

Program Assessment Guide



David Pelletier¹, Allison Corsi¹, Lesli Hoey¹, Robin Houston² and Silvana Faillace³

¹Cornell University, ²Independent Consultant, ³A2Z, the USAID Micronutrient and Child Blindness Project

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Copies of the Tool can be obtained from:

A2Z: The USAID Micronutrient and Child Blindness Project
AED
1825 Connecticut Ave., NW
Washington D.C., 20009-5721
Tel: 202-884-8000
Fax: 202-884-8432
Website: www.a2zproject.org

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OVERVIEW

With the growing recognition of the central role of nutrition in human health and social development, and the discovery of efficacious and affordable interventions, governments and their development partners are seeking effective and sustainable ways to implement solutions on a massive scale.

This scaling up process has many dimensions to it, including technical, logistical, administrative, political, and social. While the search for biologically efficacious interventions, such as micronutrient supplements, has benefitted from the application of conventional biomedical science, the search for effective and sustainable strategies for scaling up will require the systematization and applications of contextual knowledge and experience. The Program Assessment Guide (PAG) provides a structured, participatory process for rigorously eliciting and systematizing contextual knowledge and experience to strengthen the design and delivery of interventions on a large scale. It can be used for the ex ante design of interventions and implementation systems or for assessing and strengthening the delivery of interventions in an on-going manner. It is intended to complement a number of other frameworks, tools, and guides, as referenced in this manual. The present version of the PAG is based on experience applying it in Kyrgyzstan and Bolivia, with further testing and refinement planned in the near future.

The PAG is organized into modules that can be selected and sequenced to suit the context for a given country or organization. Some of its distinctive features are: it links individual interventions to broader interests and agendas in nutrition, health, food

security and agriculture; it helps analyze delivery systems as social systems, to better identify and anticipate implementation bottlenecks and remedies; it encourages a specific focus on strategies to reach the most vulnerable; it provides a practical means for building a sound program theory, operations research agenda and M&E system from the bottom up; it clearly defines the roles and responsibilities of staff from national to community and households levels; it provides a means to stress-test contextual knowledge and experience, to improve rigor, question tacit assumptions and avoid group-think; it facilitates decisions to ensure follow-up of recommendations; and it builds national capacity and ownership for rigorous intervention planning, assessment, and improvement. The modular organization of the PAG is intended to help countries or organizations selectively use the modules and tools that could strengthen their current program planning and assessment procedures, thereby facilitating the more widespread adoption of whatever features may add value to their current practices. Of particular note are the Five Needs Tool and the Stress Testing Tool located in Module 5, which add rigor to most other approaches for intervention design and implementation. The PAG is best used in tandem with the WHO ExpandNet Guide and/or other tools that address the higher-level strategic issues in scaling up.

INTRODUCTION

Background and Focus

Over the past several decades an impressive body of scientific evidence has accumulated demonstrating that undernutrition has a major impact on the growth, development, morbidity, and mortality of women, infants, and young children in developing countries (1). The Lancet Nutrition Series (Lancet Series) estimated that undernutrition accounts for 35% of young child deaths and 11% of total global disease burden, by far surpassing the impact of other causes such as diarrhea, pneumonia, malaria, and HIV/AIDS (2). The Lancet Series further estimated that universal coverage of existing nutrition interventions in the 36 highest burden countries could reduce stunting at age 36 months by 36% and mortality between birth and 36 months by 25%(3). A similar analysis for Sub-Saharan Africa estimated that roughly 4 million maternal, neonatal, and child deaths could be averted per year, representing an 85% reduction, with high coverage of a package of key health and nutrition interventions (4).

With this evidence in hand, attention in nutrition and global health more generally has begun to focus on designing and implementing large-scale interventions that can achieve very high levels of coverage and quality, especially in the most vulnerable populations (5, 6). There is very limited evidence, however, on how to ensure that efficacious interventions are effective when implemented on a large scale. In the Lancet Series, 97% of the studies reviewed were small-scale efficacy trials and only 3% were evaluations of large-scale programs (3). Thus, the nutrition community finds itself in a similar position to the larger global health field (7, 8), in seeking greater evidence on how to ensure the effectiveness of large-scale intervention programs.

The Program Assessment Guide (PAG) is designed to strengthen the quality of the analysis and decisions related to large scale intervention programs, focusing especially on the design and on-going improvement of the interventions and the delivery systems. It originally was designed specifically to strengthen the effectiveness of micronutrient interventions, but the concepts, principles, and tools are applicable to a wide range of interventions related to nutrition, health, food security and other areas. While the language and examples used in this guide reflect a primary focus on nutrition, generic language is used as much as possible in order to broaden its appeal to users in other areas.

Specific Objectives and Products

To produce the desired impacts on a national scale, health and nutrition programs must deliver commodities and/or services to the relevant target populations on a large scale basis. For this to happen successfully each country must strengthen and organize systems, people and processes to ensure the nutrients are produced, procured, delivered, and appropriately used to/ by the intended individuals, households, and communities. In each case, attention must be directed to four key dimensions: a) the supply system, b) household and community demand, utilization, and compliance, c) information and decision support at each level of the system, and d) social and political commitment. Each of these dimensions must be addressed in order to have a system-wide impact on achieving effective coverage at scale and intervention sustainability over time.

The particular contextual factors that may enable or inhibit these four dimensions can and do vary widely within and across countries. Therefore, these factors must be systematically assessed and addressed when planning, implementing and expanding interventions.

The overall objective of the Program Assessment Guide (PAG) is to strengthen the analysis and decision making procedures related to these four dimensions. More specifically, the PAG is a guide for use in designing and implementing a participatory workshop with the following objectives:

- a) Integrate, and build the capacity to integrate, evidence, contextual knowledge and experience in the rigorous design, implementation, management, scaling up, and evaluation of interventions;
- b) Strengthen the shared understanding, commitment, and ownership of large scale interventions within the relevant policy and program community in the country; and
- c) Reinforce practices that advance the scaling up of a particular intervention while forging explicit links with broader nutrition, health, food, and agricultural interests and agendas.

PAG is a guide for use in designing and implementing a participatory workshop.

The primary products of the workshop, in addition to enhanced capacities, are:

1. An action plan for strengthening the design of an intervention and its delivery system, including the individual and institutional capacities that require strengthening;
2. An operations research agenda to address critical knowledge gaps and uncertainties;
3. A list of critical points in the delivery system that should be included in the design of a monitoring and evaluation system; and
4. A strategic plan for overseeing and generating support for the action plan after the workshop.

Relationship to Other Tools and Processes

The scaling up of interventions on a national scale is an ambitious and complex process involving a host of technical, logistical, financial, political, and social considerations and decisions. Not surprisingly, a large number of tools, processes, and guides have been produced by various organizations to assist various aspects of this process (Table 1). The PAG seeks to complement and fill some critical gaps, rather than to replace these other tools.

Framework/Tool	Primary Focus	Comments	Overarching
1. PROFILES	Advocacy	Informs on magnitude, consequences, solutions, benefits and cost-effectiveness.	WHO/ExpandNet, High-level guide for orchestrating the scaling up of proven interventions on a national basis, with a heavy emphasis on the broad strategy and stakeholder buy-in and less detailed attention to the design of interventions and delivery systems.
2. REACH, Landscape Analysis, NPDA	Situation Analysis	Generates an overview of priority nutrition problems, which organizations are implementing which interventions in which geographic areas, and readiness to scale up.	
3. DCP, WHO-CHOICE, LiST, MBB, NPDA	Choosing interventions	Inform choices based on burden, potential effectiveness, cost and/or most effective delivery strategies.	
4. Logic Models, PIPs, NPDA, Results Frameworks	Program planning and M&E	Provides a high-level view of program inputs, activities, outputs, intermediate results and ultimate goals and outcomes.	
5. MOST	Management and Organizational Sustainability	Guides an assessment and change process related to 18 components of organizational design and management. Does not address intervention design.	
6. BEHAVE, Non/Doer, PD Hearth, Barrier Analysis, etc.	BCC and BC Program Design	Practical tools for rigorous design of behavioral interventions. The emphasis is primarily on the design of interventions and formative research at household and community levels rather than delivery systems.	
7. PAG	Detailed design or assessment of interventions and delivery systems	Practical tools to strengthen interventions, delivery systems and decision support in large scale programs, micro to macro.	

In broad terms these various tools can be divided into three groups: a) those that precede or assist in the choice of interventions (#1-3); b) those used to design an intervention (or package of interventions) and a delivery system (#4-6); and c) those that seek to guide the overall political and administrative processes for large-scale implementation (#7). The primary focus of the PAG is in the second category but it acknowledges the importance of the other two categories and provides some tools for building bridges between them.

In more specific terms the PAG has **eight distinctive features** that help it complement these other tools.

The PAG:

1. Links particular interventions to broader interests and agendas in nutrition, health, food security, and agriculture ([MODULES 1 AND 2](#)).
2. Helps workshop participants analyze delivery systems as social systems, to better identify and anticipate potential implementation bottlenecks and remedies ([MODULE 3](#)).

3. Encourages a specific focus on strategies to reach the most vulnerable ([MODULE 4](#)).
4. Clearly defines the roles and responsibilities of staff from national to community and households levels ([MODULES 5 AND 7](#)).
5. Provides a practical means for building a sound program theory, operations research agenda and M&E system from the bottom up, based on theory and contextual knowledge ([MODULES 6-8](#)).
6. Provides a means to stress-test contextual knowledge and experience, to improve rigor, question tacit assumptions and avoid group-think ([MODULE 6](#)).
7. Facilitates decisions to ensure follow-up of recommendations after the workshop ([MODULE 9](#)).
8. Builds national capacity for rigorous intervention planning, assessment and improvement.

The specific purpose and the strategic, technical or theoretical rationale for each of the PAG modules are described in greater detail in Table 2.

Modules	Purpose	Strategic, Technical or Theoretical Rationale
Laying the Groundwork		
1. Clarifying the Problem and the Solution	Clarify the focal nutritional problem, the type of solution(s) being proposed, the evidence and reasoning for these and how this initiative can leverage attention to the broader health and nutrition interests and agendas.	Allows stakeholders to seek common understanding and agreement on the most appropriate intervention for the stated nutrition problem, a point that often is controversial and cannot be taken for granted. The module encourages agreement by relating the intervention to other problems and interventions (current or future) and building bridges across those interests and agendas. It also employs assets-based strategies and the philosophy of Appreciative Inquiry to enable participants to recognize and honor their collective knowledge and experience.
2. Goals and Associated Values	Envision the desired future and develop a common goal statement, including a list of associated values or objectives.	Allows stakeholders to agree on a common goal, and establish a clear focus and outcome orientation for the intervention, while also encouraging (via the 'associated values and objectives') alignment with other programs and building bridges to other constituencies.
3. Delivery Systems	Map out the systems (the primary people, organizations and processes) involved in delivering commodities, education, advocacy and other intervention components, specifying these at national, regional, district, facility, community and household levels.	Via physical mapping of the delivery system(s) in a participatory process this module creates a visual and concrete image of the system, enables all participants to pool their knowledge, reveals a first round of weaknesses and questionable assumptions about certain portions of the system, legitimizes 'safe' critical analysis, and creates a product that orients attention and is referred to throughout the workshop.

4. Hard to Reach Populations	Identifying the most vulnerable and hard to reach groups, their special situations and needs and the additional contact points, strategies and resources needed to reach them.	This module creates the shared understanding that the most vulnerable often are not reached by mainstream delivery systems and encourages the group to identify who they are, what special needs they have and what special strategies may be needed to reach them. It also stimulates a re-consideration of the goal statement (in Module 2) to include special attention to these groups.
5. People, Roles & Responsibilities	Identify the people and the roles and responsibilities that must be fulfilled at each level of the delivery system in order for the intervention to reach those who need it. This includes the primary functionaries (staff, VHWs etc) as well as significant others (supervisors, mayors, grandmothers, etc) who may enable or inhibit the functionaries in fulfilling their responsibilities.	Transforms the perception of 'delivery systems' from a de-contextualized mechanical, bureaucratic, or log frame image to a people-centered image, by having participants specify the intervention-related roles and responsibilities of staff and functionaries at each level (from national to caretaker) as well as the types of significant others at each level that need to be engaged via advocacy, education, communications strategies, etc.
Building or Strengthening the Intervention		
6. Needs, Inputs, Activities, and System Changes	Identify what each person in the system needs in order to successfully fulfill their roles and responsibilities, the inputs, activities and systems changes required to meet those needs in each case, and the uncertainties in this analysis which form the basis for an operations research agenda.	Allows the group to draw upon its detailed contextual knowledge and experience to develop a sound, detailed program theory going far beyond log frame models and building on the knowledge from systematic reviews of determinants of behavior and behavior change techniques. Participants use the Five Needs Tool to analyze what each functionary needs to fulfill their responsibilities; they use the Stress-Testing Tool and the Interventions Inventory to specify what kinds of inputs, activities and systems changes are needed to meet those needs; and they keep a running tally of the critical uncertainties that emerged in this module that deserve some operations research.
7. Action Planning	Specify the people, organizations, resources, supports, accountability and timetables needed to deliver the inputs, activities, system changes and operations research identified in the previous module.	Re-visits the roles and responsibilities identified earlier based on the clarity gained in the Five Needs module. Participants use simple action planning templates to specify these and clarify accountability structures; and they use similar templates to specify accountability for the operations research agenda.
Building Support Systems and the Enabling Environment		
8. Monitoring & Evaluation and Quality Improvement	Identify critical control points (vulnerabilities) in the delivery systems that should be included in the monitoring, evaluation and quality improvement systems, in order to detect and correct implementation problems in a timely fashion and improve effectiveness over time.	Log frame-based M&E systems specify rather crude indicators based on a 'black box' view of inputs, outputs and outcomes. This module allows participants to specify the weak links in the delivery systems that deserve attention in M&E and Quality Improvement (QI) systems, based on the fine-grained, people-centered, contextual and behavior-oriented view of the system that has been built up in the other modules.
9. Organizing, Leading and Managing	Ensure that the vision, values and goals created in this workshop become a reality by creating networks of individuals and organizations with the commitment and capacity to promote, guide and support the implementation of the action plan and related aspects of the broader nutrition and health agendas.	The other modules have created three primary products: an action plan for strengthening intervention delivery, an operations research agenda to answer critical questions and the groundwork for an M&E and QI system. This module allows participants to discuss how these three products are to be moved into reality. It provides tools for the group to create Terms of Reference for new or existing working groups or structures that can follow up on these topics, as well as an overall Coordination and Support Working Group to ensure follow-through for the overall scaling up process.

Adapting the PAG for Different Interventions and Sectors

Interventions in nutrition, health, food security and agriculture each have some distinctive features from the perspective of scaling up but they also share some features in common. This can be seen by considering the various elements in WHO's ExpandNet (WHO 2009) framework (Figure 1). When contrasting a micronutrient powder with an agricultural intervention, for instance, there are enormous differences in the nature of the innovation (viz evidence of effectiveness, complexity, ease of adoption, etc.), the user organization (e.g., the perceived need and implementation capacity in the Ministry of Health versus Agriculture), the resource team promoting and supporting the innovation (e.g., the leadership, skills, experience and political connections among health specialists versus the private sector, economists or agricultural specialists) and the environment (e.g., health MDGs versus a food crisis as motivating factors).

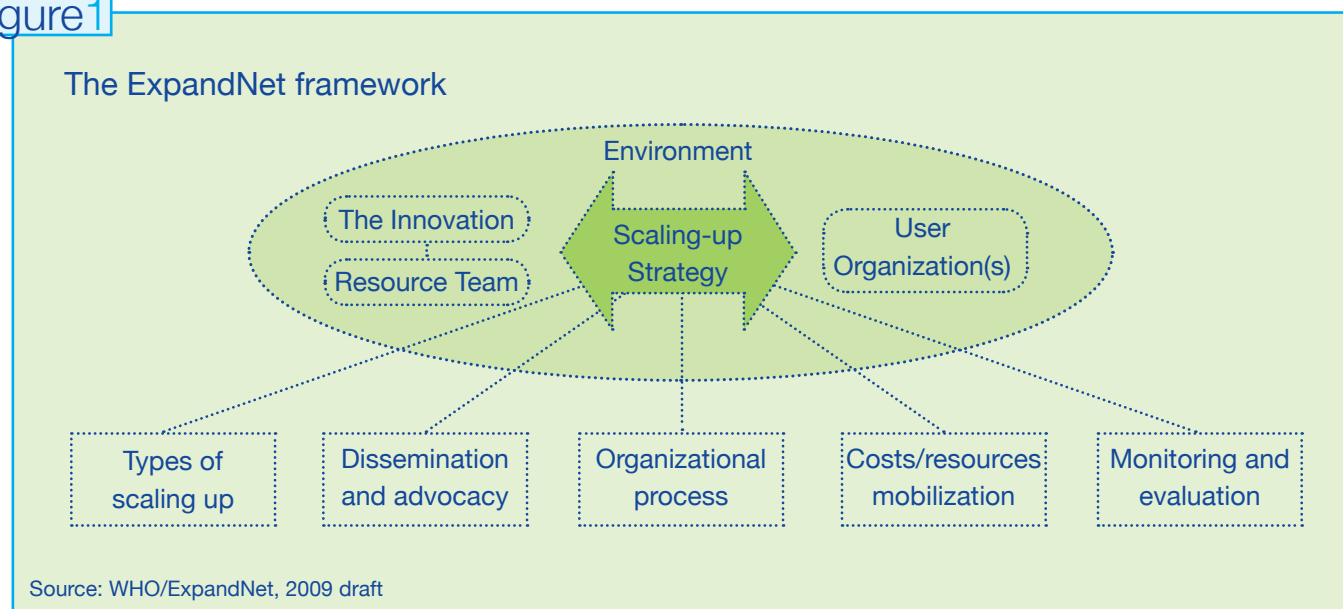
Despite these differences, the scaling up of interventions in all of these sectors requires articulating a scaling up strategy based on an analysis of each of the elements shown in the ExpandNet framework. ExpandNet is a generic guide that can facilitate this analysis in any of these sectors. In a similar fashion the PAG can facilitate a more detailed analysis of the

design of the intervention and the proposed delivery system, gaining strength from the eight distinctive features of the PAG noted above. The PAG complements the high level guidance provided by ExpandNet and is best viewed as being nested within ExpandNet. The main requirement for adapting the PAG for this purpose is to engage with a resource team and set of user organization(s) that are appropriate for the intervention, the sector and the environment.

Adapting the PAG to Different Decision Scenarios

As noted in Table 1 there are several distinct forms of analysis and decisions involved in addressing nutrition or health on a national basis, including commitment building (#1), landscaping, scoping and situation analyses (#2), selection of priority interventions (#3), high level program planning (#4), detailed analysis and design of interventions and delivery systems (#5, 6) and overall management of the scaling up agenda (#7). The numbering of these in no way implies they actually proceed in sequence. To the contrary they typically take place concurrent with each other, in an iterative manner and/or in parallel by different organizations. Nonetheless, there are clear complementarities among these decisions and tools that should guide decisions as to whether and when and how to use the PAG. A few of the potential scenarios are shown in Box 1.

Figure 1



Box 1

Adapting the PAG to Different Decision Scenarios

Scenario A: The nutrition community in a country has built commitment, conducted a situation analysis, prioritized problems and interventions, obtained buy-in for scaling up and developed a log frame for the overall nutrition program. The PAG (Modules 3-8) may now be useful for fleshing out the details regarding the design of the interventions and the delivery system, before proceeding with implementation.

Scenario B: A country does not have an organized nutrition community, nor has it conducted an overall situation analysis, but there is a recognized problem with vitamin A deficiency and a desire by one donor to implement a large-scale supplementation program, building on some (partially successful) experiences with programs implemented at a smaller scale. The design team organizes a PAG workshop to engage the various implementing organizations and other potential donors in the planning. The workshop begins with Modules 1 and 2, because there is not yet shared understanding or agreement about why this problem and this intervention have been chosen, over others, and only then proceeds with Modules 3-9. Some of the participants in this workshop later use this experience to advocate for conducting a broader nutrition situation analysis and developing a broader nutrition action agenda. After obtaining approval and financing for this larger agenda, they then conduct PAG workshops for several of the distinct interventions within this agenda. They pilot these interventions in several districts, use some PAG modules after 1-2 years to identify and address bottlenecks in these pilots, and then use the WHO ExpandNet Tool to develop and implement a scaling up plan for these interventions.

Scenario C: A country has been implementing its maternal iron/folate supplementation program for over ten years, but national coverage is only 60% and anemia rates have not changed. The national nutrition program leader organizes a PAG workshop to re-visit the objectives, program theory, design and implementation plan for this intervention (Modules 3-8), engaging participants from the national and sub-national levels, researchers, donors and guests from a neighboring country that has achieved better results.

These are but a few of the possible scenarios. Rather than being exhaustive, they are intended only to illustrate that there is a wide variety of situations in which a PAG may be useful, and the PAG modules can be selected and sequenced to fit the situation.

Adapting the PAG for Use with a Results Framework or Log Frame

While the description of the PAG modules in this manual focuses on its use for strengthening the scaling up of a single intervention, it is recognized that many programs in nutrition (or other sectors) consist of multiple interventions rather than only one. Indeed, it often is the case that multiple interventions must be implemented in unison if the overall nutrition or health goal is to be achieved. A good example would be a program that seeks to improve household food security, food

diversity, water, sanitation, hygiene, and young child feeding practices, in order to achieve the overall goal of improving child nutritional status. If all of the interventions in a program are to be delivered through the same delivery system, it may be possible to apply Modules 3-8 a single time, while being certain to analyze the distinctive requirements for each intervention even when administered by the same staff (i.e., the same staff may be used to distribute a commodity and provide education or counseling, but the requirements for doing so effectively are quite different). However, if the various interventions are to be delivered through separate

delivery systems (e.g., the agricultural extension system versus the health system) it would be necessary to apply Modules 3-8 for each interventions separately, taking care to ensure that they come together in the same households and communities if the Log Frame or program theory suggests this is needed to achieve impact.

Adapting the PAG to Existing Organizational Frameworks and Processes

The section above, related to adaptation to Results Frameworks and Log Frames, is merely a special case of a more general issue: All development organizations, be they ministries, donors, NGOs or communities, already employ their own version of tools and processes when designing, implementing and assessing large scale interventions. Some of these are highly developed, sophisticated and refined based on extensive experience, and others are less so. But in all cases it requires a considerable investment of time, money and energy to introduce new tools and processes, adapt them to the organization's context and begin to reap the benefits. And the size of the investment is in some proportion to the size of the change required: replacement of the entire planning regime would require a very large investment, while modification of only one aspect would require a smaller investment.

For this reason, organizations are encouraged to consider adopting and adapting each of the PAG modules, or tools within a module, rather than necessarily adopting the PAG as a whole. Some of these, such as Module 6, the Five Needs Tool and the Stress Testing Tool, are distinctive and could strengthen the current tools and processes in many organizations. Others may duplicate what is already done, to varying degrees, or simply may not be relevant in a given context. The decision concerning what to adopt and adapt, and how to do so, is entirely dependent on the context.

Adapting the PAG for Sub-National Uses

A PAG workshop held at the national level, with appropriate representation from national to sub-national levels, is intended to generate a shared understanding among those participants of the actions needed to strengthen overall intervention design and implementation. However, these actions often need to be tailored to a variety of contextual differences at sub-national levels, in delivery systems, cultures, ecological and food

systems, epidemiology, etc. In addition, a common weakness in large scale programs is that the staff at sub-national levels have only a tenuous understanding of the goals, objectives and design of a new interventions, and the roles and responsibilities that are expected of them. Thus, in many countries it may be useful to implement a streamlined version of a PAG workshop at sub-national level, to enhance understanding of the intervention in general and create the opportunity to tailor the implementation to fit the sub-national context. One formulation for doing this would be for national facilitators to assist staff in each of the sub-national regions to conduct a PAG workshop with those participants from their districts who will be the primary focal point for the intervention. Modules 1-3 could be presented more didactically, while modules 4-9 could be conducted in a participatory manner to identify where adaptations are needed and promote deep understanding among participants.

Not a Magic Bullet

The previous section underscores that the design, implementation and improvement of interventions on a large scale basis is a complex undertaking involving many organizations, multiple types of analyses and decisions, a long time frame and many other conditions. As such, a PAG workshop is not a shortcut or magic bullet for accomplishing this. Rather, it is a particular set of tools and analysis/decision processes that can complement other tools and must stimulate and/or fit within a larger process of design, scaling up and improvement of interventions. Since countries may find themselves in many different stages of readiness and contextual conditions (Box 1), it is impossible to prescribe a fixed way in which this should be done. Users are urged to consider the potential role of a PAG workshop in tandem with the sage guidance contained in the WHO ExpandNet guide (WHO 2009) which addresses the larger strategic issues needing attention when scaling up.

Practical Considerations

If and when a decision is reached to conduct a PAG workshop or adopt some of the modules for use in other planning processes, there are some practical considerations for doing so, related to pre-workshop, in-workshop and post-workshop phases. These were revealed in the country applications of the PAG in Kyrgyzstan and Bolivia and are detailed in Appendix 1 to this guide.

Overview of the Modules

In the description of the individual modules on the following pages a common structure is used, containing the following elements:

1. Purpose
2. Rationale
3. Process
4. Tools and Templates
5. Additional Resources

As noted, the selection and sequencing of modules can be chosen to fit the needs in a given situation. In addition, there can be variations in the design and implementation of any given module to fit local needs. Some of these variations are noted in the relevant sections.

Literature Cited

1. World Bank. Repositioning Nutrition as Central to Development: A Strategy for Large Scale Action. Washington, DC: The World Bank. ; 2006.
2. Black RE, Allen LH, Bhutta ZA, Caulfield LE, de Onis M, Ezzati M, Mathers C, Rivera J. Maternal and child undernutrition: global and regional exposures and health consequences. *The Lancet*. 2008;371:243-60.
3. Bhutta ZA, Ahmed T, Black RE, Cousens S, Dewey K, Giugliani E, Haider BA, Kirkwood B, Morris SS, et al. What works Interventions for maternal and child under-nutrition and survival. *The Lancet*. 2008;371:417-40.
4. Friberg IK, Kinney MV, Lawn JE, Kerber KJ, Odubanjo MO, Bergh A-M, Walker N, Weissman E, Chopra M, et al. Sub-Saharan Africa's Mothers, Newborns, and Children: How Many Lives Could Be Saved with Targeted Health Interventions? *PLoS Med*. 2010;7:e1000295.
5. World Bank. World Development Report: Making Services Work for the Poor. : Washington, DC: The World Bank.; 2004.
6. Peters D, El-Saharty, S, Siadat, B, Janovsky, K, Vujicic, M (Eds), Improving Health Service Delivery in Developing Countries. Washington, DC: The World Bank; 2009.
7. Mangham L, and Manson, K., Scaling up in international health: What are the key issues? *Health Policy and Planning*. 2010;25:85-96.
8. Whitworth J, Sewankambo NK, Snewin VA. Improving Implementation: Building Research Capacity in Maternal, Neonatal, and Child Health in Africa. *PLoS Med*. 2010;7:e1000299.
9. World Health Organization. Nine steps for developing a scaling-up strategy (draft). Geneva: World Health Organizations; 2009.

Table 3: Additional Tools and Information	
Tool	Additional Information
PROFILES	http://www.aedprofiles.org/
REACH	http://www.reach-partnership.org/
Landscaping Analysis	http://apps.who.int/nutrition/landscape_analysis/en/
NPDA	http://www.coregroup.org/component/content/article/119
DCPP	http://www.dcp2.org/pubs/DCP/15/Section/1663
WHO-CHOICE	http://www.who.int/choice/toolkit/en/
LiST	http://www.jhsph.edu/dept/ih/IIP/list/index.html
MBB	http://www.who.int/pmnch/topics/economics/costing_tools/en/index12.html
Logic Models	http://www.cdc.gov/eval/resources.htm#logic%20model
PIPs	http://boru.pbworks.com/
Results Framework	http://www.usaid.gov/pubs/sourcebook/usgov/mfr.html http://www.who.int/management/district/planning_budgeting/BuildingResultsFramework.pdf
MOST	http://erc.msh.org/toolkit/Tool.cfm?lang=1&TID=162
BEHAVE Model	http://www.globalhealthcommunication.org/tools/54
Barrier Analysis	http://barrieranalysis.fhi.net/how_to/how_to_conduct_barrier_analysis.htm
Doer/ Non-Doer Analysis	http://barrieranalysis.fhi.net/what_is/doer_non_doer.htm
PD Hearth	http://www.comminit.com/en/node/302827/303
WHO ExpandNet	http://www.expandnet.net/

LAYING THE GROUNDWORK

MODULE 1

Clarifying the Problem and the Solution

Purpose:

Clarify the focal nutritional problem, the type of solution(s) being proposed, the supporting evidence and reasoning and how this initiative can leverage attention to the broader health and nutrition interests and agendas.

The purpose of this exercise is to build common understanding, agreement, and support for:

- The focal nutritional problem for this workshop in the context of the broader nutrition situation in the country.
- The type of solution(s) being proposed for this problem.
- The evidence and reasoning for choosing this focal problem and this solution at this time.
- How this initiative can leverage attention to the broader health and nutrition interests and agendas.

Rationale:

Allows stakeholders to seek common understanding and agreement on the most appropriate intervention for the stated nutrition problem, a point that often is controversial and cannot be taken for granted. The module encourages agreement by relating the intervention to other problems and interventions (current or future) and building bridges across those interests and agendas. It also employs assets-based strategies and the philosophy of Appreciative Inquiry to enable participants to recognize and honor their collective knowledge and experience.

While the chosen problem and solution may seem obvious to some workshop participants, especially the organizers, it is important to be explicit about the evidence and reasoning behind these choices and to give all workshop participants the opportunity to express their views, learn from each other's views, and become invested in the present workshop. Experience shows that this common understanding and common purpose is the essential foundation for a productive workshop and for commitment to the action plan after the workshop.

Most interventions have a core of supporters at the national and sub-national levels who have a strong interest in seeing it succeed. But most interventions also require support from a wider range of actors at the national and sub-national levels whose primary interest, responsibilities or commitments relate to other public health problems or interventions. The first group usually has only limited success in convincing the second group to compromise their current interest and 'come over to our side.' A far more effective approach, for many reasons, is to find ways to design, implement, promote and publicize the focal intervention in such a way that it leverages attention and action to broader nutrition and health agendas. This module helps bridge various concerns of workshop participants while also equipping them to better advocate for an intervention after the workshop.

This module helps bridge various concerns of workshop participants while also equipping them to better advocate for an intervention after the workshop.

Variations

There are some circumstances (Scenario A) when this Module can be omitted. For instance, when there already has been extensive discussion about the problem and the proposed solution and when all of the workshop participants already have common understanding and goals. In other circumstances (Scenario B) this may be true for some of the participants, but not all of them. In such cases it may be necessary to engage with some of these participants before the workshop and/or to include presentations on the first day of the workshop in order to develop that common understanding. In yet other circumstances (Scenario C) there may have been very little prior discussion about nutrition in the country and a combination of educational presentations and an open-ended process should be followed to outline the full range of nutrition problems and establish broad strategies and priorities. The workshop organizers should make a special effort to assess which type of scenario they are dealing with. The process described below is based on Scenario B.

Focal Questions:

- **What is the focal nutritional problem for this workshop?**
- **What solution(s) are being proposed?**
- **What is the evidence and reasoning supporting these choices at this time?**
- **How can this initiative leverage attention to the broader health and nutrition interests and agendas?**

Module 1: Box 1

Leveraging Other Agendas:

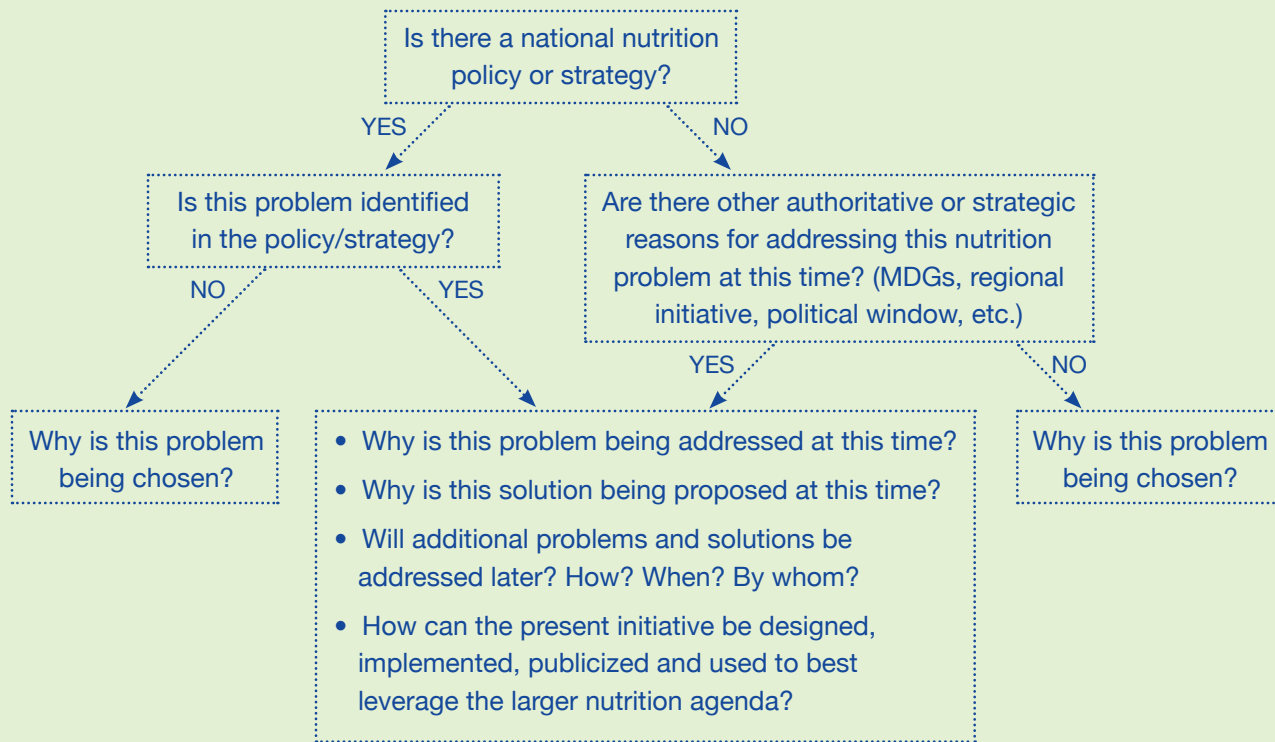
For example, this workshop might lead to the creation of health worker incentive programs to increase motivation and commitment or capacity strengthening activities to access hard to reach populations. These can have positive effects on other health programs not directly related to the target program, such as antenatal care or immunization programs. Usually the same health workers and health systems are involved to deliver these various health programs. A Sprinkles program, for example, can then act as a “leverage” to draw attention and increase efficiency to the health system as a whole with spillover effects to support other programs. These opportunities may not happen by themselves, however, so it is important that participants be looking for them as they proceed through the workshop.

Process based on Scenario B:

1. (15 mins) The facilitator briefly summarizes the current nutrition situation, the focal nutrition problem and proposed solution, to give an overview of this workshop’s focus. This overview emphasizes that the current intervention is only one component of a larger nutrition strategy and should be designed and implemented in ways that will leverage and reinforce that larger strategy.
2. (30 mins) Participants split into pairs or small groups (3-5, depending on the size of the workshop). Each small group discusses the following questions and records them on the template provided below.
 - In what specific ways could the intervention be developed, implemented, publicized and used to best leverage attention to other nutrition problems, solutions and/or the broader health or nutrition agendas (see Box 1 below)?
 - Identify 1-2 positive experiences this initiative should learn about and build upon in order to be successful in its own implementation and in advancing the larger nutrition agenda. Example might relate to the methods used for motivating community volunteers, methods used to create broad awareness in the community, methods used to detect and correct implementation problems, etc.
3. (45 mins) Each small group reports out to the plenary group in a succinct fashion.

Module 1: Box 2

Justifying the Focus: A Guide for Leveraging the Larger Nutrition Agenda



Small Group Template

1. In what specific ways could this problem be developed, implemented, publicized and used so as to best leverage attention to other nutrition problems, solutions and/or the broader health or nutrition interests and agendas?

2. Identify 1-2 positive experiences (in nutrition, health or other sectors) this initiative should learn about and build upon in order to be successful in its own implementation and in advancing the larger health or nutrition interests and agendas.

a. _____

b. _____

Additional Resources:

- <http://appreciativeinquiry.case.edu/>
- <http://www.collaborativeleadership.org/>

MODULE 2

Goals and Associated Values

Purpose:

Develop a common goal statement, including a list of associated values.

The result of this exercise is a statement of intent that the workshop participants broadly support and would be proud to share with their superiors, politicians, the mass media and the public at large.

- The goal statement will specify the ‘desired future’ as compared to ‘where you are now’.
- A list of associated values will help guide decisions on how to design and implement the intervention in ways that serve broader purpose (e.g., to build capacities, to build political commitment, to foster better relationships between health personnel and community caregivers, etc.).

Rationale:

Allows stakeholders to agree on a common goal, and establish a clear focus and outcome orientation for the intervention, while also encouraging (via the ‘associated values and objectives’) alignment with other programs and building bridges to other constituencies.

Focal Questions:

- **What do we want to accomplish?**
- **What associated values do we want to promote as we move forward?**

Process:

(60 mins) Identify the **overall goal**. This goal is specific, measurable, connected to the scope of the intervention, realistic and time bound. In addition, it is connected to larger national or ministry aspirations or initiatives. For example, a micronutrient powder intervention may be one part of a national maternal and infant health program. This statement

puts the focus of the micronutrient intervention into a broader strategic context that harmonizes with the goals of other programs, organizations or national values.

1. Participants should be split into pairs or small groups (3-5, depending on the size of the workshop). Report out from each group to the plenary group, the characteristics of the goal statement.
2. Report out the characteristics from each group of the goal statement to the plenary group.
3. Elicit one or two volunteers to listen for common themes and language that all of the group can relate to. Have these individuals take 10 minutes to draft a goal statement outside of the group (during a Break in the workshop).
4. Read that statement to the plenary group. Revise the statement based on feedback to create consensus on the final statement.

Example

To achieve 90% coverage of (product X or behavior change Y) in (the target population) within Z years, and strengthening the broader nutrition agenda by increasing technical and operational capacities through harmonizing with existing training and delivery systems for distribution, education and advocacy and strengthening caregivers’ capacity for sustaining (product X or behavior change Y) and other forms of care to their children.

Module 2: Table 1 - Guidance on Developing Goals and Associated Values			
Questions			Associated Values
What is it that we want the program to change or improve?	Purpose: (e.g. Reduce deficiencies) Goal	What are some high-level values or objectives that should be considered when pursuing the goal? Examples: <ul style="list-style-type: none"> • to utilize and strengthen existing assets (e.g. delivery systems and human resources) in building and implementing the program • to promote and support a culture of professionalism and responsiveness at all levels of the program • to collect and use information and evidence in a timely fashion for on-going documentation and improvement of program performance • to strengthen the public image and reputation of all organizations involved in implementing and supporting the program
Who are the beneficiaries that this program will serve?	Target population		
What percent of beneficiaries do we want to reach with these services?	Coverage or % of target population reached		
Where are they located?	Location		
When do we want to achieve this goal?	Time bound		

Variations

In many cases the creation of quantitative goals and targets will require some technical knowledge about maximum achievable efficacy and implementation experience in the national context, and it may be cumbersome to foster a constructive discussion of this in a full PAG workshop. In such cases it would be advisable to have a smaller group develop a draft of the quantitative targets before the workshop and engage the workshop participants in refining the statement of the target population and “associated values.” When the PAG is being used to assess an existing program, these goals and targets may already be established, although the associated values may still need to be articulated.

Additional Resources:

<http://www.cdc.gov/healthyyouth/evaluation/pdf/brief3b.pdf>

<http://rapidbi.com/created/WriteSMARTobjectives.html>

MODULE 3

Delivery Systems

Purpose:

Map out the systems (the primary people, organizations and processes) involved in delivering commodities and Behavior Change Communication (BCC) to the target populations, and specify these at national, regional, district, facility, community, and household levels.

The goal is to map out the primary “vertical links in the chain” at the different levels of the system that will be needed to implement and sustain a high quality intervention. At this stage we only need the primary links in outline form, because these will be elaborated in more detail in other modules.

An important output from this exercise will be a picture of these links in the chain for the interventions delivery system, from the point of procurement and supply to the country, to local distribution and compliance by the intended population.

Rationale:

By using physical mapping of the delivery system(s) in a participatory process this module creates a visual and concrete image of the system, enables all participants to pool their knowledge, reveals a first round of weaknesses and questionable assumptions about certain portions of the system, legitimizes ‘safe’ critical analysis, and creates a product that orients attention and is referred to throughout the workshop.

What are the delivery systems required for implementation?

Delivery systems refer to the primary people, organizations and processes involved in delivering products and/or BCC on a routine basis once the intervention is ‘up and running.’

Support systems (to be discussed in other modules) refer to all the other people, organizations and processes that must be in place to promote effective and efficient functioning of the delivery system, including monitoring and evaluation, advocacy, technical assistance, operations research, training, supervision, staff performance evaluation, volunteer retention activities, etc.

Process: (60 min)

1. Prior to the workshop a small group (2-3) of the most knowledgeable persons should create the outline of the delivery system on a large wall chart (e.g., 3” high by 20” long). It should identify the primary organizations or types of individuals that will play key roles at each administrative level, from national (including international partners) to community and household levels. One chart should be developed for the supply system and one for the BCC system.
2. (15 mins) In the workshop, these wall charts will be displayed on the walls. Each one will be explained in broad terms by one of the persons that created it (5 mins each).
3. (45 mins) Q&A with the participants to ensure that everyone understands how the current intervention design is intended to achieve its goals.

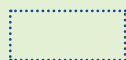
[Process Note: Although these delivery systems may be well known to some participants there are several reasons for including this module. First, some people may know parts of one system but know much less about other systems, so this step will allow everyone to gain a shared understanding. Second, this module will allow people to voice some of the questions or concerns they have had concerning various aspects of the delivery systems. Third, this will be a plenary discussion, whereas most other Steps will involve small groups, so this will generate a common conversation that can be taken up in greater detail in the small groups.]

...this module creates a visual and concrete image of the system, enables all participants to pool their knowledge...

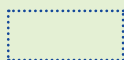
Module3:Box1

Describe the Delivery Systems

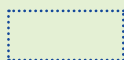
- How Will the Product Get from the National Level to All Caregivers?
- How Will BCC Get to All Caregivers?



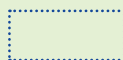
National



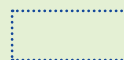
Region



District



Clinic



Community



Caregiver

Additional Resources:

http://www.ifad.org/pub/map/PM_web.pdf

MODULE 4

Hard to Reach Populations

Purpose:

Identify the vulnerable and hard to reach segments of the population and the contact points that may reach them, to ensure that this at-risk population is reached by the intervention.

The general target group was identified in Module 2, but in this step we go further to identify specific vulnerable or hard to reach groups and some of the community level people and organizations (“contact points”) that might help reach them.

Some common examples of special *target groups* are remote, migrant or transient communities, ethnic or religious minorities, very low income households or communities, children of single mothers, institutionalized children, and so on.

Contact points are the people or organizations that the caregivers may come into contact. These contact points can serve as delivery platforms for supplies, education and advocacy. Some common examples of *contact points* are women’s groups, religious organizations, local leaders, neighbors, school teachers, school children, social welfare programs, community organizations, retailers, artisans, craftsmen, tailors, hairdressers, local healers, local pharmacists and so on.

Rationale:

This module creates the shared understanding that the most vulnerable often are not reached by mainstream delivery systems and encourages the group to identify who they are, what special needs they have and what special strategies may be needed to reach them. It also stimulates a re-consideration of the goal statement (in Module 2) to include special attention to these groups.

This module creates the shared understanding that the most vulnerable often are not reached by mainstream delivery systems...

Module4:Box1

Many micronutrient programs fail to reach the last 20% of the target population who are usually the most vulnerable and in need of the nutrition program. The reason is that many times this population has different characteristics that have not been planned for, such as those with geographic, cultural or economic barriers to the program.

Therefore, we need to identify ways to create access for these groups.

Focal Questions:

- What are the vulnerable or hard to reach target populations in your country?
- Which people and organizations are available at the community level to help reach these caregivers and make the intervention successful there? These are referred to as contact points.

Process: (60 mins)

1. The plenary group brainstorms to identify the special target groups. The facilitator then works with the plenary group to bundle them into a manageable number of groupings (e.g., 5-6 groupings for a workshop of 30-35 people).
2. Small groups (of 5-6 participants each) pick a target group or grouping and identify the contact points for that target group that can play an important role in ensuring the access to and adoption of the intervention. It will be useful to consider the Five Needs of the caregivers in these target groups and how these can be met (see the example in Box 2 on next page).
3. Small groups report out to plenary group. For each target group they should report the current state of their various needs and the contact points or strategies potentially available to help meet those needs, using the Template below.

4. The facilitator will then generate a discussion among the participants to learn: a) how confident they are that these are the primary (or only) special target groups; b) that their various needs will be met by the current intervention design; and c) some of the local contact points (people and organizations) that might help reach these special target groups and meet their various needs.
5. The facilitator will then lead a discussion among the participants about whether there is a need for further consultation with local organizations to complete these analyses and modify the intervention design in light of this new information.
6. The facilitator leads a discussion of whether and how to modify the Goal Statement formed in Module 2, to reflect a special desire to reach these vulnerable groups.

Variations

With some interventions it is not reasonable to expect the intervention to reach the most vulnerable. A prime example is the fortification of staple foods or condiments, in which the centrally milled (and fortified) products may have little penetration into the rural areas or other populations groups. In such cases the country should consider using a different intervention to reach these groups, such as home gardening or the distribution of supplements or powders, to complement the fortification intervention. The detailed design of this intervention and its delivery system could be the subject of a separate PAG workshop, or could be addressed through a sub-group in the main workshop working in parallel with the fortification group.

Module 4: Template - Special Populations and Contact points		
Special Populations (vulnerable and hard to reach)	Key Needs	Potential Contact Points

Module4:Box2

Examples of the Five “Needs” of Caregivers

- 1. Awareness:** Caregivers such as Mothers that influence the target group need to have awareness of the purpose and benefits of the intervention.
- 2. Knowledge, Information & Skills:** Caregivers must have the specific knowledge, information and skills required for accessing and using the intervention appropriately.
- 3. Commitment and Motivation:** Caregivers need periodic support from health workers and mother-in-laws, reinforcement from mass media messages and local opinion leaders, and regular support from family members and others, to sustain motivation.
- 4. Resources:** Caregivers need a consistent supply of certain commodities (e.g., micronutrient powders or fortified foods); they may need time, transportation or bus fares to visit clinics; they may need to communicate the proper use of the commodity to relatives and other caregivers who feed the young children when the mother is away, etc.
- 5. Support from others:** Caregivers need support from the volunteer health workers and from the community and other social networks to reinforce the new behavior of use of the commodity. For instance, they may need husbands, mother-in-laws and other relatives to support their decision to use the commodity or to initiate and sustain the behavior change.

Additional Resources:

http://erc.msh.org/TheManager/English/V6_N4_En_Issue.pdf

<http://heapol.oxfordjournals.org/cgi/content/abstract/19/5/336>

MODULE 5

People, Roles & Responsibilities

Purpose:

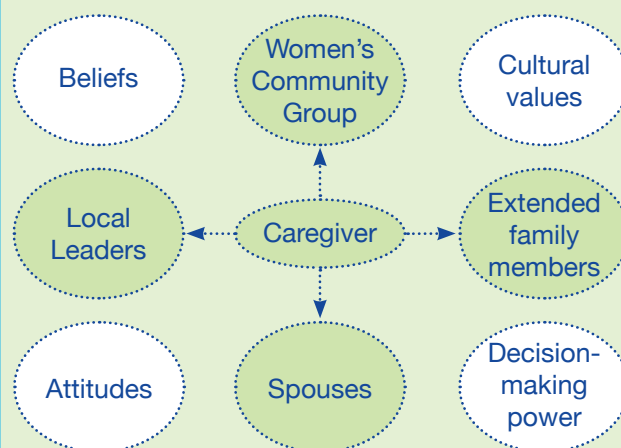
Identify the people and the roles and responsibilities that must be fulfilled at each level of the delivery system in order for the intervention to reach those who need it. This includes the primary functionaries (staff, village health workers (VHWs) etc.) as well as significant others (supervisors, mayors, grandmothers, etc.) who may enable or inhibit the functionaries in fulfilling their responsibilities.

Rationale:

This module transforms the perception of ‘delivery systems’ from a de-contextualized mechanical, bureaucratic, or log frame image to a people-centered image, by having participants specify the intervention-related roles and responsibilities of staff and functionaries at each level (from national to caretaker) as well as the types of significant others at each level that need to be engaged via advocacy, education, communications strategies, etc. This is important for the intervention to function well when it is implemented, as well as for the purpose of building broad commitment and sustainability.

Social Networks

Example: Demand for the micronutrient program will be affected by the social and environmental context within which caregivers and their children live. These networks need to be identified and possibly targeted if shared cultural values, beliefs and attitudes will affect the demand for the program and proper delivery of the intervention to the target children.



‘Functionaries’ are the people with a designated role/responsibility to fulfill in the delivery and utilization system. For example, certain health staff may need to provide training, motivation, resources and support to the next set of people in the delivery system, such as Community Health Volunteers.

‘Significant Others’ are people other than functionaries whose decisions and actions can inhibit or enable functionaries to do their jobs. For example, a Maternal and Child Health Director might be external to the nutrition program but can play an enabling or inhibiting role by integrating the intervention into an existing Antenatal Care Clinic.

Because the success of the intervention will depend on its integration into existing systems and programs, it is important to map the points or people of influence and support at each level of the program. This is fundamental for assuring that each level can function properly and that all levels are integrated into a functional system.

The next step is to identify the influential people and their roles and responsibilities at each level of the system by answering the following questions:

Focal Questions:

- **Who are the functionaries that are responsible for completing specific tasks in the delivery and support system? What are their roles, responsibilities in delivering the intervention?**
- **Who are the significant others that have an influence on the functionaries, or on the commitment, the sustainability or other aspects of the intervention? What role can and should they play?**

Process: (90 mins)

1. At each delivery step, and using the wall chart, identify the people who must perform specific tasks for the intervention ('Functionaries,' such as Health Workers, Supervisors, Volunteers).
2. Now identify the people or organizations that affect each of these functionaries, label them and put an arrow between them (Significant Others).
3. Fill in a template, such as that shown below. For each functionary or significant other, specify the following:
 - What is their position title or identity (e.g., clinic director, MCH director, father, religious leader)?
 - What is their formal role and responsibility (if they are a functionary) or their potential role or influence (if they are a Significant Other)?

Examples

For the Maternal and Child Health Director the role may be “the decision-maker to integrate a supplement into well-child clinics as part of a larger package of interventions.”

For a local leader, it may be “to demonstrate his support for the supplement when he speaks with local health officials, the mass media and others.”

Additional Resources:

http://www.who.int/hrh/resources/improving_hw_performance.pdf

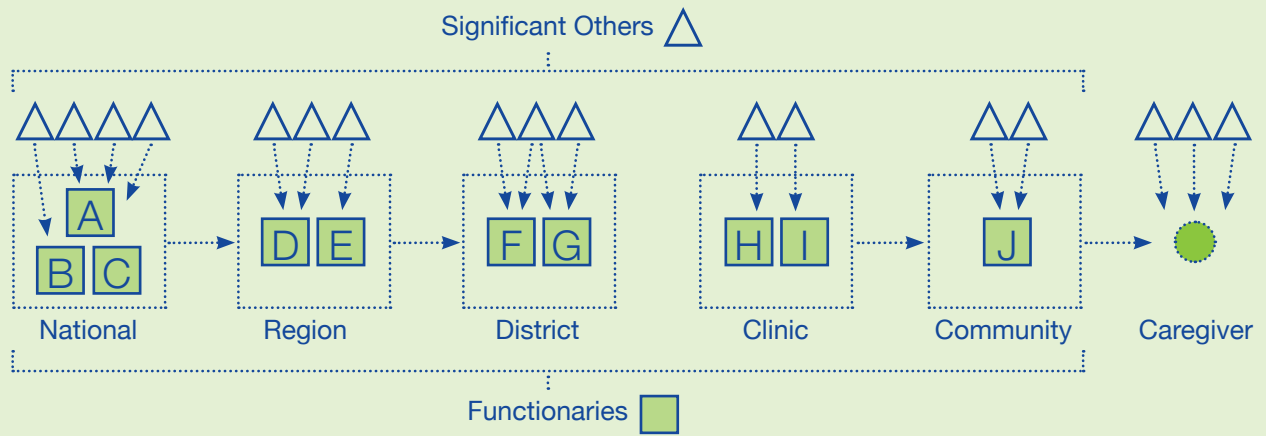
http://www.msh.org/Documents/Managers/English/upload/V8_N1_En.pdf

<http://erc.msh.org/toolkit/Tool.cfm?lang=1&CID=10&TID=192>

<http://erc.msh.org/toolkit/toolkitfiles/file/MOST31.pdf>

This module transforms the perception of ‘delivery systems’ from a de-contextualized mechanical, bureaucratic, or log frame image to a people-centered image.

Identify the Functionaries and Significant Others in the Delivery and Support Systems



Module 5: Filled-in Roles and Responsibilities Template		
Levels	People (functionaries and significant others)	Roles and Responsibilities: Description
Household	Caregiver	To provide supplement to the target child according to the guidance provided by the health worker and volunteer.
	Village Political Official	
Community	Village Health Clinic Members	
	Village Health Committee Volunteer	To provide mothers with education concerning the proper use of supplement.
	Clinic worker	Provides supply of micronutrient powders to the mother
Clinic		
	Health Facility Managers	
	Health Facility Workers	To support the Volunteer Health workers in accomplishing their tasks
District		
	MCH Manager	
	Supplies Manager	
Region		
	Supply Manager	To store and ensure the supplement supplies are delivered on time to the appropriate organizations for distribution
	MCH Manager	
National	Nutrition Director	
	UNICEF	
	SRC (Swiss Red Cross)	
	Center for Health Promotion	

Module 5 Template: People, Roles and Responsibilities		
Levels	People (functionaries and significant others)	Roles and Responsibilities: Description
Household		
Community		
Clinic		
District		
Region		
National		



BUILDING OR STRENGTHENING THE INTERVENTION

MODULE 6

Needs, Inputs, Activities, and System Changes

Purpose:

Identify what each person in the system needs in order to successfully fulfill their roles and responsibilities, the inputs, activities and systems changes required to meet those needs in each case, and the uncertainties in this analysis which form the basis for an operations research agenda.

Each person in the intervention has certain **needs** that must be met in order to fulfill their role or responsibility. These can be met through inputs, activities, and/or system changes.

Inputs are the supplies, equipment, education materials, budgets, staff and other tangible goods needed for the intervention to accomplish its objectives.

Activities are the actions needed to supply the inputs to one level of the intervention and/or to translate those inputs into desired changes. For instance, education materials (an input) must be used by volunteers during education sessions with mothers (an activity) in order to improve the knowledge of the mother.

System changes are the formal or informal rules, processes, incentives, information systems and other features of organizations and communities that can facilitate or inhibit people from fulfilling their roles and responsibilities. Examples: job descriptions; norms and expectations about work load and quality of work; supportive vs. punitive supervision; incentives and disincentives for trying new solutions to implementation problems; the information available to each functionary to assist decision making, etc.

Rationale:

This module provides a structured process for the group to draw upon its detailed contextual knowledge and experience to develop a sound program theory. This program theory is far more detailed than log frame models, due to the use of the Five Needs Tool, and builds on the evidence from systematic reviews concerning the determinants of behavior and effective behavior change techniques.

Multiple Needs Exist for Each Person

A person may have several needs in order to fulfill their roles and responsibilities. For example:

In order for the district-level Health Personnel to fulfill their roles, they need knowledge, information, skills and materials to train the next level of Health Personnel; it also must be part of their job description; and their performance in fulfilling this role should be fairly evaluated and rewarded on a regular basis.

For the local political leader to advocate for the intervention in their village, this person needs to be aware of the purpose of the intervention, know some key facts about their benefits (and absence of risks) and be motivated to promote the program. They also should have the authority to oversee the performance of the program in their local area and implement changes if necessary.

The next step in the planning process is to identify the needs of each person in the program, and how to ensure that those needs are met, by answering the following question:

- Focal Questions:**
- **What does each functionary and significant other need in order to fulfill their role/responsibility in the intervention (on a daily basis)?**
 - **What inputs, activities and system changes are required to ensure their needs are met?**

Process (3 hours):

1. Create small groups (5-6 people) with each group responsible for analyzing the Five Needs for a given set of functionaries and significant others. Initial attention should focus on the functionaries and significant others considered most critical to the success of the intervention, with special attention to those at household and community levels.
2. Each group analyzes and identifies the specific needs of one of the functionaries, using the Five Needs Tool as a guide (see below).
3. After the needs have been specified each small group must decide how to meet those needs, using the Stress Testing Tool (see below).

4. A recorder writes down the final design of the proposed inputs, activities and system changes and any lingering concerns the group may have about these. If the group is uncertain about the needs of a particular functionary, or how to effectively meet them, they should make a list of these on a separate sheet labeled “Operations Research Items.” This list will be used in Step 7 to decide how to gather this information.
5. The members now reverse roles as proposers and challengers and move onto the next functionary or significant other, and continue in this fashion until all of them have been analyzed.

6. In the final 30 minutes of this Step, members should review all their work – the needs, inputs, activities and system changes – and ask the question:

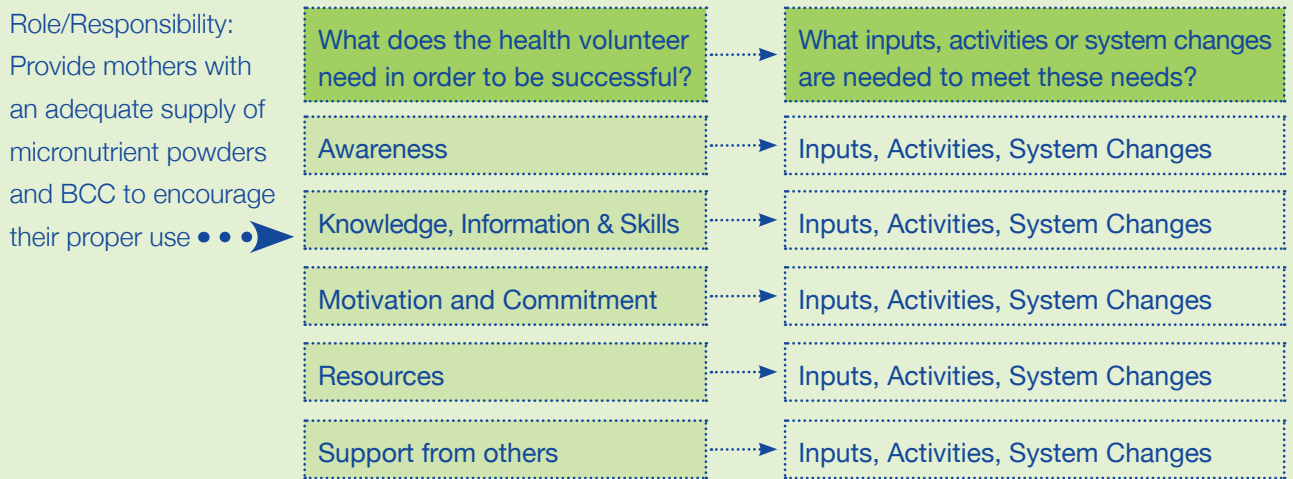
How will we know if these needs are being met during intervention start-up and operation?

It will not be possible to monitor everything through the M&E system, but it is important to identify the crucial points in the start up phase and the routine implementation phase which must be monitored regularly or assessed from time to time. After reviewing your work, make a list of these crucial points.

Example

Village Level Health Volunteer

Illustration of the analysis process to identify the needs of each functionary and the inputs, activities and system changes required to meet those needs.



There are FIVE NEEDS (or categories of needs) for all people associated with the intervention, from caregivers to policy-makers. These are defined here as a reference to help your analysis in this module.

Module 6: Table 1 - Definitions of Five Needs	
Awareness	<ul style="list-style-type: none"> Refers to the need for many people to have a general understanding of the focal health or nutrition problem and its consequences, the proposed intervention and its benefits, and (possibly) who is supporting it. Usually it requires the use of certain methods to reach a broad and large audience such as mass media, but it also can involve the use of personal communication networks with broad reach or connections to specific groups of interests (e.g., mothers groups, religious organizations, policy-makers).
Knowledge, Information & Skills	<ul style="list-style-type: none"> These are three interrelated requirements: <p>Knowledge is usually a more in-depth and foundational understanding based on professional training, organizational experience or programmatic experience (e.g., the causes and consequences of micronutrient deficiencies, how the supply system is supposed to work, how VHC's tend to function in a particular region).</p> <p>Information refers to specific elements of knowledge needed to make specific decisions (e.g., monthly reports on clinic attendance, sachets distributed, anecdotal reports of intervention bottlenecks in certain communities, reminders on the radio or other cues for caretaker actions, etc.).</p> <p>Skills refer to the personal ability to make and implement decisions (e.g., ability to operate a computer, motivate staff, conduct an effective training program, and feed a child). Skills are needed in order to put knowledge and information into practice and they usually require repetition, practice and supportive supervision or mentoring. They also can be enhanced through simple graphics or decision aids such as growth charts, calendars, etc.</p>
Intentions, Commitment, Motivation & Confidence	<ul style="list-style-type: none"> Refers to the articulation of a goal or an intention, a willingness actor to perform the behaviors or roles to achieve these goals, to go beyond their usual behavior or role in pursuit of the goal, or to indirectly support or promote the intervention (if they are a significant other rather than a functionary). Motivation can derive from intrinsic or external sources. Sometimes it can be triggered or enhanced by gaining awareness, knowledge, information or skill, but often these are inadequate by themselves. Specific inputs, activities or system changes may be needed to create commitment or motivation (e.g., performance evaluation, recognition ceremonies, site visits, testimonials, peer influences, etc). An important input into commitment is the belief or confidence that the person can succeed in performing their role, they will derive personal benefits and/or that the intervention can be effective.
Resources	<ul style="list-style-type: none"> Refers to all variety of assets that may be needed to perform a role or could be used to support and promote the intervention, including: <ul style="list-style-type: none"> - material (education materials, computers), - human (staff, time, leadership), - economic/financial (funds), - supply (micronutrient supplements/other) - organizational (authority, support systems), - symbolic (respect, reputation), or - relational (politics, alliances, personal relationships). <p>These can be inhibitors if they are lacking; they also can be powerful and hidden enablers worth identifying in the planning process.</p>
Support from Others	<p>Each functionary in the program may need or benefit from multiple sources of support from others at the same level or at levels above or below. Mothers may need support from fathers, mothers-in-law and other household members; volunteers may need support from the VHC and the community itself; clinic staff may need support from their supervisors, who may need support from the local mayor, etc. Identifying and ensuring the "Support from Others" at all levels of the program is <u>the critical step</u> for ensuring the intervention performs successfully.</p>

Stress Testing Tool

Within each small group, divide the members into two sub-groups:

Proposers and Challengers.

1. The proposers choose one of the Functionaries or Significant Others and propose some inputs, activities and system changes that may meet their Five Needs and enable them to fulfill their roles and responsibilities.
2. The challengers query the proposers about the logic and assumptions based on effectiveness (will those actions truly meet the needs) and feasibility (can those actions be implemented).
3. The proposers modify their proposal to better address the concerns raised by the challengers.
4. This dialogue continues until all group members are satisfied that the proposed inputs, activities and system changes will truly meet the Five Needs for that person.
5. The sub-groups reverse roles and analyze the next functionary.

Additional Resources:

http://erc.msh.org/toolkit/toolkitfiles/file/FC_Guide_English1.pdf

<http://erc.msh.org/toolkit/toolkitfiles/file/MOST31.pdf>

For a useful list and brief descriptions of inputs, activities and strategies for meeting the five needs of women and children see the NPDA Guide:

<http://www.coregroup.org/component/content/article/119>

Module 6 Template - Needs, Inputs, Activities and System Changes			
Functionary	Key Needs	Final Proposed Inputs, Activities & System Changes	Lingering Concerns

MODULE 7

Action Planning

Purpose:

Specify the people, organizations, resources, supports, accountability and timetables needed to deliver the inputs, activities, system changes and operations research identified in Module 6.

Rationale:

Interventions often fail because they were poorly planned. Planning often fails because it is based on faulty information and assumptions and because insufficient attention is given to the question of who should do what, with what skills and resources, in order for the plans to be implemented. In Module 6 we used “proposers and challengers” to weed out faulty assumptions and identify where additional information is needed. In this step, we will ensure that the designated staff at the national and sub-national levels will be able to follow through in delivering the inputs, activities, system changes and information identified in the previous step.

Thus, Module 7 re-visits the roles and responsibilities identified earlier based on the clarity gained in the Five Needs module. You will use simple action planning templates to specify these and clarify accountability structures; and use similar templates to specify accountability for the operations research agenda.

Focal Questions:

- **Who is responsible for assuring that the inputs, activities and system changes from Step 6 will be provided and what do they need in order to be successful?**
- **Who is responsible for assuring that the “Further Information Needs” from Step 6 are met and what do they need in order to provide this information in a timely fashion?**

Process (2 hours):

1. Working in the same small groups as in Step Five, complete the following two templates.

- **ACTION PLANNING:** Use the Action Planning Template below to create the Action Plan for **each input, activity or system change**. Similar inputs, activities and system changes can be bundled together if appropriate. For each, identify:
 - a. Who is required for intervention implementation?
 - b. What are the inputs, activities and system changes they need to fulfill their role successfully?
 - c. Who is responsible for following up?
 - d. What do they need to be successful?
 - e. Who should support and oversee the progress?
 - f. What objectives must be met within various time frames?
- **OPERATIONS RESEARCH PLANNING:** Use the Operations Research Planning Template provided below to create the Operations Research Plan, based on the list of topics created in Step 6. Prioritize the list according to immediate topics to be addressed.

2. After the workshop these templates will be used by Working Groups to organize, support and manage the inputs, activities and system changes in these templates.

Additional Resources:

<http://erc.msh.org/toolkit/Tool.cfm?lang=1&CID=10&TID=192>

Module 7: Action Planning Template							
a. "People" required for implementation (from Step 5)	b. Inputs, Activities and System Changes Required (from Step 6)	c. What organization or person will be responsible for ensuring these Inputs, Activities and System Changes are provided? *	d. What resources, support, training, policy changes, staff or other needs do the people in (c) have?	e. Who should support and oversee their progress? **	Objectives		
					x month	x months	x months

* These are the people responsible for following up after the workshop.

** These are the people to be visited after the workshop, to brief on the outcomes and seek their support.

Module 7: Operations Research Planning Template					
a. Information Needed (from Step 6)	b. Who needs the information and when?	c. How to get it *	d. What organization or person will be responsible for providing it? **	e. What resources, support, training, or other needs do the people in (d) have?	f. How will the success of the intervention be affected if this information is not provided in a timely fashion?

* Consultation with key informants, consultation with experts, document review, rapid assessments, surveys, etc.

** These are the people responsible for following up after the workshop.

BUILDING SUPPORT SYSTEMS AND THE ENABLING ENVIRONMENT

MODULE 8

Monitoring & Evaluation and Quality Improvement

Purpose:

Identify critical control points (vulnerabilities) in the delivery systems that should be included in the monitoring, evaluation and quality improvement systems, in order to detect and correct implementation problems in a timely fashion and improve effectiveness over time.

Rationale:

Good planning and strong implementation of the plan can go a long way in producing a successful intervention. But the world is a complex and dynamic place. No two districts, communities or implementing organizations are exactly alike. Surprises can and do happen and implementation “slippage” tends to accumulate. This will undermine the intervention’s effectiveness over time, even if it was successful at first, unless the intervention has built-in mechanisms for detecting and correcting surprises, errors and slippage. These built-in mechanisms go by various names but here we will call them Monitoring & Evaluation (M&E) and Quality Improvement (QI) systems.

This module helps you specify the weak links in the delivery systems that deserve attention in M&E and QI systems, based on the detailed analysis you did in Modules 5 and 6, and then identify who can detect problems when they occur and who has the authority to correct these problems. Answers to these questions can then inform the design of the M&E and QI systems.

This module helps you specify the weak links in the delivery systems that deserve attention in M&E and QI systems

The experience gained by developing and using M&E and QI systems for this intervention is one of the powerful ways that this initiative can create important benefits for the broader nutrition and health agendas. All interventions, regardless of their focus, require effective monitoring and evaluation systems in order to produce results and sustain those results over time. They also depend upon such systems in order to document results to communities, policy makers, funders and other actors whose support is needed for long-term sustainability. The intervention you are designing can contribute to the country’s capacity to design and manage these information systems.

The development of these systems is a long and complex undertaking that cannot be accomplished at this workshop. However, given the intensive analysis conducted in this workshop, the participants are in a unique position to make a limited but crucial contribution: to identify some “critical control points” that deserve careful attention in these systems. The process below is designed to identify these critical control points.

Monitoring and Evaluation System:

a system for the regular collection of statistics on the inputs, activities, outputs and/or outcomes of the program, generally used to inform decisions at higher levels of the program (managers and above).

Quality Improvement or Quality Assurance Systems:

This refers to a set of activities that set standards and monitor and improve performance so that the service provided is as effective and safe as possible. It is based on Four Tenets:

1. Oriented toward meeting the needs and expectations of the patient and the community.
2. Focuses on systems and processes.
3. Uses data to analyze service delivery processes.
4. Encourages a team approach to problem solving and quality improvement (at multiple levels of the delivery system).

Focal Question:

- **Where are the critical control points for detecting implementation challenges and who is responsible for assessing and correcting these challenges at these points?**

Note: Critical control points are stages in the delivery system or support systems which are especially vulnerable to bottlenecks or problems and therefore deserve high priority in monitoring, supervision and management systems.

Process: (90 mins)

Errors, surprises and slippage in the implementation of an intervention can occur in many ways and at several levels, but all of them would produce the same result: Caregivers either would not have a regular or reliable supply of a needed commodity and/or they may not use them properly or make the desired behavior changes.

Working in the same small groups as before:

1. Using the templates below make a list of the most likely reasons at your level of analysis (i.e. related to the func-

tionaries, significant others, inputs, activities and system changes you have been discussing) why there may be:

- a) an irregular or unreliable supply of a commodity, and
- b) improper use of the commodity, or lack of behavior change, by caregivers

2. In column 2 identify who might be in the best position to detect this problem (multiple answers are ok).
3. In column 3 identify who might be in the best position to correct this problem (multiple answers are ok).
4. In columns 4 specify what the person in col 3 needs in order to fulfill their role and responsibility.
5. In column 5 specify who has ultimate responsibility for the integrity of this component of the intervention.
6. Share succinct summaries in plenary.

After the workshop, these templates will be used by a Working Group dedicated to the development of the M&E and QI systems.

Templates Key:

(Note: One template refers to problems in the supply chain the other refers to problems in utilization or behavior change)

Column 1. Examples of reasons could include: lack of appropriate and timely transport between the Supplier warehouse and the Health Facilities leading to late arrival of a commodity and a slow distribution channel. Or at the household level, an example is: lack of appropriate education could lead to improper use of a commodity by the caregivers (e.g. adding a commodity to a liquid rather than on solid food where it is shown to be most effective).

Column 2. This step identifies the functionary (e.g. health facility workers, voluntary health workers) that has the best access to and understanding of what is happening at a given implementation step whether supply, demand or compliance. Different functionaries will come into contact with the intervention at these various stages and therefore, will provide relevant information to determine if the intervention is or is not working at that step. This functionary is also required to

Module 8: Monitoring and Evaluation Template 1, Supply Chain				
1. Reasons for <u>irregular supply</u> of the commodity at household level	2. Who is in the best position to detect and correct this problem?	3. What organization or person will be responsible for ensuring these are provided? *	4. What resources, support, training, policy changes, information or other needs do the people in (3) have?	5. Who should oversee their progress and provide this support? **
Module 8: Monitoring and Evaluation Template 2, Utilization or Behavior Change				
1. Reasons for <u>improper utilization</u> of the commodity (or lack of behavior change) at household level	2. Who is in the best position to detect and correct this problem?	3. What organization or person will be responsible for ensuring these are provided? *	4. What resources, support, training, policy changes, information or other needs do the people in (3) have?	5. Who should oversee their progress and provide this support? **

* These are the people responsible for following up after the workshop.

** These are the people to be visited after the workshop, to brief on the outcomes and seek their support.

be able to 'act' upon this information in order to provide the right information to the right people to correct this problem. Use the answers provided in column 1 to determine which type of functionary would best address these problems listed.

Column 3. This step identifies the organization or person who has the authority and responsibility for ensuring that the implementation problem is corrected. Often it is the same functionary as in column 2 but sometimes it is not. For instance, the clinic staff may be in the best position to detect irregular delivery of supplies but they do not have the authority to fix the problem.

Column 4. This step identifies the Needs that the functionary in column 3 has in order to take the corrective action and the inputs, activities or system changes to meet those needs.

Column 5. This step identifies the functionary with the authority and responsibility for ensuring that the functionary in column 3 has the knowledge, skills, motivation, resources and support needed to resolve the implementation problem.

Additional Resources:

<http://www.globalhealthcommunication.org/tools/63>

<http://www.qaproject.org/>

<http://www.qaproject.org/pubs/PDFs/improhq601bk.pdf>

MODULE 9

Organizing, Leading and Managing

Purpose:

Ensure that the vision, values and goals created in this workshop become a reality by creating networks of individuals and organizations with the commitment and capacity to promote, guide and support the implementation of the action plan and related aspects of the broader nutrition and health agendas.

Rationale:

Let us review our progress so far: We now have done some systematic and rigorous planning in which you used available evidence, contextual knowledge and experience. You challenged each other's conventional beliefs, assumptions and practices. You created an Action Plan that ensures follow-up and an Operations Research Agenda to fill some critical information gaps. You recognized that implementation is a messy process that seldom proceeds as planned, by identifying key components of error detecting and error correcting systems. These all are enormous improvements in planning an intervention.

Now there is one more step, without which none of the above can happen:

Organizing and mobilizing your individual and collective commitments, talents and resources to create the changes identified earlier.

The key word here is change. Everything you have proposed requires changes in people, rules and processes. And change does not come easy. It will require:

- shared commitment to the vision, values and goals;
- well-organized teams;
- skillful, supportive and shared leadership on these teams, and
- the ability to manage a detailed but flexible implementation process (Action Plan);
- the availability of monitoring information to detect critical points that are and are not functioning and to identify the actions needed for improvement.

This step in the process lays the groundwork for developing these commitments and capacities.

In Module 1 of this process each of you shared your thoughts on "*How this initiative can leverage attention to the broader health and nutrition interests and agendas.*" This was done in recognition of the fact that the intervention is a promising and important intervention to address a particular problem, but it is only one small part of the larger nutrition and health agendas that motivate you, that define your jobs and that need attention in the country. We now must return to your earlier thoughts in order to design a follow-up process that will not only ensure strong implementation of this intervention but also will help leverage attention to these broader agendas.

In the course of this workshop many activities have been identified that will need systematic follow-up:

1. The inputs, activities and system changes identified in the Action Planning Template (Module 7).
2. The information gathering activities identified in the Operations Research Template (Module 7).
3. The Monitoring and Evaluation systems (Module 8).

One way to ensure follow-up is to form Working Groups responsible for each of these (#1 above may require more than one working group). In addition, a fourth Working Group will be needed to provide the overall coordination and support for each of these:

4. Overall coordination and support (e.g., assuring that the needs in column 4 in the Action Planning Template and column 5 in the Operation Research Template are met).

The final step in this workshop is to draft the Terms of Reference for these Working Groups.

Variations

In some countries working groups or structures may already exist because of the extensive planning that already has taken place. In those cases, this Module should be modified in ways that will be most useful to those groups. For instance, each of the numbered items in the Working Group Template can be reviewed to see if they can strengthen the focus, organization, performance, resources or support for the existing group.

Process: (90 mins)

The purpose of this exercise is to draft the Terms of Reference for each Working Group.

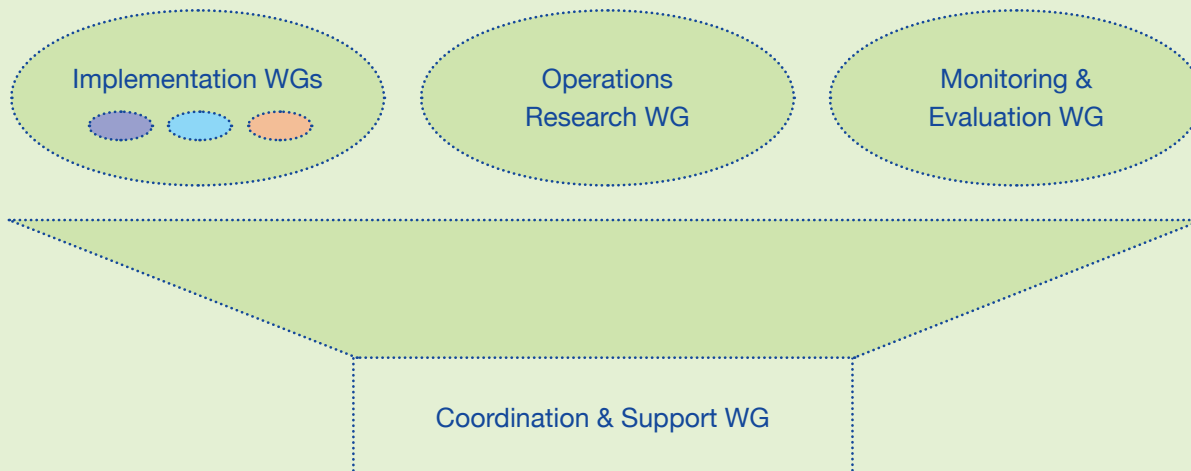
1. Distribute the four Working Group Templates to all participants and in plenary review the Draft Mission Statement for each.
2. Have each participant self-select into one Drafting Group. Some participants may eventually need to contribute to more than one Working Group (especially the overall coordination group), but for present purposes each should join one Drafting Group.
3. The Drafting Groups should revise the draft mission statement and fill in the remaining information in the template.
4. Summarize in plenary and invite additional suggestions.

The Coordination and Support Working Group will meet after the workshop to organize the next steps and re-convene the other Working Groups to begin the follow-up work.

Everything you have proposed requires changes in people, rules and processes.

Module9:Box1

Relationships Among Working Groups



Working Group Template

Implementation Working Group¹

1. Draft Mission Statement:

This Working Group will:

- a) Finalize the analysis (as per Step 6) of the needs that must be met for each functionary and significant other to fulfill their role, and identify the inputs, activities and system changes that will meet these needs.
- b) Work with the Coordination Working Group to ensure that the resources, support, training, policy changes and other requirements of this Working Group are provided.
- c) Organize and implement these changes.
- d) Broaden the participation of other staff (from other health or nutrition programs) in the trainings, technical assistance, discussions and other activities of this working group, in order to strengthen their capacity to plan and implement effective programs related to broader nutrition and health agendas.

2. Revised Mission Statement (on reverse):

3. Proposed Members (specific individuals or types of individuals) these may be participants in this workshop as well as others:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Working Group Leader and Liaison to the Coordination Working Group (name of specific individual):

5. Alternate Lead and Liaison (name of specific individual):

6. First meeting date (proposed):

¹ More than one implementation working group may be needed, as per the division of responsibilities identified in the Action Planning Template. If so, complete one Working Group Template for each of these.

Working Group Template

Operations Research Working Group

1. Draft Mission Statement:

This Working Group will:

- a) Finalize the operations research agenda based on the template from Step 7 and additional information needs identified by the Implementation Working Group after the workshop.
- b) Develop a specific Scope of Work for each operations research task, detailing the information needed, the likely sources or ways to acquire that information, timetable and resource requirements.
- c) Work with the Coordination Working Group to ensure that the resources, support, training and other requirements are provided so that this information can be acquired.
- d) Gather the information, through the efforts of Working Groups members themselves, by working through other partners, by contracting with other organizations, etc., as appropriate for the task.
- e) Broaden the participation of other staff in the trainings, technical assistance and operations research activities of this working group, in order to strengthen their capacity to plan, conduct and use operations research in their work related to broader nutrition and health agendas.

2. Revised Mission Statement (on reverse):

3. Proposed Members (specific individuals or types of individuals):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Working Group Leader and Liaison to the Coordination Working Group (name of specific individual):

5. Alternate Lead and Liaison (name of specific individual):

6. Date of first meeting (proposed):

Working Group Template

Monitoring and Evaluation Working Group

1. Draft Mission Statement:

This Working Group will:

- a) Refine and extend upon the templates produced in Step 8 to define who in the program requires what type of information, at what intervals, gathered by what means in order to i) document and reward/ recognize excellent performance; and ii) detect and correct performance problems
- b) Design the key information elements for the monitoring and management systems and identify new or (preferably) existing information systems that can gather this information on an on-going basis to support management decisions at all levels of the program.
- c) Work with the Coordination Working Group to ensure that the resources, support, training, technical assistance and other requirements are provided to this Working Group.
- d) Work with the impact evaluation team to identify ways in which the monitoring information might also be used to complement or strengthen the evaluation activities.
- e) Broaden the participation of other staff in the trainings, technical assistance and discussions of this working group, in order to strengthen their capacity to design and use information in their work related to broader nutrition and health agendas.

2. Revised Mission Statement (on reverse):

3. Proposed Members (specific individuals or types of individuals):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Working Group Leader and Liaison to the Coordination Working Group (name of specific individual):

5. Alternate Lead and Liaison (name of specific individual):

6. First meeting date (proposed):

Working Group Template

Coordination and Support Working Group

1. Draft Mission Statement:

This Working Group Will:

- a) Work closely with each of the other working groups to identify the types of resources, training, technical assistance, policy changes and other supports needed to fulfill their missions.
- b) Through a variety of means, cultivate networks of strong working relationships and alliances with policy makers, senior managers and other influentials in government, donor, NGO and international partner organizations, civil society and mass media.
- c) Use these relationship to generate the resources, policy changes and other supports needed by the other working groups.
- d) Arrange for this working group to receive on-going professional training and coaching in leadership and strategic management.
- e) Broaden the participation of other staff in the trainings, technical assistance, strategizing and other activities of this working group, in order to expand the breadth and capacity of a national health and nutrition coalition that can generate the supports needed for the intervention as well as the broader nutrition and health agendas.

2. Revised Mission Statement (on reverse):

3. Proposed Members (specific individuals or types of individuals):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Working Group Leader and Liaison to the Coordination Working Group (name of specific individual):

5. Alternate Lead and Liaison (name of specific individual):

6. First meeting date (proposed):

Additional Resources:

http://erc.msh.org/toolkit/toolkitfiles/file/FC_Guide_English1.pdf

<http://erc.msh.org/toolkit/toolkitfiles/file/ResourcestoSupportManagersWhoLead2.pdf>

APPENDIX 1

Practical Considerations

In addition to the higher-level strategic considerations described in the WHO ExpandNet guide (WHO 2009), the following practical considerations apply specifically to the planning and implementation of a PAG workshop. More details on generic workshop planning that can be adapted for a PAG workshop are available here:

http://www.globalhealthcommunication.org/tool_docs/54/the_behave_framework_-_full_text.pdf

Pre-Workshop

1. Formation of a core workshop planning group to decide on strategic purpose and focus, participants, modules to be included, venue, invitations and logistics, pre- and post-workshop consultations / advocacy with policy makers (govt and donor), publicity and media coverage and other strategic considerations.
2. Decide whether sub-national PAG exercises will be employed after the national workshop, and how the national workshop should be designed in light of those plans.
3. Participants should include individuals from national and sub-national levels intimately familiar with the implementation and management issues that exist at each level, along with representatives from key donors, government departments or NGOs, subject matter experts, operations researchers and M&E organizations.
4. Identify the presenter and content for the presentation in Module 1.
5. Form a small group to draft the quantitative targets in Module 2.

6. Form a small group to draft skeleton of the delivery system in Module 3.
7. Obtain large parchment paper (2' x 20') for use in Module 3 in addition to flip charts for other modules.
8. Identify workshop facilitator(s).
9. Send invitations well in advance of workshop including a clear explanation of the purpose of the workshop and any supporting material.
10. Develop a powerpoint presentation (and similar handouts) that contain the instructions and related materials (e.g., examples of filled in templates) for each of the modules to be used in the workshop.
11. Develop pre- and post-workshop evaluation forms and instructions.
12. Identify or hire accountable workshop coordinator(s) to ensure smooth and reliable arrangements for venue, logistics, per diems, workshop materials, etc.

In-Workshop

In addition to the generic guidance for workshop facilitation provided here (http://www.globalhealthcommunication.org/tool_docs/54/the_behave_framework_-_full_text.pdf) the following pertain specifically to a PAG workshop:

1. Ensure that key pieces of group work remain publicly visible during the workshop (e.g., the Goals, Targets and Values from Module 2, the delivery system produced in Module 3, the hard to reach populations in Module 4, etc).

2. Provide 'parking lot' flip chart sheets to each small group, for recording issues requiring operations research (in Module 6).
3. Provide a locally-drawn graphic depicting The Five Needs and keep it visible during Modules 6 and later (see example below).
4. Be prepared to offer definitions, explanations and local examples of concepts that may not be familiar to all participants, such as operations research (as distinct from baseline surveys or formative research), Quality Improvement Systems, intervention (as distinct from a program), hard to reach populations, associated values, implementation bottlenecks, etc.
5. Ensure that products from the small groups and plenary discussions have been properly recorded and documented (using the templates as much as possible) so that a succinct report with actions steps can be quickly produced after the workshop.
6. Ensure clear arrangements and expectations for follow-up to the workshop have been established (in Module 9).

Post-Workshop

1. Brief key policy makers (the same ones consulted before the workshop) on the outcomes of the workshop, highlighting what is needed from them to implement the action plan, operations research, M&E, QI and strategic plan. Maintain communications with them as the follow-up work proceeds.
2. Complete the succinct workshop report within two weeks of the workshop.
3. Ensure the Working Groups (or the other designated structures) meet and fulfill their defined roles and responsibilities.
4. Ensure that the outcomes of the workshop feed into or link up with the larger scaling up processes or other government, donor or NGO initiatives at the national level. Re-package the results from the workshop (notably modules 5-9) into a Results Framework, Log Frame or other format as used/required by government and/or key donors.
5. Consider applying the PAG to another intervention, with appropriate modifications to the PAG based on this experience.

**A2Z: The USAID Micronutrient and Child Blindness Project
AED**

**1825 Connecticut Ave., NW
Washington D.C., 20009-5721
Tel: 202-884-8000
Fax: 202-884-8432
Website: www.a2zproject.org**