidated information that may be available, such as maternal and neonatal mortality rates.

If national population census figures are not available, it may be possible to use representative demographic data points which can be determined from national or regional estimates, whichever is most appropriate for the country concerned. If an official population forecast already exists, this can also be used for CHP. The purpose of assembling demographic data is to arrive at a realistic projection of population and population composition forecasts relevant to an understanding of the nature and magnitude of current and future health problems.

3. Economic data

It will be desirable to obtain plans and breakdowns of budgets allotted to such sectors as agriculture, public works, education, transportation and defence, in addition to health. Somewhat greater detail will be required in breaking the health budget into its main components, not overlooking significant expenditures on health by other sectors when these can be identified. It will be desirable, where possible, to show information on health budget trends over a period of several years. If private sector expenditure on health is substantial, estimates should be obtained to the greatest extent feasible. It will be important to indicate the ratio of the health budget to the total national budget and, more significantly, the projected trend of this ratio over the next few years, when possible. Other data such as the country's foreign exchange earnings, income distribution pattern, and current interest rates may be useful.

There are many uses for economic and financial data of this kind, but the essential purposes are: (a) to delineate some boundaries for the potential growth of a national health

budget, and (b) to take account of the likely impact of general development policy which may affect the setting of priorities and the definition of targets in the health and health-related sectors and the development of strategies deemed feasible for combatting priority health problems.

4. Health status data

The availability of reliable and comprehensive data on the health status of the population varies from country to country, but an attempt should be made to draw a national picture of the disease situation by age, sex, location and other social and economic factors. Hospital in-patient records can serve as a supplementary source of morbidity and mortality information, but these records alone will be insufficient to give a representative national picture. Data on work absenteeism, when available, can be used for assessing the health status of the working population. Particular attention should be given to areas which have long been recognized as areas of special concern of the local population (communicable diseases, etc.). The data should be presented in two basic sets of tables, one showing the mortality rates (if possible by age, sex and location) for a recent period of time by cause of death, and the second showing the morbidity rates and relevant intercountry comparisons by disease groups. The CHP group can use these two sets of tables to establish health priorities and to fix targets for the programme period.

5. Environmental health data

These would include, as relevant, the distribution and coverage rate of communities by the water supply systems, natural and man-made; the extent to which potable water is used by communities, and the estimated average use per household; status and development schemes for electricity supply and roads; the distribution of liquid and solid waste disposal systems in various urban and rural settings; information on housing conditions and household environment as related to home gardening and farming and irrigation practices, and on internal household hygiene as related to food storage and conservation; the social and cultural environment as related to child-raising and food practices; and details of existing legislation on environmental hygiene, food processing and sale, and related information.

6. Data on health service resources and facilities

A summary of the various existing categories of health establishment should be presented by major groupings, by type of activities performed, and by main administrative subdivisions of the country. Examples are data on health facilities (hospitals, health centres, clinics, dispensaries, bed ratio per population), health training institutions (medical schools, nursing or midwifery schools, other faculties and training institutions for preventive, curative or health research personnel), utilization of health services (use of physicians, nurses, midwives and auxiliary personnel, and breakdown of these services by type of health institution), preventive services (number of people vaccinated against major communicable diseases, preventive examinations of mothers during pregnancy, and of children during the first five years of life, preventive screening of schoolchildren and workers), community participation in health development, and health activities of the non-governmental voluntary agencies.

7. Health manpower data

The estimated number of physicians, nurses, midwives, technicians and other health personnel should be given, with an indication of their urban/rural distribution, as well as their distribution among the facilities in which they practise, their distribution by speciality, and rough estimates of various health professionals graduating annually from existing schools and educational institutions. Data about traditional practitioners and birth attendants should be included where relevant.

8. Unit cost data

Tables should be given covering existing service programmes, with the cost per unit of output activity (cost per vaccination, cost for case-finding, daily cost for a hospital bed, cost for a health clinic visit, etc.). Data should also be obtained on maintenance and other recurring costs of average facilities, materials and equipment, transportation, staff salaries, etc. If absolute numbers for some unit costs are not available, percentage breakdowns based on best guesses will suffice. These data will be used in the feasibility analysis of strategies and of health development programmes and ultimately in the preparation of programmes.

9. Other data and information

The CHP Group will no doubt require additional specialized information during the course of the programming process. Various categories of such information may be identified during the information collection phase, and those specifically charged with data collection should familiarize themselves with existing statistical publications and other sources of information, or identify responsible persons in the country capable of providing information. For instance the assessment of the health needs of the public education school system requires data on student population, its distribution pattern and depletion rates, etc.

Illustration: Criteria for priority selection

Example of criteria used for the selection of priority problems: (Any given set of criteria may produce different priority ranking compared with an alternative set. Therefore, the selection of criteria must be made with great care.)

1. Criteria applicable to technological aspects

Technological feasibility

Availability of manpower

Balanced attack on all phases of the situation (for example, perfection of diagnosis would not be valuable without possibility of treatment)

2. Criteria applicable to health aspects

Problem likely to disappear by itself

Probable duration of problem if undisturbed

Importance and prematurity of mortality

Degree of disability

Importance of morbidity

Severity of distress, duration of discomfort or pain

3. Criteria applicable to general concerns

Importance of resource consumption

Conformity with major goals

Public concern, public dissatisfaction

Public acceptance of health action (such as family planning)

Political feasibility

Speed of change

Effects on productivity

Avoidance of other predicted problems

Protection for next generation

Effectiveness

Efficiency

Community involvement

Labour intensive versus capital intensive

4. Criteria applicable to planning concerns

Compatibility with higher-level plans

Gain in stature, power, or capacity to solve other problems

Commitment of health sector's resources for the future

Improvement of the health administration's image

Permanent mechanisms to ensure the continuity of the CHP process

When CHP evolves as a continuing health development planning process, some permanent administrative structures and mechanisms may become necessary. In countries where these already exist, their further strengthening and adaptation may be required at all levels and in all sectors, not only the health sector. CHP calls for constant review of countries' administrative systems to ensure that coordination can take place at central, intermediate and local levels.

The Ministries of Health naturally have a central role in defining national health policies, in ensuring the preparation of strategies and plans of action to give effect to them, and in the subsequent formulation of health programmes, and the design, operation and control of health systems. To be effective, Ministries of Health must be an integral part of the mainstream of policy decision-making at the highest governmental levels, and maintain close contacts with ministries of planning or similar bodies, as well as with other ministries and authorities dealing with socioeconomic development.

Ministries of Health, in fulfilment of their important function of mobilizing political, professional and public support for, and participation in, the development and control of the new policies, strategies and plans of action in relation to the health development process, may find it useful to propose the establishment or strengthening of a National Health Council. These can be particularly valuable in ensuring that health systems are developed as an integral part of overall social and economic development, and involve representatives of relevant professional, educational and scientific societies and corporations.

In addition to National Councils of Health, Ministries of Health may consider establishing or strengthening one National Centre for Health Development, or many of them at regional level. The purpose of such centres is to promote or further strengthen, primarily at the technical level, links between various sectors and institutions concerned in the planning and programming process, in the investigation and clarification of management aspects concerning the development of primary health care, and in the development and coordination of health research. In addition, the centres may deal with information systems development, evaluation, training, consultation and exchange of information on the concept, methods and experiences of CHP. This ensures better coordination and the mutual support of various elements, both within and outside the government, in furthering the health development process.

Technical planning units within Ministries of Health may be useful in supporting the decision-making process by providing a coordinating mechanism. In addition to the types of staff normally employed in the Ministries of Health, it may be necessary to draw on expertise in such other fields as the economic, political and social sciences. Experience has shown that in the preparation for, and the conduct of, the programming, in some situations, the best results are accomplished if a special intersectoral working group is convened for a specific period of time.

Such CHP working groups should include the expertise and representation necessary for their work, encompassing a wide range of disciplines including health generalists and specialists, senior administrators, field operations staff, professional planners, budget officers, economists and statisticians. Which health-related sectors are invited to contribute to the CHP work on a full or part-time basis will necessarily depend on the nature of the prevailing health concerns. In any case, representatives of the ministries of planning, finance, agriculture, education and environment should be called in to participate in CHP working groups. Group membership will change depending on the stage of CHP, but, to ensure consistency, it is wise to maintain a core group throughout the process.

When formulating the details of specific programmes, similar working arrangements could be used. Each programme's formulation group will obviously be somewhat specialized in the subject

area being planned. The organizational arrangements for implementation and operation of programmes must depend on the administrative mechanism in each country and on the approach designed during programme formulation.

In addition to CHP becoming the country's mechanism for generating health policy (through continual interchange between the technical planning and policy formulation levels), it is also vital that the policy and programme decisions which flow from the process are reflected in budgets, financing schemes and staffing plans. Often, well-formulated programmes fail to materialize because administrative steps are not taken to ensure that the necessary resources are allocated. Such linkage with budgeting and staffing procedures can be facilitated by scheduling the programming and programme formulation phases just prior to budget and plan submission. In addition, it is necessary to include budget personnel and staff from the Ministry of Health in the CHP steps which produce resource estimates. The participation of budget staff is necessary during collection of cost data, scheduling of the programming process, estimation of overall resource requirements, and the budgeting of detailed programme operating and development costs.

The scheduling and management of CHP will also provide an entry point for technical cooperation between governments and UN multilateral and bilateral agencies and organizations in support of priority-determined programmes by governments through CHP processes.

Illustration: Structure of a CHP document

The following is the table of contents extracted from a CHP document. Many of the annexes contain details which particularly required the contribution of the programme staff.

Part 1

Main document

Executive summary

Situation analysis summary

Development policies and health policies

Long-term goals and objectives

Health strategies and selection of priority programmes

Detailed design: Health activities of the programme (standard activity description in Part 2)

Development activities (1): Manpower development

Development activities (2): Health facilities

Development activities (3): Intersectoral action

Programme budget proposal: Capital investment

Recurrent budget

Timetable for implementation

Comparison of proposed alternatives

Management of the programme

Other aspects

Part 2

Annexes

The terms of reference for CHP working group: list of persons, sectors, agencies and community representatives consulted

Demographic tables by district, age and sex distribution

The national budget; health budget

Organization diagram of Ministry of Health

Health manpower and health facilities

Training institutions in health, current student population

Description of current health action, particularly in rural areas

Standard activities for the programme (2 alternatives)

Constraint analysis

Recommended organization and management matrix

Prototype work schedule and organization of daily work (various examples)
Standard list of drugs, chemicals and reagents
Standard list of equipment recommended, costed
List of expendable supplies recommended, costed
Expected consumption rate per 1000 population per year
Manpower needs, by category
Manpower projections (2 alternatives)
Manpower projections, costed
Student population, future projections
Manpower training projections, costed by annual salaries and wages (2 alternatives)
Manpower job descriptions for main categories
Specific needs for teachers
Proposed staffing and budget for training (proposals for various schools)
Criteria for selecting essential resources and vehicles
Criteria for site selection for facilities
Proposal for recurrent budget (2 alternatives)
Proposal for investments (2 alternatives)
Supply network for the programme

Intersectoral implications:

Rural communities' role in health matters and support from district councils
Ministry of Education - health role of teachers and health
education mass screening and vaccination
Ministry of Agriculture - training of rural extension workers
Ministry of Information - public education campaign through mass media
Ministry of Finance - improving custom procedures for health supplies; budgeting
health programmes
Ministry of Public Works and Reconstruction - norms for health facilities
Ministry of Commerce - regulating the sale of iodized salt, and imports of
baby food, etc.

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