
IMPACT

# Field Guide

## *Peer and Participatory Rapid Health Appraisal for Action*

## For Secondary Health Care Facilities

PRRINN-MNCH

Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

DFID Department for International Development

State Department of the Norwegian Government

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Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

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**State Department of the Norwegian Government**

PRRINN-MNCH is a programme of collaboration with Nigerian partners to develop partnerships for reviving routine immunisation and strengthening MNCH services in Nigeria. It is funded by the UK Department for International Development (DFID) and the State Department of the Norwegian Government.

The PRRINN-MNCH Programme is managed by an international consortium on behalf of DFID. Members of the consortium are:

Health Partners INTERNATIONAL

GRID

Save the Children UK

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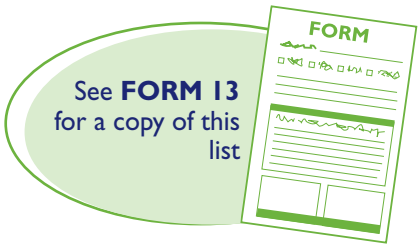
# Introduction

This Field Guide (for the SHC PPRHAA appraisal) complements the larger PPRHAA SHC manual. The field guide is for the use of the PPRHAA teams when they are in the field doing the appraisal or facilitating the Hospital Appraisal Feedback workshop, the Planning Workshop or the Zonal/State Summit. Before the teams start work there will be a one to two day training workshop on how to do a PPRHAA appraisal, how to write the reports and so on. This will be followed by a one day planning training workshop in the second week of the PPRHAA period. Throughout, the teams will be supported by the PPRHAA catalysts and consultants.

Thus, the field guide is a short document that teams can refer to when in the field. The material here will be supplemented by forms and guides that will be handed out during the training workshops. In addition, the field guide is a short introduction to prospective PPRHAA team members. Issues that PPRHAA team members want to discuss can be covered in the training workshops. Remember that the full manual and all the forms are available on the CD.




Before setting out for an appraisal at a facility, make sure that you have the following forms:

## *FOR EACH HOSPITAL:*

- ❑ 1 copy – Form 2: "Interview Tools for each PPRHAA Area" (A, B, C and D) for team members to use as they go around the hospital
- ❑ 2 copies — Form 5: Hospital Outputs. Send 1 copy to the hospital to fill out before the visit
- ❑ 2 copies — Form 4: Reporting Formats for each PPRHAA theme (1 for CCV clients, 1 for communities)
- ❑ 2 copies — Form 6: Financial data. Send 1 copy to the hospital to fill out before the visit
- ❑ 1 copy — Form 7: Tracer drugs and supplies
- ❑ 1 copy — Form 8: Rational drug use
- ❑ 1 copy — Form 9: Essential tracer equipment
- ❑ 2 copies — Form 12: Performance Ranking (fill in 2 copies, leave 1 for the Hospital).
- ❑ About 70 red problem cards, 70 yellow suggestion cards, 70 green recommendation cards (more for bigger hospitals) and 10 copies of Hospital Form 10.

SECTION

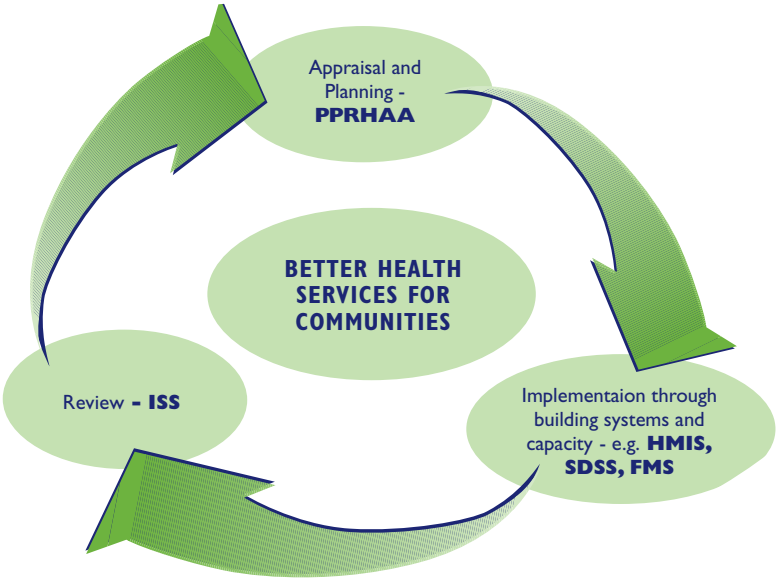
# Preparation

*This section outlines the IMPACT/PPRHAA initiative and describes how the PPRHAA process is conducted.*

# Introduction

IMPACT is an approach used to strengthen management capacity and health systems. IMPACT has been developed largely in West Africa and follows the well known planning cycle (appraisal, planning, implementation and evaluation). To strengthen management capacity and health systems three discrete approaches or tools have been developed – PPRHAA; ISS; and QAR. These tools/approaches are complemented by systems strengthening initiatives in a wide range of areas (including HMIS, SDSS, FMS, SM). Together this is termed IMPACT.

***FIGURE 1: IMPACT***




## PPRHAA — Peer and Participatory Rapid Health Appraisal for Action

PPRHAA is a simple and rapid way of assessing performance at health facilities, identifying problems and achievements, from which managers and staff prepare plans based on their needs, community priorities and within available resources. PPRHAA involves the managers and staff of the SMoH/SHMB and hospitals and builds their skills in appraising, analysing, understanding and implementing key aspects of health management. It also involves communities, strengthening the relationship between them and health service providers.

## Building Management Systems and Capacity

Many activities under the PRRINN-MNCH Programme help Nigerian partners to develop and strengthen their essential management systems. These are systems for such areas as finance and accounting, patient care, health management information, drugs and supplies, human resources, maintenance and community accountability.

### Integrated Supportive Supervision (ISS)

Plans and systems often have little effect, because they are not put into practice. Support, follow-up and implementation are therefore the most important elements of IMPACT. This includes such activities and systems as: regular support and supervisory visits; quarterly reviews; joint progress updates; mentoring; and on-the-job assistance in establishing new systems and building capacity.

### Quality Assessment and Recognition

QAR is a tool used to assess progress of facilities and institutions that have been strengthened through IMPACT. The approach is to assess facilities that are judged ready against benchmarked criteria. Various levels of recognition have been developed depending on the outcome of the assessment.

The PPRHAA appraisal is done annually, while systems strengthening, building management capacity and ISS are ongoing. QAR is on request and when the facility is deemed ready for the assessment.

## What is PPRHAA?

PPRHAA stands for:

**P**eer... *Carried out by peers within the health sector*

**P**articipatory... *Staff from all facilities being appraised and community representatives participate*

**R**apid... *Normally done in just two weeks for a whole state*

**H**ealth... *Focused on health systems and services*

**A**ppraisal for... *An annual appraisal*

**A**ction... *Leads directly into action planning and later into operational planning*

PPRHAA appraises and collects information on all the major aspects of a health facility or group of health facilities and their management structures (e.g. SMoH, SHMB), with a focus on management systems, as well as the views of the community and clients served. This process includes

collecting information for a range of indicators on the services, coverage and performance of the health facility/institution over five years, so progress and trends can be assessed objectively and comparisons made between similar facilities and the same facility over time

PPRHAA examines and assesses five aspects of health services:

A: Patient Care Management

B: Internal Facility/Institutional Management and External Linkages

C: Finance, Accounting, Equipment and Infrastructure

D: Client and Community Views

E: Facility/Institutional Output and Coverage

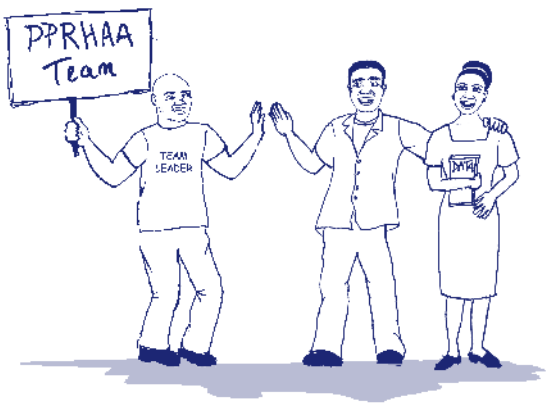
PPRHAA not only appraises and collects information, it also helps facility staff analyse the causes of any problem and develop action plans to overcome these problems. By bringing together health staff, managers and community members from different facilities; experiences, best practices and action plans can be discussed and shared. This helps to build the management skills and capacity of those involved and also identifies common issues across facilities.

The PPRHAA process includes hospital Appraisal Feedback workshops and Planning workshops where senior health officials, the appraisal team, hospital staff and community members have an opportunity to discuss the findings, develop plans and address cross-cutting issues. This is followed by a state or zonal Summit where all hospitals attend (often combined with the PHC facility summit).

The focus of the SHC PPRHAA is the hospitals and their associated management structures (SMoH, SHMB). Thus teams appraise both the headquarters and the facilities using separate tools. Tools and forms for SHC facilities and management structures will be distributed during the training workshops.

## Who Carries Out PPRHAA?

For each hospital there is a team of eight people that are assigned to cover the five key areas. The allocation of the team is as follows:




| | |
|---|---|
| Patient Care Management | 2 people |
| Internal Management and External Linkages | 1 person |
| Finance and Equipment | 1 person |
| Client and Community Views | 3 people |
| Output data | 1 person |

Each team usually covers one hospital per day.

# The Process

The diagramme on the following page is a guide to the annual PPRHAA process. The process can be shortened, lengthened and adapted to cover more or fewer facilities and to meet State-specific needs.

The two week annual appraisal usually looks like this:

| Two Week Plan | |
|---|---|
| Week 1 | |
| **Monday** | **Appraisal Training** |
| **Tuesday-Friday** | **Two (or more) teams: each team appraises 4 SHC facilities** |
| **Saturday** | **Report writing** |
| Week 2 | |
| **Monday** | **Planning training** |
| **Tuesday** | **Planning workshops concurrently in each hospital (8 workshops)** |
| **Wednesday/Thursday** | **Preparation for State/Zonal Appraisal Summit** |
| **Friday** | **State/Zonal Summit** |

# Prior Activities

Most of the preparatory work (including making arrangements with facilities so that you are expected) will be done by the team of catalysts and consultants facilitating the PPRHAA appraisal – they will explain to you what they have done in the training workshop. But two areas are important for the PPRHAA team members. Usually they can help with these.

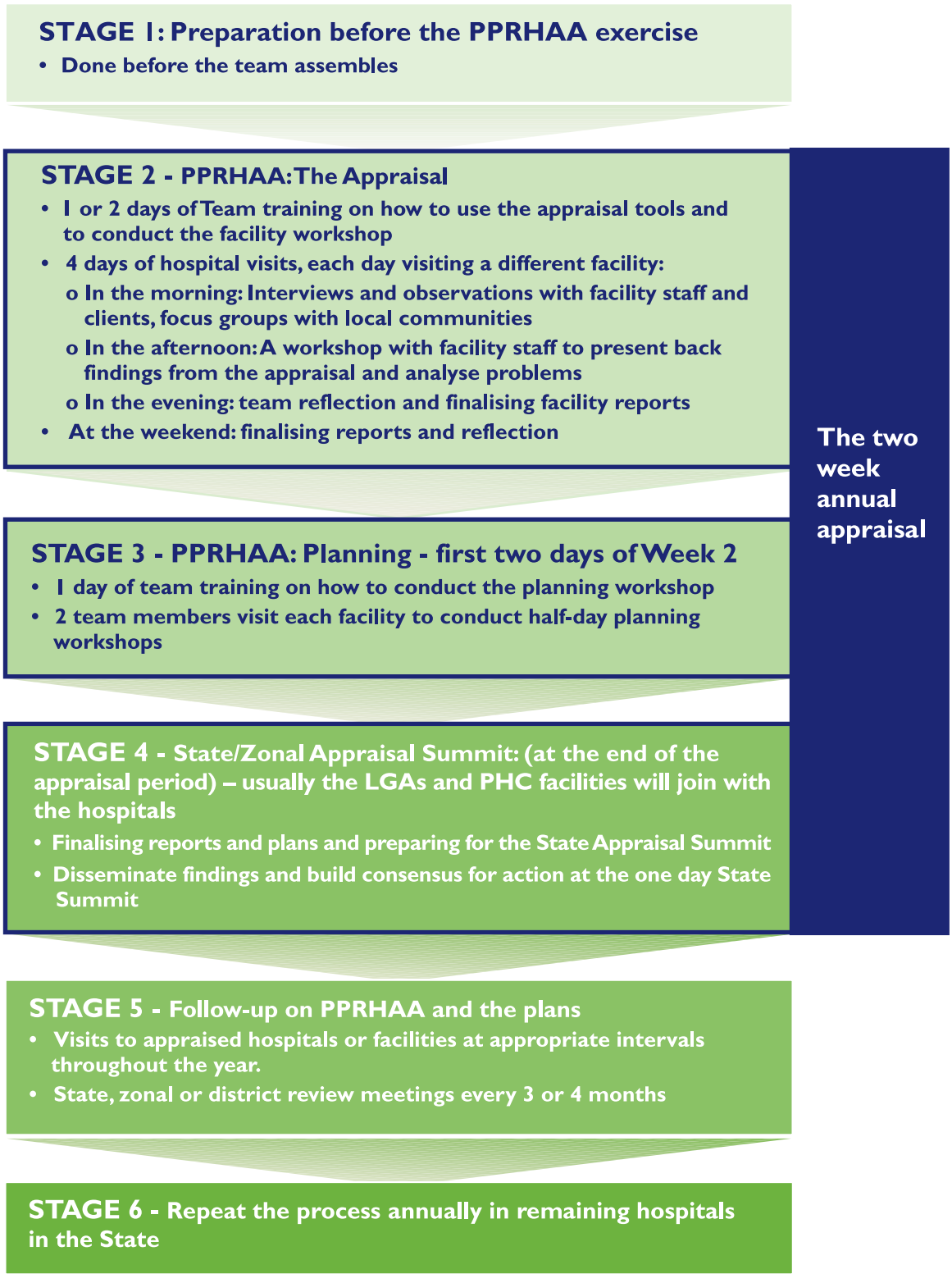
## Getting previous PPRHAA reports

For many institutions, this will not be the first PPRHAA appraisal. Thus, it is important to get reports from previous years. Copies should be printed and the team should make use of the reports during institutional visits and at the hospital Appraisal Feedback workshop and hospital Planning Workshop. When writing reports, ensure that you make comparisons with the information from previous appraisals.

## Getting LGA population Data and HMIS data

LGA population figures are very helpful in estimating the catchment population of health facilities. The most recent census population data for the LGA should therefore be obtained before PPRHAA starts. This might be available from the HMIS section. Similarly, all data for the hospital from the HMIS section should be collected prior to the visit.

*FIGURE 2: The PPRHAA Process*



# The Appraisal Visit

SECTION
2

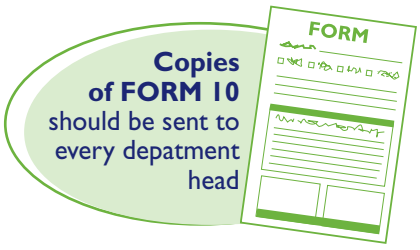
*Section 2*
*describes what happens on the day of the appraisal visit at the Hospital.*
*It includes a description of the work of the CCV team.*

## Introductory Meeting

When the team arrives at a hospital, it will meet first with the hospital Management Team:

- Introduce the appraisal team members to the hosts;
- Explain the purpose of your visit;
- Mention the upcoming hospital Appraisal Feedback workshop (on the same afternoon) and the Planning Workshop the following week, and the State/Zonal Summit with all the hospitals at the end of the following week;
- State that you have not come to find fault, but to share experiences and learn about how they manage their facility/institution;
- Tell them that the team represents a cross-section of key professional staff working in health care and/or community settings from similar hospitals facilities within the State;
- Be sure to thank management for allowing you to visit their facility and say that you hope that they will have time for further interaction while you are there.

## Distributing Form 10 *(Problem Identification Cards)*




After meeting with the hospital Management Team, distribute copies of the form (Form 10) and the coloured cards for identifying problems and solutions to every head of department in the hospital. Make sure that each unit head has enough cards and forms for their staff. Emphasise that their suggestions should identify solutions that can be implemented by the hospital team and not by outsiders.

- Encourage them to fill in the coloured cards between their normal tasks.
- They should address one problem, solution and recommendation per card.
- Tell them that the completed cards will be collected during the appraisal or just before the appraisal feedback workshop that afternoon.
- Encourage them to suggest their own ideas, particularly for improvements.
- Help those needing clarification or those of low literacy to fill out the cards. This can be done as the team goes through the facility.

The CCVOs conducting focus group discussions in the community and interviewing clients should use three problem and solution cards to capture the key problems and solutions identified by the community and three each for the clients. Similarly, complete cards for key informants if they have raised important problems and/or solutions.

These cards will be used at the hospital Planning Workshop . If you have a 'Minister for Paper' he or she should be responsible for collecting and keeping all cards safe until they are used in the workshop. In addition, the same person should collect all parts of the reports and the indicator ranking forms for that hospital, as well make sure they are typed.

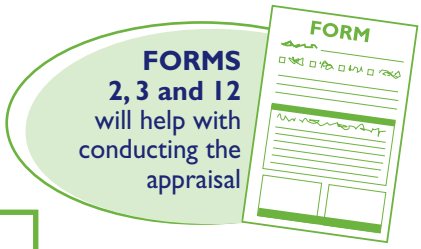
## Conducting a PPRHAA Appraisal

As a reminder, here is how the team will cover the different areas:

| | |
|---|---|
| A. Patient Care Management | 2 people |
| B. Internal Management and External Linkages | 1 person |
| C. Finance and Equipment | 1 person |
| D. Client and Community Views | 3 people |
| E. Output data | 1 person |

Team members complete allocated tasks and interact with the staff and/or community/ clients:

- Try to minimise interrupting their normal work.
- Interview staff, check records and observe the way things are done in the facility.
- Use the SHC interview Appraisal Guides to help you keep on course.
- Remember that the questions in the guides are there to help you cover all the relevant issues. They are not questions for you to ask the facility staff. Discuss with them and enquire in your own words. Decide what issues need more or less investigation.
- Keep in mind the questions from the Performance Ranking Tool (Form 12).




### *Tips:* when conducting an appraisal

Take full notes in your notebooks, but not on the tools

Record any observations that you think are relevant for the appraisal

Cross triangulate information as far as possible. Check important issues with two or more people or data sources

Collect as much information as you can from the HMIS before starting.

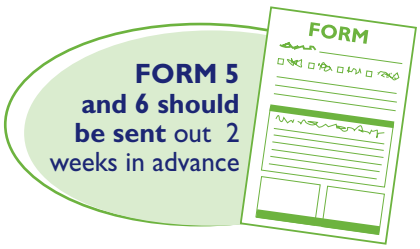
Use the reporting format as the basis for your report. Use breaks effectively to compile the report

# Collecting and Verifying Data on Service Outputs

Measuring service output through selected indicators quantitatively assesses the performance of the hospital. These indicators cover issues such as utilisation, quality, efficiency and other specific service issues. Comparison is made of the different hospitals over the last 12 months. As the annual appraisal becomes institutionalised, comparison over the previous years will become possible.

## *Steps for collecting HMIS data on service outputs*

1. Where there is a functional HMIS, available data needs to be collected from the appropriate unit (whether SMoH, SHMB or another site). Data must be collected on a month by month basis for the last year. Data must be collected by hospital to be appraised.
2. Output Data Collection Forms (see Forms 5 and 6) are sent out to the institutions to be appraised at least 2 weeks before the appraisal exercise. These are either blank (if no HMIS is operational) or completed as per paragraph one above.




3. It is the responsibility of the head of the institution to see that the form is either filled prior to the visit of the PPRHAA Team or if filled in already, the completed form is compared and corrected based on the data available at the hospital. Usually most of the data is collated by the head of the records department or equivalent person in the hospital. The head of accounts fills the financial section of the form.
4. On arrival of the PPRHAA Team at the hospital, the person responsible for service outputs should immediately ask for the completed form. Sometimes the form is not filled by the time the team arrives and you need to help the facility managers to fill the form. You also need to check the data to see if it is complete and accurate. Quite often you can do this by comparing the data you have with the data source in the registers where the data was collected (e.g. the attendance registers).

## *Estimating Catchment Area Populations and Service Coverage*

A tricky aspect of the data collection is that of estimating the catchment population of the SHC facilities. Catchment populations are needed as a denominator for several indicators (e.g. coverage indicators). You need to work with a fairly senior person from the hospital such as the MRO or the medical director/nursing manager. You will also need the population of the LGAs (from the most recent census) and the different wards (if available). You can obtain this from the SMoH. You must project it at 3% per annum from the base year.

For the hospital you can use one of three methods:

- First ask which wards the clients of the facility come from. You may get a list of 2 names, 3 or even up to 7. Write down the names of these wards. Then go through your list of names one by one and ask the manager assisting you to give you her best guess of the proportion of each ward that uses the facility. Your list should look like this.

| Ward Name | Proportion using Facility | Ward Population (Census Year-1991) | Estimated Population Using Facility |
|---|---|---|---|
| **Kazaure** | **60%** | 82,360 | **49,416** |
| **Roni** | **20%** | 55,264 | **11,937** |
| **Gwiwa** | **25%** | 55,184 | **11,053** |
| **Yankwashi** | **20%** | 46,356 | **9,271** |
| | | **TOTAL** | **80,777** |

If you have the software, enter the formula and the computer will do the rest. Similarly to extrapolate the population for the last 5 years you are assessing (e.g. from 2006 onwards) use formulas in the spreadsheet utilising a growth rate of 3% (for Nigeria) or calculate manually.

- The second method is to allocate population within the LGA to each hospital using hospital workload as a guide. For example, if the LGA has two hospitals and one is twice as busy as the other, then the catchment population for the busier one is 2/3 of the LGA population and the less busy one is 1/3 of the LGA population.
- Another way is to use the catchment figures that have been calculated and are in use by the HMIS.

Determine the best method prior to setting out for the appraisal. Estimating catchment populations for hospitals is usually easier than calculating catchment populations for PHC facilities.

### *Calculating denominators for populations*

| |
|---|
| **Estimated deliveries, first ANC = 4% of the catchment population** |
| **Total infants 0-1 years = 4% of the catchment population** |
| **Total children under five = 20% of the catchment population** |
| **Total adults aged 15 years and over = 55% of the catchment population** |
| **Females of reproductive age (15-44) = 20% of the catchment population** |
| **Male population aged 15 and over = 28% of the catchment population** |

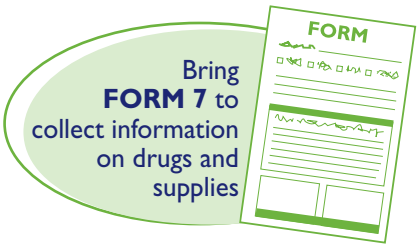

## Collecting Data about Rational Drug Use (RDU) and the Availability of Drugs and Other Medical Supplies

For the RDU, you want to work with the prescriptions of patients. Ask for all the prescriptions of the previous week or day and follow these steps:

1. Pull out 30 prescriptions at random
2. Take each of the 30 prescriptions one after another and count the number of drugs on the prescription and put the number in the first column of your Rational Drug Use Form (Form 8).
3. Count the number of drugs prescribed using generic names and record in column 2.
4. See if there is an antibiotic on the prescription. If yes, record 1 even if there is more than one antibiotic. If there is no antibiotic, record 0 in column 3.
5. Now look for injections and if you find any, record 1 in column 4. For no injection, record 0 in column 4.
6. Pick another prescription and go through the process again and continue until all the 30 cards are analysed.
7. Add up the numbers in each column for calculating your RDU indicators.

## Collecting Information about the Availability of Drugs and Medical Supplies

This is usually done by the same person who is doing the RDU.



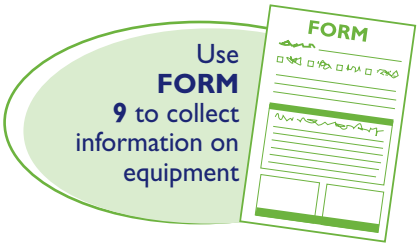

Step 1 Go to the pharmacy or the stores for supplies with the appropriate PPRHAA form (Form 7).

Step 2 Ask the officer working the store or pharmacy to show you each of the items listed in your form one by one.

Step 3 For each item he shows you, tick it in your form. If there is none, mark a cross. The quantity shown does not matter at this point.

Step 4 Add up the total number of items you saw. Record the total number of items you asked to be shown.

## Collecting Information about the Availability of Equipment




This is usually done by several members of the team. They need to decide who collects what information. As the team does the rounds of the hospital they need to tick off the items on the equipment form (Form 9).

## Software for Recording and Analysing Outputs

Analyse the service output data either manually or through using one of these programmes:

- the PPRHAA Service Output Program
- the DHIS software
- linked excel spreadsheets

# Indicators

## *PPRHAA SHC Performance Indicators*

| No | Indicator | Optimum | Explanation |
|---|---|---|---|
| **1. Use/coverage** | | | |
| 1. | **OPD Utilisation per 1000 population:** (Total annual OPD Visits/ catchment population) x 1000 | **0,3 - 0,7** | An indicator of utilization of the facility for minor ailments and the confidence clients have for the facility. Too high an estimate of catchment population would give too low values. |
| 2. | **Admission rates per 1000 population** (Total admissions/catchment population) x 1000 | **20-30** | An indicator of utilization of the facility and the confidence clients have for the facility. Too high an estimate of catchment population would give too low values. |
| 3. | **Caesarean Coverage Rate** (Total Caesareans /total expected deliveries in the catchment population) x 100 | **2-5%** | Caesarean Coverage is an indicator of the availability of emergency obstetric care and safe motherhood. It is estimated that a minimum of 5% of deliveries require a Caesarean. A higher rate might mean too many Caesarean sections but is most likely due to an underestimate of the catchment population. |
| 4. | **Proportion of deliveries at hospital** (Total deliveries at hospital/total expected deliveries in the catchment population) x 100 | **20 - 40%** | This is an indicator of utilisation and is again affected by the estimate of the catchment population. Interpret in a similar way to OPD Coverage |
| **2. Efficiency** | | | |
| 5. | **Average Length of Stay** (Total (annual) in-patient days divided by total admissions) | **5 - 7 days** | Also should be between 5 to 7 days for the secondary hospitals we have. A low level might indicate inappropriate admissions and a high one may be due to many chronic care patients such as TB or orthopaedic patients or that doctors are keeping patients for too long. (note: some staff call in-patient days as bed state days) |
| 6. | **Bed Occupancy Rate** (Total (annual) in-patient days/ (active beds x 365) x 100 – can also calculate monthly | **75-85%** | BOR indicates how effectively hospital beds are being used. If beds are being under used constantly below the optimum, it means the hospital does not really need the number of beds it has now and the hospital might consider scaling down to make use of nurses more effectively. |

| No | Indicator | Optimum | Explanation |
|---|---|---|---|
| 7. | **Recurrent cost per Patient-day Equivalent*** (Total (annual) in-patient days/ (active beds x 365) x 100 – can also calculate monthly | | Low values indicate judicious use of finances but be sure all expenditure has been included. Alternatively, there could be a lack of resources<br>Compare facilities of similar type. |
| 8. | **Budget performance rate** (Expenditure in quarter/(annual budget/4)) x 100– use this indicator only when reasonable financial data is available | **> 80%** | Indicator tracking release of budget |
| **3. Workload** | | | |
| 9. | **Average PDEs per doctor per day** (Total (annual) PDEs/number of doctors)/365 | | Indicator of workload for doctors. The higher the value, the more work there is in this hospital for doctors. It is very sensitive to the addition of 1 or 2 doctors. |
| 10. | **Average Patient-Day Equivalents per nurse** (Total (annual) PDEs/number of nurses)/365 | | Work load indicator. Gives you an idea of the average number of patients each nurse takes care of for 24 hours in one day. The higher the value the bigger the workload for nurses. |
| 11. | **Average Patient-Day Equivalents per staff member** (Total (annual) PDEs/number of nurses)/365 | | Interpret as for PDE per Nurse. |
| **4. Quality of Care** | | | |
| 12. | **Maternal death audit rate** (Maternal deaths audited/total maternal deaths)/365 | **90 -100%** | All maternal deaths should be audited. Low values needs the intervention of management. |
| 13. | **Newborn BCG coverage rate** (Newborns receiving BCG/total newborns) x 100 | **100%** | Measures the quality of the maternal health services. |
| 14. | **ANC HIV counselling rate** (Total first ANC attendees receiving counselling/total first ANC attendees) x 100 | **100%** | This measures both the quality of the ANC and HIV/AIDS services |
| 15. | **U5 weighing rate** (Total U5s weighed/total U5s attendance) x 100 | **100%** | Measures the quality of the child health services |
| 16. | **Reported staff with good attitude rate** (number of patients reporting good staff attitudes/number of PCQA questionnaires) x 100 | **>90%** | Use only if PCQA questionnaires available – measures clients views on the quality of services |
| **5. Availability** | | | |

| No | Indicator | Optimum | Explanation |
|---|---|---|---|
| 17. | **Tracer drugs availability rate** (Number of tracer drugs available/ number on list) X100 | **90-100%** | Lower values indicate problems with procurement and need to be investigated and corrected. |
| 18. | **Tracer supplies availability rate** (Number of tracer supplies available at the end of quarter/number on list) X 100 | **>80%** | Lower values indicate problems with procurement and/or maintenance and need to be investigated and corrected. |
| **6. Rational Drug Use** | | | |
| 19. | **Items per prescription** Total items dispensed/number of prescriptions | **1-2** | Four indicators measure the clinicians rational drug use skills |
| 20. | **Prescriptions - generic drugs only rate** (number of drugs prescribed using generic name/number of drugs prescribed) x 100 | **100%** | |
| 21. | **Prescriptions – antibiotic rate** (number of prescriptions with antibiotics prescribed/number of prescriptions) x 100 | **<10%** | |
| 22. | **Prescriptions – injection rate** (number of prescriptions with injections/number of prescriptions) x 100 | **<10%** | |
| **7. Access** | | | |
| 23. | **Exemption rate** (number of patients given exemptions/ [total inpatient admissions + total OPD headcount]) x 100 | **6-10%** | Lower than 6% indicates that the criteria are being applied to strictly, while more that 10% indicates they are being applied too loosely. |
| 24. | **Deferral rate** (number of patients given deferral/ [total inpatient admissions + total OPD headcount]) x 100 | **10-20%** | Lower than 10% indicates that the criteria are being applied to strictly, while more that 20% indicates they are being applied too loosely |
| **8. Participation** | | | |
| 25. | **Community Participation - HMC Rate** (number of HMC meetings with community reps in attendance/ number of HMC meetings) x 100 | **100%** | An indicator of whether the community is participating in the management of the facility |
| **9. Accountability** | | | |
| 26. | **DRF Decapitalisation rate** (money in bank+cash in hand +stock value)-total initial value of DRF]/ total initial value of DRF x 100 | ≥ 0% | This indicator measures the functioning of the DRF system |

** PDE (Patient Day Equivalent) links inpatient and outpatient services – 3 OPD visits = 1 in-patient day*

# Assessing Client and Community Views – The Work of the CCV Team

## a) Incorporating CCV into PPRHAA

The incorporation of client and community views (CCV) about health services is an integral part of the overall PPRHAA process for hospitals. It has four main aims:

- To provide hospitals with the views of clients and communities on their services and how they feel they should be improved.
- To raise awareness among facility and management staff of the need to hear and listen to the views of clients and communities.
- To support facility staff to develop action plans that respond to the concerns of clients and communities.
- To encourage hospitals and communities to work together to resolve some of the problems identified in the SHC facility and included in the action plan.

To do this, it is important that some community representatives attend the hospital Appraisal Feedback workshop and the Planning workshop. During the CCV assessment, the CCV team should identify possible community representatives who can represent the views of the community – and not just their own personal views - at the workshops. You need to look for people who have some involvement in the health sector e.g. community representatives on a facility health committee. The people you select also need to be comfortable speaking in a public forum.

## b) Assessing Client and Community Views during the PPRHAA Appraisal

Assessing Client and Community Views involves:

- Conducting two community focus group discussions, one with men and one with women.
- Conducting up to 10 interviews with clients at the facility .
- Conducting interviews with key informants such as community leaders.

You will have approximately 4 hours to complete the CCV assessment during each PPRHAA appraisal visit. Two members of the CCV team do the focus group discussions and the key informant interviews; the third member does the client interviews.

## c) Things to do before the PPRHAA Visit begins

- Ensure that the hospital Community Liaison Officers have worked with community representatives sitting on Facility Health Committees, where they exist, to notify selected communities of your planned visit and that community leaders are willing to arrange two focus group discussions.

- Get enough flipchart paper, pens and masking tape for the facility/ community visits from your PPRHAA team leader
- Draw up two flipcharts with the outline of the ranking matrix (see example below).
- Buy a bag of beans or groundnuts to use in the ranking exercise during the focus group discussions.
- Get enough money from the PPRHAA team leader to pay for light refreshments for the focus group discussion participants.
- Discuss and agree with the PPRHAA team leader how many community representatives can be invited to and supported to attend the hospital Appraisal Feedback workshop and the Planning Workshop.
- CCVOs may need an interpreter if they don't speak the same language as the clients/communities.

## d) The CCV Interview Guide

The CCV Interview Guide will help you to structure discussions during client interviews and focus group discussions. You should not use it as a questionnaire. Instead, it should be used as a reminder for you of key areas of interest, which you should discuss with clients/community members.

## e) What you need to do on arriving at the facility/ community:

On arrival in the community the CCV team members assessing community views will:

- Meet and greet the community leader.
  - Explain to him that you are here to conduct two focus groups, one with men and one with women, as part of the PPRHAA appraisal of the local hospital.
  - Ask whether the focus group participants have been selected and are ready to participate and check which group you should start with.
  - Agree with the community leader where the focus group will be held. Try to choose somewhere quiet where few interruptions are likely.
- Confirm with the community leader that the CCV Team can interview him later in the morning.
- When gathering the focus group participants together, make sure you have different age ranges involved and that different social or ethnic groups which live in the community are represented. Each focus group should involve 10-15 people.
- Ask the community leader or someone in the community to organise light refreshments for both groups (make sure you have brought funds with you to cover this).

## f) How to Conduct a Focus Group Discussion in the Community

- Explain to the participants that you are conducting a PPRHAA appraisal.
- As part of the appraisal, facility users and communities are being asked their views on the services provided by the facility and invited to contribute to finding realistic ways for improving the services.
- At the start of the focus group discussion, ask participants which local health providers they use, including the facility being assessed by PPRHAA and write/ draw these as column headings on the prepared ranking matrix.
- Facilitate a discussion on the first thematic area in the CCV Interview Guide (barriers to access).
- Give each participant five beans/groundnuts.
- Ask each participant to vote with their beans or groundnuts to indicate which facility/health provider performs the best under theme one. If the participant places all of his/her 5 beans or groundnuts on one health facility this indicates that they believe the facility is the best out of all the health providers for this theme; placing no beans or groundnuts indicates that the facility/health provider is the worst under that theme. They can place between one and five beans or groundnuts with any facility.
- Add up the number of beans or groundnuts under each facility and write this in the relevant box of the matrix and return the beans or groundnuts to the participants. Make sure all participants can see the result. Sometimes, participants like to debate the result – they might not agree with it and you will be able to find out more about their views of particular health services.
- Discuss the next theme and then ask the participants to vote with the beans/ groundnuts as before. Repeat until you have covered all the themes and completed the ranking matrix.
- Sometimes, you may find that the result of a ranking vote doesn't reflect the discussion that preceded it. If this is the case, try to find out why participants have voted in the way that they did and how this matches up with what they said earlier.
- Once you have covered all the themes, add up the totals for each health provider (i.e. down the column) to find out their overall score.
- At the end of the focus group discussion, take the completed ranking matrix with you. You will need to summarise it in your report and use it in the hospital Appraisal Feedback workshop and Planning Workshop.
- During the discussion, one of the team acts as the note-taker and writes detailed notes of the main discussion points.
- Finally thank the group for their participation and ask the group if there are any members who would like to represent the views of the community at the hospital Appraisal Feedback workshop that afternoon and the Planning Workshop to be held the following week.

### *An example of the ranking matrix to prepare before the focus group*

{Ask the group to choose four or five local health providers and write as column headings during the focus group}

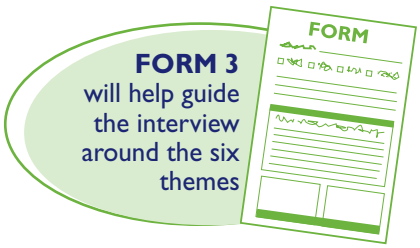
| THEMES | Provider 1 | Provider 2 | Provider 3 |
|---|---|---|---|
| Cost and affordability | | | |
| Satisfaction with care | | | |
| Drug availability | | | |
| Staff attitudes and behaviour | | | |
| Hygiene and upkeep of environment | | | |
| Community Participation | | | |
| Totals {add up for each health provider, i.e. down columns} | | | |

An example of the results of a ranking exercise carried out in a women's focus group in Enugu state:

| | General Hospital (undergoing Appraisal) | Private hospital | Herbalist | Health centre | Private Chemist |
|---|---|---|---|---|---|
| Cost and affordability | 50 | 0 | 0 | 0 | 0 |
| Quality of care | 10 | 25 | 3 | 2 | 10 |
| Drug Availability | 17 | 26 | 0 | 0 | 7 |
| Staff attitude | 19 | 17 | 3 | 0 | 11 |
| Cleanliness and environment | 0 | 27 | 3 | 5 | 16 |
| Total | 96 | 95 | 9 | 7 | 44 |

## g) How to Conduct Client Interviews

- Select individual clients randomly, trying not to let the facility staff choose clients for you. Where possible, interview an equal number of men and women of different ages, who have come to the facility with different health problems.
- At the start of each interview, explain briefly that you are conducting a PPRHAA appraisal. As part of the appraisal, facility users are being asked their views on the services provided by the facility and invited to




contribute to finding realistic ways for improving the services.

- Conduct interviews in privacy, out of ear-shot of staff.
- Emphasise that the interview is anonymous and confidentiality will be kept.
- Ask the client if they are still willing to talk to you. If they say no or look too ill or unsure, don't force them, just let them go.
- If the client agrees, use the CCV Interview Guide (Form 3) to help you ask questions relating to the six key themes. After each theme, ask them how they feel the facility could improve.
- Jot down the client's responses. Try to write down particularly pertinent quotations.
- At the end of the interview, feedback the main points with the interviewee and check that you've understood everything s/he has said
- Thank them.
- Once all the interviews are complete, fill in the 3 priority and solutions cards with issues identified by the clients.

## h) How to Conduct Key Informant Interviews

Key Informants are community leaders who may have experience of engaging with their local hospital e.g. they may be on the Hospital Management Committee or another such body in the community. Use the same approach as for the clients but in addition:

- Focus the interview on systems or structures the community use to engage with the health facility e.g. the Facility Health Committee where one exists.
- Once you have found out about community involvement in the facility, ask about the four main strengths and four main weaknesses at the facility. Get the interviewee's ideas about possible solutions to address the weaknesses and how the community could contribute to realising these solutions.

## i) Sharing CCV Findings with the PPRHAA Team

Throughout the whole PPRHAA process it is important for the CCV team to share the issues that arise from the interviews and focus groups with other members of the PPRHAA team. This is particularly true during the facility visits when members of the PPRHAA team looking at other issues such as External Linkages or Patient Care Management find information that appears to contradict what the clients or community say. Discuss this with other team members before the LGA Appraisal Feedback workshop and the Planning Workshop to allow time to check the information obtained or agree to discuss the issue with facility staff during the workshop.

## *Tips:* Client/Key Informant interviews

You are aiming to get clients/key informants to open-up and tell their point of view, NOT just reconfirm what you think; so try to ask open-ended questions not closed or leading questions.

Examples of open-ended questions include:

- How do you feel about…..?
- What do you think about….?
- Why….?

Try not to use closed questions, for example:

- Did you wait too long?

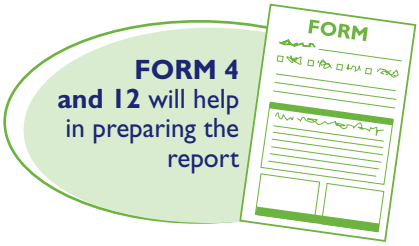
Or leading questions: i.e.

- Do you feel the staff here have a bad attitude?

Establish rapport with clients, chat to them informally before the interview begins

Try to interview somewhere quiet away from facility staff, if they do come and listen, ask them politely to leave

# After the Appraisals and Before the Workshop




Team members should finish the appraisal visits around the hospital and to the community about 12 noon. This will give them time to start writing their reports by filling out Form 4, as well as time to fill out Form 12 (the Performance Ranking Tool) and to prepare for the workshop.

Team members should use the notes they made during the appraisal to fill out Form 4. Key points in these reports:

- Answer questions in the guide with each sub-heading in a separate paragraph. Your report will be too long if you answer every question, so choose the most important ones to deal with in your report
- be specific and factual, give evidence and facts to back up your opinions
- Give an assessment of performance for each sub-heading
- Highlight good practices as well as bad practices.


See also suggestions in section 3 on report writing.

For the workshop presentations, team members should decide on the 4 most important strengths and the 4 most important weaknesses for the key area they assessed and perhaps write these on a flip chart. In addition they will need to fill out Form 12 and add up the score for their key area. One member of the team should also prepare a large blank Spider Diagram. One or more members of the team should also be collecting the completed problem/solution/recommendation cards.

# Workshop at the Hospital

The workshop should start by 1.30 pm, attended by all people who filled in the problem and solution cards. Do not however rush the managers if they are not ready. When the workshop begins, explain its purpose, which is to give feedback on findings. The workshop is also designed to help management prioritise problems and prepare for the planning workshop on Tuesday the following week. Use the opportunity to explain the IMPACT Initiative again.

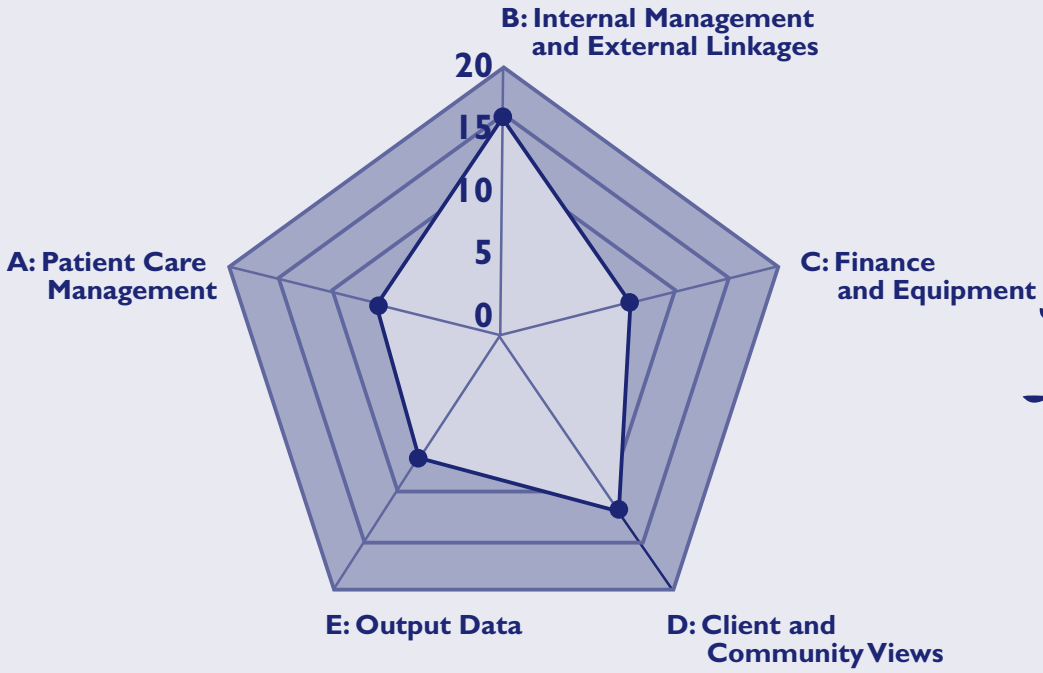
## a) Team Feedback

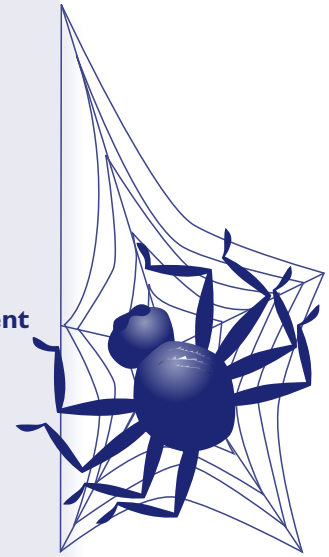
Next, the appraisal team presents a summary of its findings to the workshop. This must be kept brief – a maximum of 1 hour for team feedback. The team members responsible for each of the five key areas (A-E) present a summary of their findings and by presenting the 4 most important strengths and the 4 most important weaknesses they have observed. The CCV team makes a presentation that covers both client views and community views. All these presentations must be kept brief — a maximum of 5 minutes per presentation, and 5 minutes for discussion. If available, you can ask for feedback from the Patient-Focussed Quality Assurance (PFQA) process that is occurring in many of the hospitals. This feedback should be given by the person responsible for PFQA in the hospital.

If there are community spokespersons attending, they should also be given the opportunity to give feedback from the community's perspective on the services provided by the hospital.

## b) Spider Diagrams

Spider diagrams are a way of presenting a summary of the hospital's performance in each of the 5 PPRHAA areas. Just by looking quickly at the diagram you can see which areas of the hospital are performing well and which still need improvement. The diagrams should be kept so it is easy to see which areas have improved or deteriorated over time. Once the PPRHAA exercise is over they can be displayed at the hospitals to keep clients informed of how well their hospital is performing.



In the example, using the performance ranking questionnaire the following scores were calculated:

A: Patient Care Management scored 5 out of 20

B: Internal Management and External Linkages scored 15 out of 20;

C: Finance and Equipment scored 10 out of 20

D: Client and community views scored 12 out of 20

E: Output data scored 6 out of 20

There is the need to provide support in gaining an understanding of the spider graph generated, as this is the basis for developing action plans as part of the PPRHAA process. In interpreting the spider graph, it is important to link the discussion to some of the responses received during the data collection exercise. This element is critical as it helps to justify the situation and therefore reduces resistance to the outcome of the exercise. When people are exposed to a situation where the graph shows poor performance on most categories, there is the tendency to challenge the outcomes. The spider graph has the ability to expose in a graphical manner the weaknesses in the system and therefore could be found to be unpleasant by those who are directly involved in service delivery.

To create a spider diagram for the hospital:

- Draw a blank spider diagram on flipchart paper for each hospital. Follow the example above with an arm for each area of the appraisal and a scale of 0-20 up each arm.

- The PPRHAA team responsible for each hospital uses the performance ranking questionnaire (see Form 12) to rank their area (A,B,C,D,E) where yes = 1 and no = 0. Add up all the ones. As there are 20 indicators, this gives you a score between 0 and 20.
- Mark each score on the spider diagram.
- Finally, join all the ranking marks together to give a clear visual representation of performance. For a greater visual effect you can colour in the area below the marked lines as demonstrated in the example above.

During the training workshops, those interested will be shown how to draw a spider diagram using excel.

## c) Divide into Groups

Divide the hospital staff and managers into 5 groups – based on the five key areas. This can be done by making the hospital team number themselves. At the end of the numbering all number ones will be in group one, number twos in group two and so on.

For one hour, each group will be assigned to work on one of the key areas, discussing the feedback and the identified areas of strength and weakness. They will try to identify specific problems that the hospital can address and prioritise these. Explain carefully the tasks that each group is expected to carry out:

- Discussion on the PPRHAA appraisal feedback
- Prepare a list of the 3 or 4 problems at the hospital that the group thinks are most important for its key area, in order of priority, based on their own ideas, as well as the findings of the PPRHAA appraisal.
- Prepare a list of the 3 or 4 important successes at the hospital for the group's key area.

This group work will be continued during the planning workshop the following Tuesday. This is important to realise. You will be coming back in the following week to visit the hospital for the planning workshop. Be flexible and use the time wisely (both the initial afternoon workshop and the follow up planning workshop).

## d) Plenary: working group reports

When the groups are finished, they return for a wrap-up plenary session. At the plenary, select one person to chair and direct the proceedings. Call group Chairmen and Reporters in turn to present their reports. This will be their lists of problems and successes. The plenary session should last about half an hour.

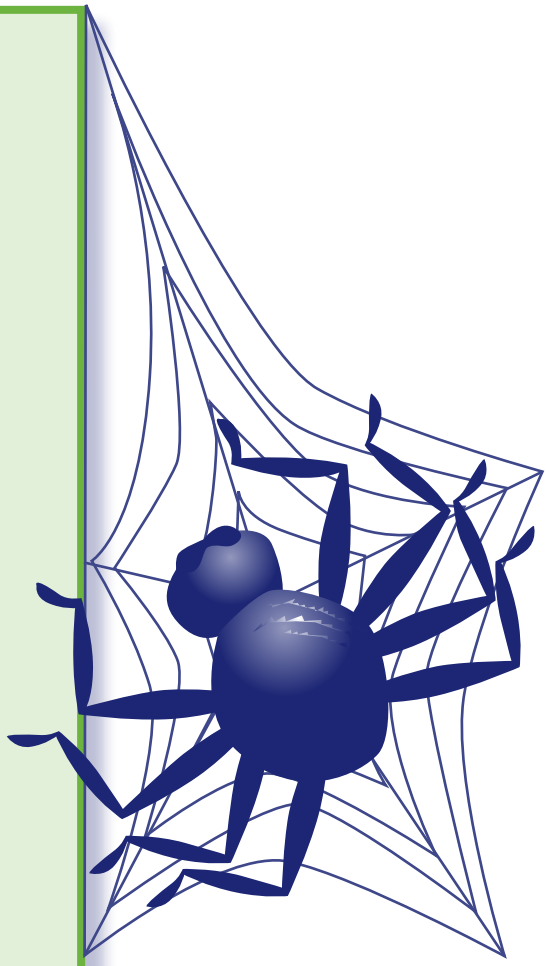
## e) Next Steps

Ask the group to prepare themselves for the planning workshop the following Tuesday, by thinking through the problems identified and considering possible local solutions. This should be done in the same groups. There is no need for plenary feedback as this work will be built on during the planning workshop in the coming week. At the end of the afternoon workshop, ask the hospital management to arrange for each of the 5 groups to hold a follow-up meeting before the planning workshop.

# Writing Appraisal Reports

SECTION 3

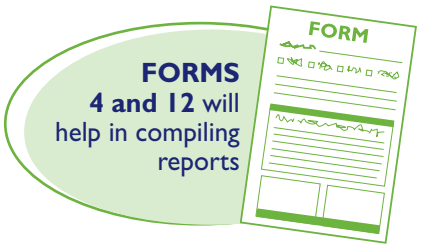
*This section will assist you in writing the reports for the different workshops and summits*



# OVERVIEW

Reports for the Hospital Appraisal Feedback and Planning Workshops include:

- Reports for each facility, using Form 4, and service output data. This includes the performance ranking tool (Form 12).
- The reports cover all five PPRHAA thematic areas (patient care management, CCV etc).




Later the reports from all the hospitals appraised are compiled into five theme reports (patient care management, CCV etc) for the State/Zonal Appraisal Summit and an overall report.

To make report writing easier, remember the following:

- A report format is used by all appraisal teams. This format is based on the Interview Guides.
- The performance ranking tool was developed (Form 12).
- Members of the appraisal team are encouraged to take notes in a note pad during appraisal interviews. At the end of each day, each facility report must be completed using the report format (Form 4).
- In addition, four areas of strength and four areas needing improvement need to be extracted
- As the team members do not have time to type up their reports, each individual institution report is typed by an outside person

## *Tips:* Facilitating Report Writing

Keep the evening reflective meetings going throughout the PPRHAA exercise so even on report writing days the team can share concerns and experiences.

Experience shows report writing can be the most difficult part for team members when they are doing this for the first time

Spend time with each of the groups, asking questions and helping them analyse and highlight important issues

# Writing Hospital Reports

Following the afternoon workshop the team should meet to:

- Review the institution appraisal and workshop
- Sort out any contradictions between the different sections of the appraisal
- Discuss what has been found
- Review problems that were prioritised
- Discuss and feedback on process (including facilitation skills)
- Extract key overall messages for the institution

A Report is then compiled for each hospital. This is based on the reports drafted for the Appraisal Feedback Workshop. Different sections of the reports are drafted by the team members (e.g. CCVO writes the CCV part; another member writes the patient care management section). The report now needs to be integrated into a single report and should include the discussions of the afternoon workshop. Key elements of the report and the presentation at the planning workshop need to be discussed by the team prior to the planning workshop.

Team members should use the notes they made during the appraisal to fill out the report formats (Form 4):

- Answer key questions from the Interview Guides in the Appraisal Tool with each sub-heading in a separate paragraph. Your report will be too long if you answer every question, so choose the most important ones to deal with in your report
- Avoid vague generalisations, be specific and factual, give evidence and facts to back up your opinions
- Give an assessment of performance for each sub-heading
- Highlight key issues, especially those that concern systems
- Discuss the management systems and procedures currently in place and whether or not they are working (not an activity report)
- Bring out differences and highlight "best practices" to share with others
- Mention serious problems at specific institutions but be constructive
- Emphasise issues the institutions can resolve on their own
- Draw out the most common findings across the hospital
- Remember to include the name of the hospital and the date of the report.
- Review problems that were identified in the coloured cards
- Extract key overall messages for the

hospital

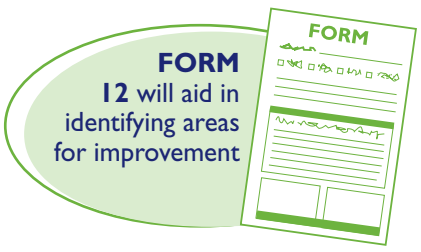
- Identify any dangerous practices (especially those related to patient care management such as universal precautions) for feedback to management at the hospital Appraisal Feedback workshop or Planning Workshop.
- For the CCV aspects look out for differences in views by age, gender, and education/wealth levels; and indicate whether views were held by a majority or only apply to an individual.
- The hospital report must be finalised before visiting the next facility to avoid piling up reports and mixing up important issues.
- While travelling back after the workshop or to the next facility the following morning, the team can discuss and comment on reports from the various groups. This will enable other team members to help fill in gaps and sort out contradictions. Make sure to incorporate the changes in the report.

## Ensuring Qualitative Data is Captured

Shifting the focus to report formats and using the performance-ranking tool has caused concern that the reports (and thus the PPRHAA appraisal) will over emphasise quantitative data at the expense of qualitative data. Thus it is important to:

- Include any quotations that you have noted down, this will make your reports and presentations much more interesting and give a stronger voice to the clients and communities
- Ensure community members are present at all workshops, summits and review meetings
- Use the evening team meetings to concentrate on qualitative aspects
- The four areas of strength and weakness must include qualitative aspects
- When completing the report format, concentrate on adding tips and comments from what you have observed and heard.

## Systems Analysis




The team should develop other important skills, particularly the ability to conduct a systems analysis on the institution. This is not easy to do. It is easier for the PPRHAA appraisal team to use the appraisal tool, the performance ranking tool (Form 12) and the report format to identify and list what needs to improve. This will leave the hospital with a large number of areas they need to work on. It is useful, though, for the appraisal to identify the underlying systems that need improvement. Otherwise, only the symptoms of malfunctioning systems will be addressed, not the underlying causes. This is obviously more difficult and the team needs to develop these skills over time.

As an example, if the light bulbs in the hospital are burned out, changing bulbs is an activity; but implementing Planned Preventive Maintenance is the appropriate systems response. PPM is a system that allows for proactive monitoring and maintenance of equipment and infrastructure, rather than reactively responding when pieces of equipment break down or buildings need maintenance. Developing a PPM system in the hospital is an example of the systems development that IMPACT promotes.

### *Examples of systems analysis*

During the appraisal, the team found that the DRF was not working. Investigating further, they discovered that the D&E part was being overused with little follow up to recover deferred fees. This had led to decapitalisation. No guidelines were available to say who qualified and two staff members allowed many people to use the D&E scheme.

The rest of the DRF could easily be revitalised. The issue was the D&E scheme.

During the appraisal, no sheets were found on the beds in the paediatric ward. Looking deeper, the problem was a budget not based on income and no prioritisation committee re spending. The MD and the accountant decided what to buy and the paediatric ward manager was not their favourite.

## *Tips:* Conducting systems analysis

When identifying four strengths and four weaknesses, think systems

Use the hospital Appraisal Feedback and Planning Workshops to identify system problems not symptoms

Use the 'but why' technique to get participants to look critically at deeper issues (see section 4)

Use the evening team meetings to discuss systems problems

Before the hospital Appraisal Feedback and Planning Workshops prepare a short input highlighting institutional systems issues

Distill the ideas from the appraisal, the hospital Appraisal Feedback and Planning Workshops and the evening discussions

# Analysing Service Outputs and Indicators

To analyse and calculate service output indicators from data collected at the institution use:

- The custom built software designed for PPRHAA or
- Excel, Access or another statistical software package (e.g. the DHIS).
- Or calculate the indicators using the formulae in the indicator tables in section 2.

For hospitals, put the indicators into the following related groups

### *1. Use/coverage indicators*

- OPD utilisation rate
- In-patient Admission rates
- Caesarean coverage rate
- Proportion of deliveries at hospital

### *2. Efficiency indicators*

- Bed Occupancy Rate (BOR)
- Average Length of Stay (ALOS)
- Average Recurrent Cost per Patient Day Equivalent
- Budget Performance rate

### *3. Workload indicators*

- Patient-day Equivalent (PDE) per doctor per day
- Patient-day Equivalent per Nurse per day
- Patient Day Equivalent per Staff per day

### *4. Quality of Care indicators*

- Proportion of maternal deaths audited
- Newborn BCG coverage rate
- ANC HIV counselling rate
- U5 Weighing rate
- Reported staff with good attitude rate

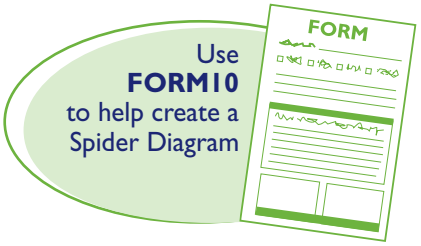
### *5. Availability Indicators*

- Percent availability of Tracer drugs/consumable on day of appraisal
- Percent availability of Tracer equipment on day of appraisal

### *6. Rational Drug Use Indicators*

- Average Number of Drugs per Prescription
- % of Drugs Prescribed using Generic Names
- % of Prescriptions containing at least one Antibiotic
- % of Prescriptions containing at least one Injection.

### *7. Access Indicators*




- Exemption rate
- Deferral rate

### *8. Participation Indicators*

- Community participation in HMC rate

### 9. Accountability Indicators

- DRF decapitalisation rate
- Patient preferential treatment rate
- Patient payment receipt rate

For each indicator,

- Explain briefly what the indicator tells the institution
- Compare to the norms where there is a known norm
- Discuss trends and implications
- Make comparisons between institutions

For more information on interpreting indicators see the ISS Manual.
Your report should also describe the state of medical record keeping, data collection, collation, analysis and use of data for decision-making.

# Collecting Reports and Action Plans

Make one team member responsible for collecting all reports and action plans (developed during the hospital Planning Workshop – see section 4) for each hospital. Make sure reports are typed as soon as they are submitted. Back up copies must be made once typed. Action plans will be on the flipcharts used during the hospital Planning Workshop.

Do the same for the reports and action plans during the State/Zonal Summit.

A simple checklist like the one below can be used to track the collection of reports.

## *Checklist For Monitoring Submission Of Facility Reports & Action Plans*

***Tick appropriate block when report submitted***

| Name of Hospital | Institution report | Client and Community view report | Hospital Output & Coverage | Action Plans | Remarks |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
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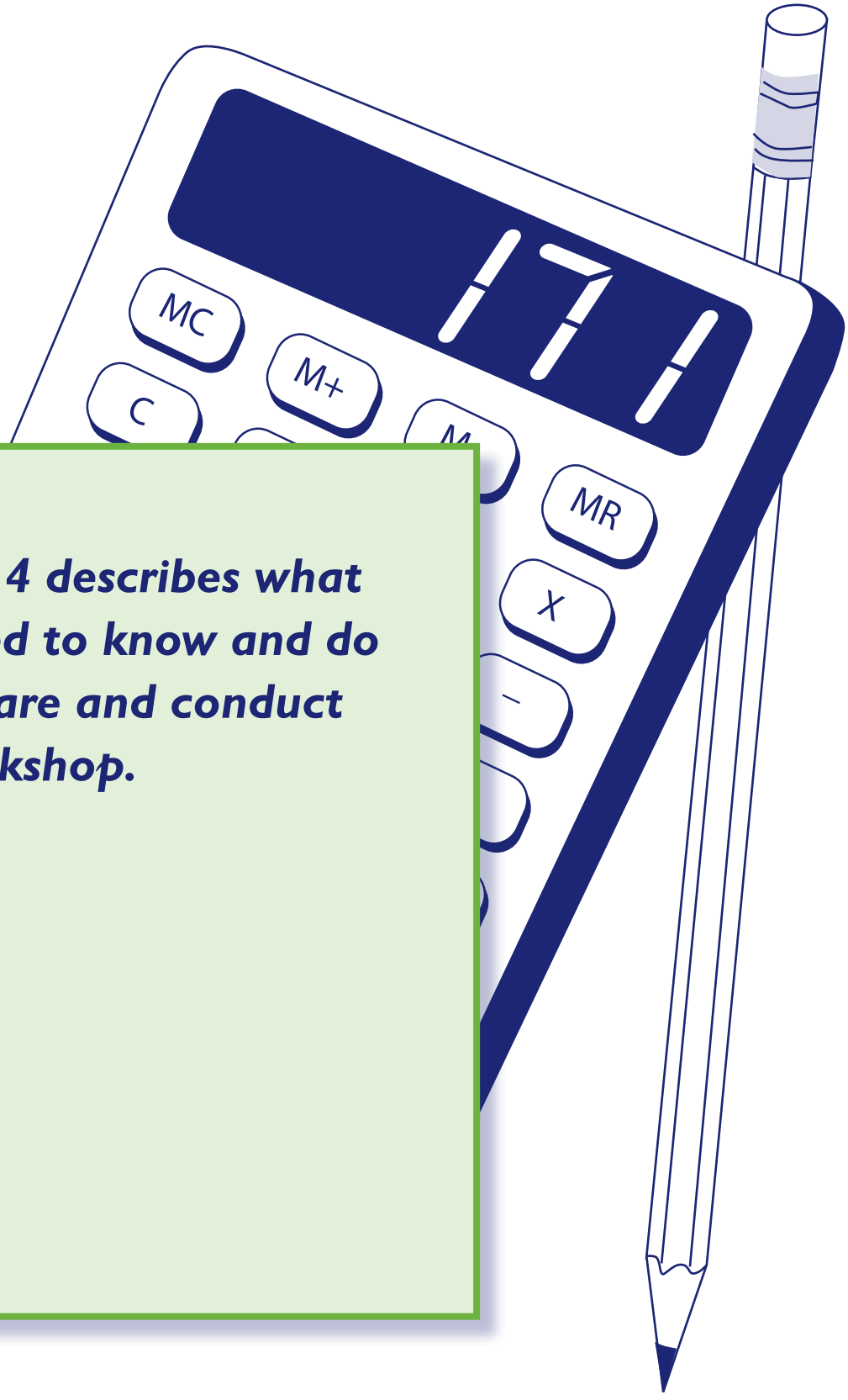
# The Hospital Planning Workshop

SECTION
4




***Section 4 describes what you need to know and do to prepare and conduct the workshop.***

# Introduction

The Hospital Planning Workshop occurs on the second Tuesday of the two-week appraisal period. Each appraisal team of eight divides into four teams. Each team of two runs a planning workshop at one hospital. Ensure that appropriate community members are invited – preferably those that attended the appraisal feedback meeting the previous week and/or HMC members.

# Prior Preparation

The hospital report forms the basis for the feedback and the action planning that occurs during the two hospital workshops (Appraisal Feedback and Planning). Key elements of the report and the presentations at the workshop need to be discussed by the team prior to the workshop and again after the workshop.

First, the team must analyse the data collected from health facilities, management structures, and communities. Then, they must produce summary reports and presentations for dissemination at the planning workshop (described in Section 3). To recap, for the Planning Workshop, the following need to be prepared and used:

- A composite report for each hospital that covers all five key PPRHAA themes (refined after the appraisal feedback workshop).
- A presentation on key output data.
- A spider diagram for the hospital (produced during the appraisal feedback workshop).
- The ranking exercise from the FGDs.

In addition to the institutional reports and presentations, the appraisal team should also have collected the completed problem and solution cards. When reviewing the problem and solution cards for each hospital, the team should group the problems identified according to the headings of the assessment tool such as

- Patient care management
- Finance and Equipment
- Internal management and external relations
- Community and Client Views
- Service Outputs

NB. Client and Community Views could relate to any of the five categories. For example, if clients and communities have raised concerns about poor staff attitudes towards patients, then this should be included under patient care management.

The cards are pasted on flipcharts under the heading of that theme area. Any duplicates can be removed and replaced with a number to indicate how many times this problem/suggestion has been raised. These are to be used in the Planning Workshop.

# Agenda

***Proposed time-table for Hospital Planning Workshop:***

| Time | Activity | Method |
|---|---|---|
| **8.00 – 8.30 am** | **Introduction to Planning**<br>• What is planning?<br>• Simple planning formats<br>• Action versus operational planning<br>• Strategic versus operational planning<br>• Introduce Federal HSR process and state SHP | Short inputs and plenary discussions.<br>Use catalysts if available<br>Use formats and handouts in annexes<br>Prepare summary on HSR status and state SHP |
| **8.30 - 10.00 am** | **Recapping of Appraisal Feedback workshop**<br>• Recapping IMPACT/PPRHAA<br>• Summarising appraisal report, appraisal workshop feedback and the problem/solution cards<br>• Present output data<br>• Review key problems identified in the appraisal feedback workshop<br>• Review spider graph | Plenary session<br>Ensure all five key areas are covered (especially CCV, as this can be lost)<br>This is a recap of the first workshop – during the appraisal visit.<br>Discuss a few problem statements that have been generated and agree that they meet the 5 gold standards.<br>Ensure that this is not critical and threatening. |
| **10.00 – 10.30 am** | **Break – refreshments** | |
| **10.30 – 11.30 am** | **'But Why' exercise in groups**<br>• Use this session to do 'but why' exercises to get to systems issues | After this, groups do the 'But Why' exercise on their own 1-2 problem statements.<br>No need to write this on flipchart paper – use ordinary A4 paper.<br>Facilitators to move from group to group to help where necessary. |

| Time | Activity | Method |
|---|---|---|
| **11.30 - 12.00 noon** | **Plenary** | Feedback and discussion from the groups on problem identification, the five gold standards and the 'But Why' exercise<br><br>Possibly use the gallery presentation method |
| **12.00 - 13.00 pm** | **Prepare Action or Operational Plan** | Use formats (see below)<br><br>Divide into groups<br><br>Use SMART to identify appropriate activities from the 'but why?' exercise<br><br>Complete the planning format for the prioritised and grouped problems |
| **13.00 - 13.45 pm** | **Lunch** | |
| **13.45 - 14.45 pm** | **Plenary** | Gallery presentation<br><br>Each theme group has a station and posters with their plans<br><br>Participants and PPRHAA team members ask questions<br><br>Encourage participants to relate the plans to the appraisal and the hospital spider<br><br>Facilitate a discussion after the gallery session<br><br>Half an hour for gallery and similar for plenary discussion<br><br>Include a discussion on the way forward |
| **14.45 – 15.00 pm** | **Final wrap up** | Deal with any outstanding issues |

### *Notes for facilitators:*

1. The times above are suggested times – in reality you will probably need longer for each activity, especially if this is the first time. The planning workshop at a hospital may take most of a day.

2. Appraisal Presentation could be done as a gallery with 5 stations: each station has flipcharts (strengths and weaknesses; pink cards); service output station has graphs as well (this might not be possible during the appraisal workshop but could be prepared for the planning workshop). These need to be prepared beforehand.

3. Before breaking into groups for the problem statement definition/'But Why' exercise, in plenary use an example to illustrate the use of the five gold standards (all the tools mentioned here are explained in detail later). Example could be: 'This General Hospital does not provide adequate maternal services for pregnant women'. In plenary apply the 5 gold standards to this problem statement. Also, in plenary discuss a few problem statements developed during the appraisal feedback workshop and agree that they meet the 5 gold standards. Ensure that this is not critical and threatening.

4. Before breaking into groups to do the 'But Why' exercise on the problem statements - do a 'But Why' exercise in plenary using the example in note 3. Draw this on a flipchart paper. Try to identify not more than 5 roots and follow these down.

5. After this, groups apply the 5 gold standards to their problem statements and do the 'But Why' exercise on their own 1-2 problem statements. No need to write this on flipchart paper – use ordinary A4 paper. Facilitators to move from group to group to help where necessary.

6. Before breaking into groups to do the SMART exercise do a SMART exercise using the problem statement in note 3 that was developed into a root diagram in note 4. Also discuss SMART and apply this to some of the activities identified. Then show people how to fill in the planning format by writing 4-5 SMART activities on the paper (A4) and then completing each row. Prepare 10 flipchart sheets beforehand.

7. Break into the same theme groups and ask the groups to identify SMART activities from their 'But Why' root exercise and then to complete the planning format and put this on the flipcharts prepared by the PPRHAA team beforehand. Present this as a gallery presentation.

You should now have a plan that is based on the appraisal with 1-2 problems identified in each theme.

Remember you can use the whole day for this workshop. Start the process in the appraisal feedback workshop and continue during the follow up planning workshop. By the end of the appraisal feedback workshop you hope to get to the problem statement identification phase. You can then ask the hospital teams to review these statements in preparation for the planning workshop the following week.

# From Appraisal to Planning

Why do we plan? All institutions operate in a resource constrained environment. We cannot do all the things that we would like to do. We have to choose. Often it is not apparent how the choices are made. At times, certain key members of management decide and implement what they think are the priorities. Planning helps management allocate scarce resources by developing systems that allow:

- Identification of needs
- Prioritisation according to identified strategies and criteria
- Development of tools to monitor implementation
- Processes for review and revision of plans

In a sense, planning is an important management tool as it allows a structured process for allocation of scarce resources according to priorities and the review of the implementation and effectiveness of the plans adopted.

Planning starts in the appraisal feedback workshop; continues during the planning workshop; and culminates in the State/Zonal Summit. The plans are then reviewed and refined during the monthly and quarterly follow up visits (see ISS manual).

Use the following steps to move from the appraisal feedback to the development of plans.

## Appraisal

Presentation by team: Appraisal of the five themes; Strengths and weaknesses on flipchart for 5 themes (PCM; CCV; finance; internal management; service outputs)

Pink problem cards on flipchart for each theme

Spider for hospital

Presentation by hospital: PFQA, if available

## Problem Statement Definition

Use 5 Gold standards: Break into five theme groups – each group to identify 1-2 priority problems from weaknesses identified in the appraisal; problems identified in the PCQA (if available); and red card problems

Define simple problems; and define them as systems problems and not a lack of resource problem

## Root Causes Identification

Use 'But Why' Approach

Five theme groups to do exercise for each of their 1-2 problems; identify root causes at higher levels as well.

## Identify SMART activities

Following the 'But Why' approach, theme groups have identified 4-5 activities per problem

Apply SMART criteria to the activities; Activities need to be able to be addressed locally

## Transfer SMART activities onto Planning Format

List 4-5 SMART activities on planning format

Complete planning format for each activity: - responsible; resources; timeframe; outcome/indicator

Be specific

# Tools for Planning

## Five Gold Standards for a Problem Statement

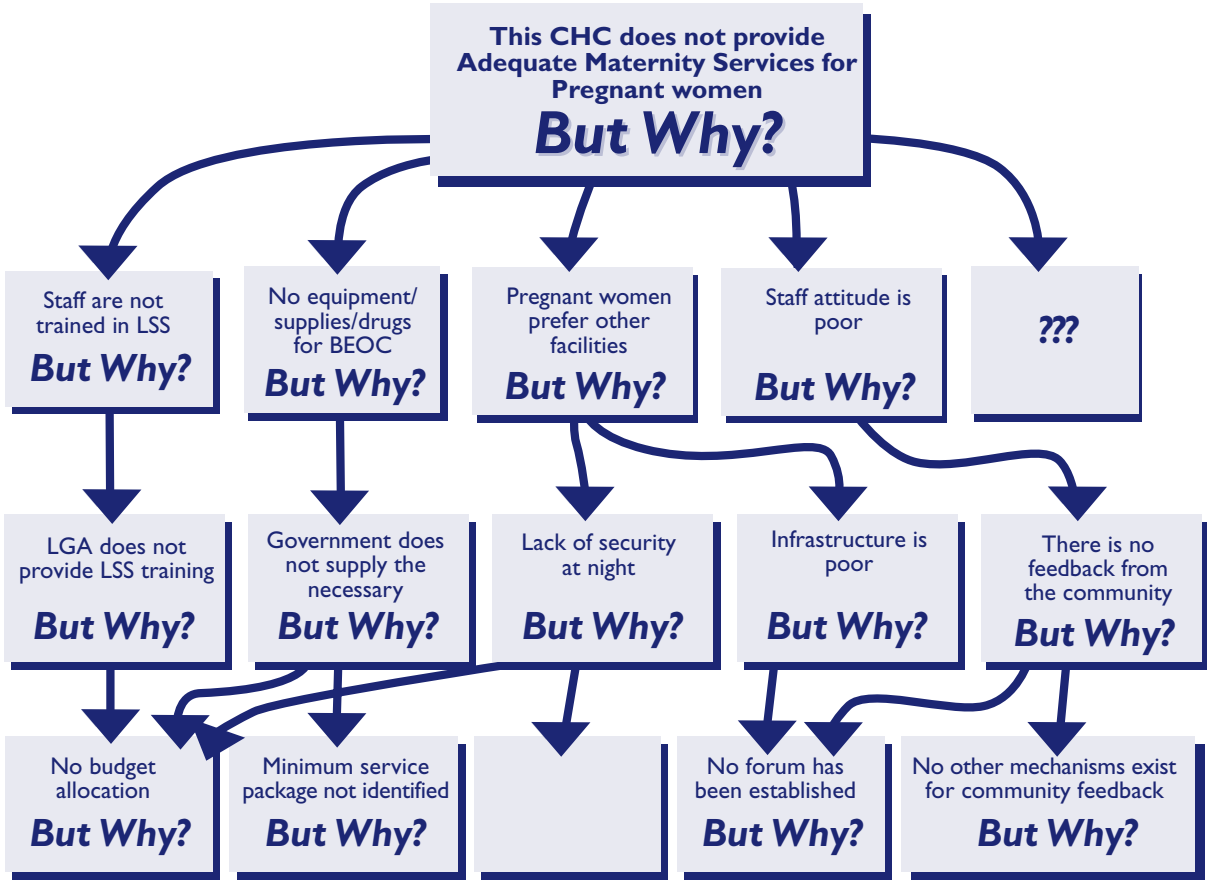
1. Is it a serious and important problem for the hospital and/or the community?
2. Is it a problem with the quality, efficiency, access and/or coverage of services from the hospital?
3. Is it a problem about how things are done or managed at the hopital, or the end results needed?
4. Is it a problem we can adequately handle at our level?
5. Is the problem statement a clear and understandable sentence?

### *'But Why?' Exercise*

Using the 'But why?' exercise is a good way to help staff think about the root causes of problems and start to identify systems within the hospital that need to be established or improved. The 'but why' exercise follows these steps:

- During the planning workshop the participants break into groups covering the 5 PPRHAA areas.
- Each group takes the priority problems in their area
- Each priority problem is written at the top of a piece of flip-chart paper
- Taking each problem in turn, the group ask themselves, 'but why does this problem exist?'
- Each time the group come up with an answer, which is effectively a new problem, they write this on the flip chart
- The group then looks at this new problem and again asks, 'but why does this problem exist?'
- The process continues until the group feel they have got closer to the root causes of the problem.
- The PPRHAA team members facilitating the LGA Appraisal Feedback and Planning Workshop should spend time with each group to help them identify the underlying causes to the problems – often the lack of effective systems.

### *An example of a 'But Why?' diagram*




### *Smart Activities*

Specific; Measurable; Achievable; Realistic; Time bound

Possible SMART activities that can be identified from the maternity services example that can be done locally at facility level:

1. Hospital to initiate LSS training.
2. Hospital to list/cost minimum resource package needed to provide BEOC/CEOC.
3. Hospital to develop budgets and ensure minimum resource package is included.
4. Hospitals to develop DRF and D&E schemes.
5. Hospitals to establish links/forums with the local communities.
6. Links/forums to discuss maternity service issues.
7. Etc.

# Planning Format

To assist in the planning, a standardised format will be used. To avoid a complex planning format and process, a simple format has been adopted for the three month action plans. As the planning process matures a more complex form can be used. This is to ensure that the valuable time of institutional managers is not consumed by the process but by the outputs. The fundamental thrust of the IMPACT Initiative is to ensure action. The planning process and formats[1] hopefully reflect this.

Plans that are developed using the standardised format need to be shared with and used by all hospital staff and managers. Plans should be displayed in departments and hospitals.

Following the first round of the PPRHAA process, it is important that institutions do not develop plans which are too complicated so they will not be understood or used by all hospital staff. Plans must be SMART. If institutions develop plans that can never be realised, we are setting up our institutions for failure. On the other hand if the plans developed do not address the underlying system problems; we are not going to see significant improvements over time.

There is a delicate balance here. There are no fixed answers for this dilemma. Each state and each PPRHAA team needs to make judgements as the PPRHAA process unfolds and to ensure that the planning and review process reflects the maturity of the emerging health system.

In the first PPRHAA round, short three month action plans need to be made. These need to reflect key problems identified by the institutions and be activities that can be achieved. If possible, more systemic problems need to be addressed. Encourage the hospitals to choose around 4 problems from those identified during the appraisal feedback workshop.

During the cyclical PPRHAA process, plans need to deepen in two significant ways:

- Plans need to be based on the state (or equivalent) Strategic Health Plan (SHP).
- The time frame needs to widen from short three month action plans to one year operational plans. There can be an interim six month plan phase.

At the end of the hospital Planning Workshop, each hospital should have prepared an action or an operational plan that address the main issues identified in the PPRHAA appraisal and cover all the five PPRHAA themes. This is then brought to the State/Zonal Summit (usually on the last Friday).

1 The formats will be presented and explained during the training

## Tips: Improving The Planning Session

Facilitators must be confident and know the material well

Ensure that the introductory inputs are simple and clear

Don't assume the senior people in the institution necessarily know better than the junior ones.

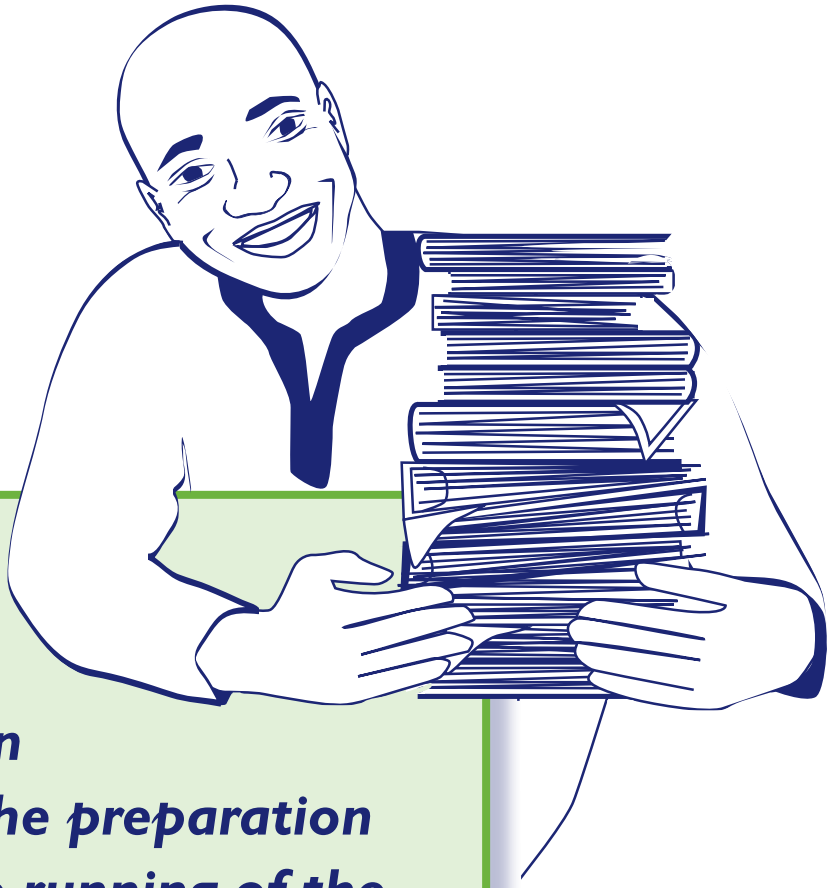
Planning must be made simple and output focussed

Group problems; ensure all five themes are covered; and the links to key state strategies are identified

Plans must have activities that institutions/facilities can do

# The State/Zonal Appraisal Summit

SECTION 5



*This section describes the preparation for and the running of the state/zonal summit which is normally held together with the PHC appraisal team at the end of the whole PPRHAA exercise.*

The team has two days to plan the appraisal summit and prepare all the reports. This is the Wednesday and Thursday of the second week. All the teams now work together.

## Summit Agenda

| Time | Activity | Method |
|---|---|---|
| **8:30 – 10:30** | **Session 1: Appraisal**<br>• Report by PPRHAA team on four key areas (A, B, C, D) | Use performance ranking/spiders<br>Besides individual institutional spiders, develop a state spider<br>Identify four key points of excellence and four needing improvement for each area<br>Presentation is not in plenary, but a gallery presentation – a PPRHAA member stands by a station with graphics, spiders and posters behind and answers questions<br>CCV station has quotes on wall |
| | • Output data presentation (E) | Plenary presentation of output data<br>Use graphs liberally |
| | • Plenary discussion | Following gallery presentation<br>Facilitator is key<br>PPRHAA team needs prior discussion with facilitator re points/areas to cover |
| **10:30 – 10:45** | **Tea** | |
| **11:00 – 11:30** | **Session 2: Planning**<br>Official opening session | Official opening by dignitary (Commissioner or PS)<br>Overview of IMPACT<br>Handout (one page) explaining IMPACT<br>Fit this session in at an appropriate time |
| **11:30 – 13:30** | **Session 3: Planning**<br>• Presentation by hospitals of institutional plans | Second gallery presentation<br>Each hospital has a station and posters with their institutional spider and their plans<br>Participants move around and ask questions<br>Encourage participants to relate the plans to the appraisal |

| Time | Activity | Method |
|---|---|---|
| | • Plenary Panel discussion | Each hospital has a representative on the panel and 'defend' their plans<br><br>Audience members and the facilitator ask questions on the plans<br><br>Facilitation and prior planning are key again<br><br>Query whether plans are SMART |
| ***Note: if you have a large number of institutions, run parallel group discussions in Session 3 – try to keep groups not bigger than 4-6 institutions*** | | |
| **13:30 – 14:30** | **Lunch** | |
| **14:30 – 15:30** | **Session 4: Crosscutting issues**<br>• Presentation<br>• Plenary panel discussion | A PPRHAA team member presents (in plenary) the cross cutting issues and the recommendations to higher levels<br><br>Identify key people for panel – politician, senior administrator, donor etc<br><br>Discuss arising from the presentation |
| **15:30 – 16:00** | **Session 5: Way forward** | Plenary discussion on way forward<br><br>Discuss quarterly review process<br><br>Try to get commitment from key role players |
| **17h00 – 17h15** | Wrap up and Evaluation | |

# Session Details

## *Session 1: Appraisal – Gallery presentation*

The appraisal feedback presentation is done as a "gallery" presentation which consists both of visual material (e.g. spider graphs on a flipchart, a flipchart on four strengths and weaknesses, the ranking exercise from the focus group discussions) and short presentations. Each presentation covers one theme; which means that there will be four stations.

In the gallery presentation, the audience is divided into four equal groups and rotates from one station to the next. At each station, the visuals are presented and other areas highlighted. There is approximately 10 minutes per station. This is followed by a plenary presentation on the service output data and then a general discussion.

## *Session 2: Opening Ceremony*

This session includes an opening ceremony, which is optional but necessary if you have invited a public figure such as a politician or a senior civil servant to open the Summit. Talk with the master of ceremonies, the chairman and the VIP so they understand the agenda. The opening ceremony can be slotted in where appropriate to accommodate the VIP's schedule.

This opening ceremony includes an explanation of IMPACT and PPRHAA

- IMPACT stands for Improving Management through Participatory Appraisal and Continuing Transformation (see figure 1).
- PPRHAA stands for Peer and Participatory Rapid Health Appraisal for Action.
- PPRHAA is carried out by peers of managers and professionals from other neighbouring hospitals.
- Managers of the hospital being appraised also participate.
- The process encourages immediate local action by managers and staff, using local resources.
- Following PPRHAA there is a cyclical process of support and follow up
- In addition, there are specific systems strengthening initiatives

## *Session 3: Planning - Action Plans for each institution*

Now it is the turn of the hospital groups to present the action plans they prepared when the team held the hospital Planning Workshop. This again is a gallery presentation followed by a panel 'defence'. Each hospital group should have flipcharts with their appraisal spider and their action plans (over time, the action plans will become operational plans).

### *Have some Fun with Planning*

For some fun, you might ask participants to rank the top three plans, or the three most improved plans or the three plans that best address the weaknesses identified in the appraisal. Make this entertaining (e.g. use 'Oscars'). Get participants to anonymously rank; a PPRHAA team member will count the votes and present the outcome in the final session.


### *Session 4: Cross cutting issues and recommendations*

Ensure that a PPRHAA member has a good presentation – preferably on power point. Ensure that the panel has been briefed and is representative and senior. The facilitator needs to have excellent skills and be adequately briefed.

### *Session 5: Way forward*

Now you need to decide with all participants what the next steps are. The lead facilitator should lead the discussion on the following issues:

- Dates for follow-up visits of the PPRHAA team to facilities
- Date for review meeting in 3 months
- Role of PPRHAA team when they return to their institutions
- Any state-level activities
- Commitments from key role players

## Preparation for the State/ Zonal Appraisal Summit

You have two days to prepare for the state/zonal appraisal summit. What you need to do on each day is described below.

### Day 1

The whole team needs to prepare the following (one set for PHC and one set for SHC):

- A composite report for each theme which covers all the reviewed hospitals e.g. one report for Patient Care Management for all the SHC facilities in the state/zone. This is presented in a gallery presentation style. In addition, each team designs one or more flip chart posters which identify four key points of excellence and four areas needing improvement in each theme.

- A presentation on key output data - with charts and figures of the service output indicators (use power point if possible)
- A spider diagram combining data from all the hospitals visited in the state

To do the preparation, PPRHAA team members work in theme groups.

Remember that in the preparation for the hospital Appraisal Feedback and Planning Workshops (see section 3) that individual hospital reports, spiders, CCV reports and service output data reports have been prepared. The teams preparing for the summit use these reports to prepare a theme report.

Refer to sections in section 3 (e.g. "key points to consider in preparing consolidated reports" and "analysing service outputs and indicators") to help you.

### *Report writing by team groups on each Theme*

This can take up to 8 hours. When you have got all the reports on all institutions, you need to compile a consolidated report on each theme for all institutions. This is used as the basis for your presentation and does not need to be typed as it will not be submitted to anyone. Use the same reporting format as a guide. The report should follow the same pattern as that for individual institutions, again making sure you are answering the questions on your assessment guide and giving evidence where you are making a judgement. What are the common practices? What is done differently in the different facilities?

Areas of interest should be part of your presentation and put on the flip charts for the gallery session. Finally, extract four key areas of excellence and four areas needing improvement. These will be presented during the appraisal summit.

In addition, to the theme reports for areas A, B, C and D the team needs to prepare a consolidated service output data report for presentation in the plenary. Some members need to be allocated this task.

### *Day 2*

Day 2 should be reserved for

- Discussing each consolidated theme report by all the PPRHAA Team members
- Finalising the consolidated presentations
- Drawing up presentations on flip charts
- Preparing for the gallery session
- Picking out major issues to address (four areas of excellence, four areas needing improvement)
- Finalising the agenda for the summit.
- Arranging for the summit
- Discussing the facilitation

**Tips:**

### Preparing Posters for a Gallery Presentation

- Focus on the four key points of excellence and four points needing improvement for your theme
- Keep your poster clear and simple – you will be standing next to your poster to explain in more depth if you need to
- Write in clear large handwriting so people can read your poster from a distance
- Use diagrams and pictures if you can – this can be more interesting than text alone
- Use quotations where you can, especially the CCV team, to help your poster come to life.
- Prepare the spider graphs

- Discussing desired outcomes from each session
- Identifying potential panellists
- Allocating team members for the consolidated report on crosscutting issues and recommendations to higher levels

### *Discuss Team Group reports*

It is important that all of the reports are finished on the first day. On the second day, each theme group presents the consolidated reports to the rest of the PPRHAA team. If they have time the previous day, they could prepare their posters for the gallery presentation and discuss these. This is to enable other team members to comment on your report (or poster) and to avoid repetition of issues or contradictions across the different reports/ posters. Keep notes of all suggestions from members of the team so you can edit your report accordingly.

During the discussion, major issues that cut across all institutions are listed on a flip chart. Your recommendations will be derived from this list. They should focus on issues that the institutions can address themselves.

### *Pick out cross-cutting issues*

By the end of the presentation and discussion, the whole team will assemble a list of main areas of excellence and weakness for all hospitals. Make sure all thematic areas are covered and try to keep to a maximum of four areas of excellence and four of weakness per theme. For each of the four areas of

weakness, list actions that the institutions can take to reduce or solve the problem. When you have finished this, take the same issue and see what the SMoH/SHMB can do towards solving the problem. The table below provides examples of two crosscutting issues and actions.

### *Example of a Table of Cross-Cutting Issues and Actions*

| | Issue | Action By Hospital | Action By State MOH | Action By PRRINN-MNCH |
|---|---|---|---|---|
| 1. | Quality of Care | • Set up suggestion boxes in prominent places and create awareness for use.<br>• Develop systems for keeping essential emergency drugs in emergency unit | Set-up quality assurance systems in hospital including system for monitoring patients' views and satisfaction, clinical, morbidity and mortality audits, standard treatment protocol and strengthen emergency services | Procure an expert in quality assurance and support setting up of program in hospitals in the state |
| 2. | Patient records and registers | • Produce standard record forms and registers<br>• Orientate staff on the use of forms | Produce templates of standard record forms and registers and mandate hospitals to charge for them | |

This will form the basis of Session 4 during the State/Zonal summit.

### *c) Finalise the Summit agenda and share out roles and responsibilities*

The Team is now ready to share responsibilities for the Appraisal Summit. Take the draft agenda which you drew for the Summit and insert the names of those who are going to do the presentations and be the facilitators. Other roles you need to assign are:- recorders for discussions; registration; raising key issues, etc. Remember to discuss desired outcomes/issues to be raised in each session.

## Other Considerations

Before the Workshop, have someone visit the venue to be used to:

- Re-arrange the chairs into a horse-shoe arrangement.
- Set up stations for the gallery sessions and ensure there is enough free space around each station

- Test multi-media (LCD) or overhead projectors, if you plan to use them.
- Make sure materials are available, including flipcharts, flipchart stands, loud speaker if necessary, note pads, pens, A-4 paper, and copies of reports.
- Paste charts around the conference room for the gallery session
- Select and brief chairperson(s)
- Organise participant registration

The Appraisal Summit is the zenith of all your work. The purpose of it is to present your findings and the plans of the hospitals to the managers of the institutions you have appraised, SMoH/SHMB staff, political heads, etc. In addition, it is an opportunity for advocating for action by higher management authorities on key issues that hospitals cannot solve by themselves.

## Looking Forward

At the end of the Summit, PPRHAA team members should include the input of other participants into the final appraisal report; the agreed-upon list of cross-cutting issues and actions to be taken by the different stakeholders; and action plans for each hospital for the next 3-4 months.

Participants can then decide the next steps. The lead facilitator will lead a discussion on the following issues:

- Dates for follow-up visits of the PPRHAA team to facilities
- Date for review meeting in 3 months
- Role of PPRHAA team when they return to their institutions
- Any state-level activities
- Any hospital-led activities
- Commitments from key role players

## Evaluation

At the end of the summit, it may be useful to get feedback on both the summit and the whole PPRHAA process. The following are some evaluation ideas:

***As an energising way to get an instant impression*** you could ask all the participants to stand up and make a line – ask them if they think the PPRHAA exercise has been useful. The ones who feel it has stand at one end of the line and those that think it has not stand at the other end. Those who found it quite useful stand somewhere in the middle – the line becomes a scale and you can get an instant view of how valuable people found PPRHAA. You can ask different questions and adapt the exercise for use at any point during the summit or during the PPRHAA process.

***To get more detailed feedback*** hand out two post-it notes to each

participant ask them to write one good thing about the PPRHAA exercise and one thing that needs improvement. Stick two pieces of flipchart on the wall and label one flipchart as 'PPRHAA Positives' and the other flipchart as 'PPRHAA Improvements'. As participants leave the summit they can stick their post-its on the appropriate flipchart.

***To gauge the mood*** throughout the summit you could use 'smiley-faces.' On a flipchart draw a matrix with three columns. Give each participant enough stickers for each session. If they feel happy with the way the session is going they place the sticker on the happy face and so on. If during the Summit you find a lot of miserable faces, the facilitator can ask participants what the problem is and try to rectify it.

| |  |  |  |
|---|---|---|---|
| **Session 1** | | | |
| **Session 2** | | | |
| **Session 3** | | | |
| **etc** | | | |

You can adapt these ideas and come up with your own to use throughout the PPRHAA exercise.

# ACRONYMS

| | |
|---|---|
| **ALOS** | Average Length of Stay |
| **ANC** | Antenatal Care |
| **BEOC** | Basic EOC |
| **BOR** | Bed Occupancy Rate |
| **CCV** | Client and Community Views |
| **CCVO** | Client and Community Views Officer |
| **CD** | Compact Disc |
| **CEOC** | Comprehensive EOC |
| **D&E** | Deferment and Exemption |
| **DfID** | U.K. Department for International Development |
| **DHIS** | District Health Information System |
| **DRF** | Drug Revolving Fund |
| **HIV** | Human Immunodeficiency Virus |
| **HMB** | Hospital Management Board |
| **HMC** | Health Management Committee |
| **HMIS** | Health Management Information System |
| **HSR** | Health Sector Reform |
| **IMCI** | Integrated Management of Childhood Illnesses |
| **IMPACT** | Improving Management through Participatory Appraisal and Continuous Transformation |
| **ISS** | Integrated Supportive Supervision |
| **LGA** | Local Government Authority |
| **LSS** | Life Saving Skills |
| **MD** | Medical Director |
| **M&E** | Monitoring and Evaluation |
| **MRO** | Medical Records Officer |
| **OPD** | Outpatient Department |
| **PATHS** | Partnership for Transforming Health Systems |
| **PCM** | Patient Care Management |
| **PCQA** | Patient Focussed Quality Assurance |
| **PDE** | Patient Day Equivalent |
| **PFQA** | Patient Focussed Quality Assurance |
| **PHC** | Primary Health Care |
| **PPM** | Planned Preventive Maintenance |
| **PPRHAA** | Peer and Participatory Rapid Health Appraisal for Action |

| | |
|---|---|
| **PRRINN-MNCH** | Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative |
| **PS** | Permanent Secretary |
| **PTB** | Pulmonary TB |
| **QAR** | Quality Assessment and Recognition |
| **RDU** | Rational Drug Use |
| **SHC** | Secondary Health Care |
| **SHMB** | State Hospital Management Board |
| **SHP** | Strategic Health Plan |
| **SMART** | Specific Measurable Achievable Replicable Timebound |
| **SMI** | Safe Motherhood Initiative |
| **SMoH** | State Ministry of Health |
| **STI** | Sexually Transmitted Infections |
| **TB** | Tuberculosis |
| **U5** | Under Five |
| **VIP** | Very Important Person |