WEST BENGAL DISTRICT HEALTH PLANNING

Decentralising for better healthcare

DEPARTMENT OF HEALTH & FAMILY WELFARE
GOVERNMENT OF WEST BENGAL
West Bengal’s 18 districts
The Department of Health and Family Welfare has embarked on a mission to improve the health status of all its citizens especially the poorest and those in greatest need. It is a vision in which people and communities join together to promote a healthy and vibrant State.

We view District Health Planning as a process that creates opportunities for the people through panchayats as well as development partners in the State to synchronise programmatic efforts and thereby maximise collective efficiency leading to improved health outcomes. The framework for District Health Planning has been designed to encourage the involvement of personnel and persons from panchayats, different government departments, non-government agencies and the community itself. The planning process begins at the community level and flows upwards giving the people an opportunity to identify their needs and suggest actions. The District Health Plans thus prepared, form the basis of State level planning and resource allocation.

This effort as part of our decentralisation process enables the State to plan realistically to address felt needs of the people and specially the vulnerable sections. I am confident that in coming years the process will gain in strength and the people of the State will become truly empowered to safeguard their health and help the system to cater to their needs more efficiently and effectively.

The following document captures the background, process and the lessons learnt for the first round of District Health Planning during 2006-07. I dedicate this document to all those people at State, districts, blocks, GPs and villages who made this process a success.

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Minister-in-Charge
Department of Health and Family Welfare
Government of West Bengal
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Background

The Government of West Bengal (GoWB) is committed to ensuring improved health status for all the people of West Bengal, especially the poorest and those in greatest need through a comprehensive health sector strategy. The Health Systems Development Initiative (HSDI) is a 5-year reform programme (2005-2010) initiated to implement the strategy. Decentralisation is a priority of the State under the HSDI, as also under the National Rural Health Mission (NRHM) of the Government of India, launched in 2005. The aim of decentralisation is to empower local governance to manage, control and be accountable for public health services at various levels.

District health planning is the cornerstone of the decentralisation process of DoHFW. It provides an opportunity to sensitise stakeholders on local/area specific issues that affect health outcomes such as access and demand, gender, and convergence and encourages them to find local solutions to some of these problems. The activity was initiated in the State in 2006; all 18 districts prepared District Health Plans (DHPs) for the first time. A bottom-up approach was introduced, that is, the planning process started at the Gram Panchayat level and moved up to the district level.

The DHP process was not an end in itself. It was rather perceived as the beginning of a continuous cycle of planning, implementation, monitoring and evaluation that strengthens the triple ‘A’ process of assessment, analysis and action at each level. In a dichotomous system of a traditionally top-down policy and goal-setting and the more recently introduced decentralised decision-making and control, DHP is seen as a process that will help to strike a balance between passively obeying orders from top and taking control of resources and authority to augment regular ongoing health services at each level.

MISSION STATEMENT

“The mission of the Department of Health and Family Welfare, Government of West Bengal, is to improve the health status of all the people of West Bengal, especially the poorest and those in greatest need.”

1 http://www.wbhealth.gov.in/health_sector/strategy.PDF
Aim of District Health Planning

The aim of District Health Planning is to develop a decentralised planning process at the district, block and gram panchayat levels specifically to:

- Initiate and institutionalise a decentralised planning approach within the health system of the DoHFW, GoWB in an effort to make the health interventions/system more responsive to local needs.

- Develop capacity for decentralised planning at State, district and downward, bringing clarity to roles, issues, and resources.

- Use the multi-sector approach in planning and sensitising the various stakeholders towards health issues at each level, generating discussion and awareness on the effective use of decentralised resources to address these.
Approach

The State began its preparations for district health planning in April-May 2006 under the leadership of the State NRHM Mission Director. The Technical Assistance Support Team (TAST) was requested to provide technical expertise to lay the foundation for decentralised planning for health in the State. Since this was the first time that the State had attempted to decentralise its planning process, an external agency was hired to provide facilitation to the government. This was over and above the institutional set-up within the government. The steps to planning included the following:

a) Envisioning and designing
The NRHM Mission Director with the assistance of a high-level technical group conceptualised the DHP process. The high-level group comprised key officials from DoHFW, the Strategic Planning and Sector Reform Cell (SPSRC) and TAST. This group developed the overall framework for planning in the State with special emphasis on institutional mechanisms and processes for planning. Most importantly, the group prepared the blueprint for setting into motion the health system / machinery and stakeholders across the State for a common purpose.

b) The tools for planning
To bring uniformity in understanding and outputs, a set of guidelines and formats were developed for the DHP process. An external agency was engaged by DoHFW in April 2006 to prepare the planning tools. TAST along with DoHFW provided technical inputs and oversight and facilitated finalisation of the tools. The tools were field tested and finalised after several rounds of discussion and consultations with stakeholders.

DHP tools
Planning tools were prepared for 3 levels:
- Gram Panchayat
- Block, and
- District
The following were the tools:
- Planning templates: for data collection, analysis and planning
- Facilitation guide: to provide guidance and reference to sections in template
- Training module: for training/ sensitising planning teams

The SPSRC has been formed within the DoHFW to provide support to DoHFW in framing policies and recommending strategic options to achieve the MDGs in the health sector. The focus of the Cell is to design and recommend sector wide reform measures and not mere technical / systems improvements. It works closely with other divisions of the Department to translate policy into implementation plans.
Tools were then translated into the local language, Bengali, to facilitate planning at the block and GP. Districts used the English version of the tools.

**Planning Templates:** Health planning is a complex task because of the multiplicity and diversity of issues. To simplify the process and make them user friendly, the planning templates were organised in sections and sub-sections so that all issues, big and small, were addressed at each level.

Each section of the templates was designed to guide planning teams through the steps of

- Collection of data and information from current records and registers
- Situation analysis
- Identification and prioritisation of issues
- Activity planning

The format was designed to encourage evidence-based (data, records, etc) discussion to identify local issues. The next step was to prioritise them based on local resources, capacity and importance. Once the issues were prioritised under each section, a goal was set for each one and a corresponding action and detailed activity plan developed. Block and district planning teams were required to work out the budget for each activity proposed in their plan.
Sections in a typical template

**Geographic, Socio-economic & Demographic** – This section provides an overview of the area (GP, block, district) under consideration, facilitates identification of vulnerable pockets and groups, their location.

**Health Infrastructure** – This provides a picture of the condition and availability of public health infrastructure (Sub-centre, PHC, BPHC and Rural Hospital), government dispensaries, ICDS centres and private facilities. Coupled with mapping, this section becomes a useful tool to identify underserved areas.

**Human Resources** – This section provides an updated statement on status of staffing in public health facilities, including private practitioners, RKS, etc, and highlights areas/pockets where manpower shortages are acute or where supplementary private resources are available.

**RCH programme** – the coverage of services under Maternal and Child Health. Programmes and schemes related to maternal and child health, Family Planning, Adolescent Health, School Health Programme, Nutrition, RTI/STI & HIV AIDS, Tribal Health is a key feature of this section. It helps to set district priority areas in terms of programmes.

**National Disease Control Programmes** – This section gives the current status of the prevalence and incidence of diseases, and efforts to control them. Separate sections on Leprosy, Malaria, TB, Vector Borne Diseases, Blindness Control and Endemic Diseases. Once again the focus is on coverage.

**NRHM New initiatives** – The focus is on decentralised resources and includes use of untied funds given to facilities (Sub-centre, PHC, BPHC, RH), annual maintenance grants for health facilities, flexible funds given to RKS, etc.

**IEC/BCC activities** – This mostly dealt at the district level. The focus is on current strategies and approach, need for integration and convergence with other programmes and sectors.

**Public Private Partnerships** – The effort is to identify geographic areas where PPP can be effective as well as technical areas for such partnerships within a district.

**Drinking water, Sanitation** – These are cross-cutting issues in preventive health care. Included to give a broader scope to the multi-sector approach.

**Urban Health** – An emerging area of health planning, this will help sensitise stakeholders to issues and understand issues from their point of view.

**Birth & Death Registration** – this section is aimed at generating data to enable accurate forecasts for population and services required over time.
A four-tier planning framework was established for the DHP (2007-08) planning process to guide, implement and create resources for decentralised planning at district and lower levels. The figure above gives an overview of the framework indicating the role of each body at each level.

Planning Committees: The apex body that steered and monitored the process was the State Planning Committee. District and Block Planning Committees performed this role at district and block levels, respectively. The Committees at each level had representations from departments of Health, Women and Child Development, Panchayat and Rural Development, Public Health Engineering and Backward Classes Welfare. NGOs and donors working in the State were included at the State-level bodies.

Steering committees: Steering Committees at State and District levels were in reality a sub-groups from the respective Planning Committees. It was the steering committee that was mainly responsible for kick-starting the process, coordinate with all stakeholders, monitor and gather feedback on the
progress of the process.

**The planning teams:** The district, block and GP level planning teams facilitated the planning process. Staff members that were available from Health, ICDS, PRDD and other departments concerned were inducted into the planning teams. Their role was to:

(i) sensitise and train the committee and planning team members at the next level

(ii) Provide technical inputs, facilitate and guide the planning exercise at the next level, and

(iii) Participate in and contribute to the planning process at their own level.

**State Resource Group:** A State Resource Group was formed with members from DoHFW, State Institute of Health and Family Welfare, prominent State-level NGOs and faculty (Department of Community Medicine) from medical colleges. This group was involved in sensitisation, training and facilitation of DHP preparation in the districts. Resource group members visited all 18 districts to conduct and facilitate initial training at district level, to oversee the block and GP level planning processes in selected areas and finally support the district to compile and shape its plan document.

**State Core Team:** DoHFW officials from within the State Resource Group formed the State Core Team for DHP. They were also responsible for monitoring and reviewing the process in the districts.
Launching the process

Dr Surjya Kanta Mishra, Minister-in-charge, DoHFW, speaking at the launch of the District Planning Process

The Honourable State Health Minister formally launched the District Health Planning process on 20 November 2006. Senior officials from PRI, DWCD, DoHFW shared the platform, thereby sending out a strong message for convergence at all levels to make the DHP a truly decentralised activity. Detailed instructions were issued jointly by heads of the three key departments DoHFW, DWCD and PRI. The participants of the launching ceremony included District Magistrates, Sabhadhipatis of Zilla Parishads and CMOHs from all 18 districts. The occasion provided an opportunity to sensitise the district players to the process and their roles and responsibilities. Media coverage provided additional mileage and set the tone for a multi-sectoral planning environment.

In order to facilitate a time-bound approach to the planning process, a calendar of activities was developed during this workshop. The DHP process, being undertaken for the first time, required a long and intensive preparatory phase before actual planning could start. The initial phase lasted two months and was devoted to sensitisation and training of stakeholders from the State, the district, block and finally the GP. This was followed by a two-month planning phase from the GP level and upwards.

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A cascade training plan was used to sensitize and impart planning skills to stakeholders at all levels within the stipulated time frame. State Resource Group members were active participants in sensitisation and training activities and to ensure quality and uniformity in the process across the State.

The training calendar started with a training of master trainers at the State level. The State Resource Group underwent intensive three days of training by the State Core Team and TAST. Sub-teams of two State Resource Group members visited districts to sensitise and train district planning committees and teams. A member from TAST also attended the district training sessions to oversee them. Once the district planning team was trained, it took the task to blocks and block teams trained the GP teams.

Two-day training sessions were organised at district, block and GP levels to:

(i) Sensitise stakeholders
(ii) Train planning teams in facilitation skills
(iii) Familiarise with planning tools
(iv) Develop the training schedule for the next level

### Schedule for the two-day training programme

- **Day 1, 1st half:** sensitisation to DHP process to all stakeholders, including elected representatives, other department representatives, NGOs, co-opted members.
- **Day 1, 2nd half** - **Day 2, 1st half:** sessions on the planning process, steps, issues to be considered while planning, introduction to templates and facilitation guides, simulated exercises with templates with planning team members.
- **Day 2, 2nd half:** preparing training schedules, trainers’ teams and responsibility for the next level
To ensure uniformity in content and understanding, a set of training materials prepared at the State level were used by trainers for districts, blocks and GPs. The training curricula included explanations of planning process roles, responsibilities and activities, steps in planning and prioritising, emphasised collection and analysis of data to encourage evidence-based planning, and provided technical inputs needed for planning. It also included components on budgeting. Hands-on practice through simulated planning exercises on DHP templates was used to impart skills for planning and organisation.

Additional support for priority districts

The State has prioritised six districts – Birbhum, Malda, Purulia, Murshidabad, Uttar Dinajpur and Dakshin Dinajpur – on the basis of scores on the Human Development Index and low female literacy rates. It is perceived that these districts would need additional support to accelerate improvements on development indicators. Thus for the district planning process additional support was provided in terms of larger planning outlays for these districts. This mostly translated into additional facilitators being provided by the facilitating agency. In priority districts, 3 facilitators were provided against 1 in other districts. This meant greater penetration of external support in these districts. The key outcome was that in these districts the final expenditure outlay for a population of 100,000 (1 lakh) was Rs 82.34 lakh compared to Rs 61.43 lakh for other districts.
A bottom-up planning approach was used with the actual planning process starting from the GP level.

**GP-level planning:** The main focus of planning at the GP level was coverage and access to services. Planning was carried out by the GP planning team under the supervision and guidance of Block planning teams. Due to time and resource constraints in some places, GPs were clustered for the planning exercise. For others, individual GP plans were developed. The planning process went down to the sub-centre level in some places. The GP planning exercise provided a common platform for dialogue among stakeholders from different sectors/departments. They jointly identified local problems and priorities and planned on how to address priority issues.

GP-level planning did not include budgeting for activities. However, being a first-time effort, the quality of GP level planning was not uniform. In some cases, it was difficult to find reliable data on which the planning would be based. One-time sensitisation was found insufficient to develop capacity for high-quality planning.

**Block-level Planning:** Block planning teams developed the block plans, which consisted of a compilation of GP/sub-centre plans and issues related to BPHCs and PHCs. Based on available information, the plans attempted to determine block priorities as well as to identify poorly performing areas in the block. The block plans also needed a detailed activity plan with budgets for the year. At this level too, there is need for further training and practice to improve the quality of the planning process. Block plans failed to set clear priorities and actions and were often incomplete because of weaknesses in the GP plans.

**District-level planning:** The district plan was a compilation of the block plans and also...
has sections to address district-level issues like training plans, IEC/BCC and untied institutional funds, Programme Management Units and Rogi Kalyan Samitis.

Based on inputs from block plans and district situation analysis, district priorities were determined for each section of the planning template. Actions and activities were detailed out for the respective priorities and the costing was done.

Glimpses of planning activity in GPs

**Health outcomes affected by changing economic situation**

The changing economic situation in Domjur GP of Howrah District has forced many male workers to migrate to the gold factories of Mumbai and Gujarat. Subsequently, there has been a growing number of HIV positive cases in the area and now even women and children are also infected. The GP Pradhan (headman) raised this issue during the planning process. In response the district health plan includes more intensive awareness generation and additional referral facilities in affected blocks.

**Making a case for disabled children**

The Sakka GP of Raghunathpur block in Purulia district reports an unusually high number of children suffering from disabilities due to polio or other causes. GP-level discussions concluded that the practice of holding camps to identify disabled children and issue certificates was inadequate to deal with the needs of these children. The situation is delicate and cannot be addressed by health planning alone.

**Topographical vulnerability and disease**

In Murshidabad District, Kanchantala GP of Shamshadganj Block is a particularly vulnerable area. The region is low-lying and gets inundated regularly making agriculture viable. Women and girls have taken up bidi making as their main source of livelihood. This has resulted in a higher than normal prevalence of TB in the area. Last year, 35 new cases were reported among the population of 1800. DHP has proposed the setting up of additional TB units to serve the vulnerable population.

**Innovative planning**

The major problems in Kurumgram GP, Birbhum district include early marriage, incomplete immunisation coverage and poor availability of iron folic acid tablets. The GP plan suggested two innovative ways to address the problems: first, to sensitise and educate fathers and husbands on health issues to ensure greater involvement of men in health programmes; second, to issue birth certificates after the immunisation schedule is completed.
Finalising the district health plans in the State

State core team members and State programme managers reviewed the final drafts of the district plans. Programme managers gave final approval to the action plans proposed by the districts, after due consideration of programme guidelines. An excel-based DHP compilation template was designed at the State level to facilitate easy analysis of the contents of the plan. This proved very useful in aligning the budget heads and amounts in the draft DHPs. District outlays were matched with State allocated resource envelopes and plans recast as needed.

Developing the district resource envelopes

Districts were provided with estimated resource envelopes comprising the various sources of funding such as NRHM, RCH, HSDI, Disease Control Programmes, etc., to help them develop realistic plans. The Medium Term Expenditure Framework (MTEF) developed for 2006-11 was used as a reference point for this purpose. The projection of various resources based on estimated trends and advance information from MoHFW, GOI about programme funds was used to ascertain the overall resource envelope for the State. Thereafter, district-wise allocations were worked out and sent to the districts.

The advantage of this approach has been that:

- The complete resource envelope is available for each district with various sources of funds identified;
- The linkage with MTEF ensures that the figures remain aligned to long-term State priorities and budget projections
- The district allocation criteria allows priority funding for weaker districts
- Resource matching is carried out at the district level and leads to prioritisation of activities, although at the sub-district level, planning is not limited by resource constraints
Appraisal of DHPs

A team comprising key DoHFW officials, all State programme managers and TAST appraised the plans. The State Core Team set the appraisal criteria (see box) and findings were shared with the districts. Some weaknesses in the DHPs identified during the appraisal are:

- Prioritisation of issues and activities need to be more specific to the district situation and linked to analysis of problem issues.

- DHPs have stressed on pro-poor initiatives and reaching the vulnerable: however some districts have not identified hard-to-reach areas or vulnerable groups, but have proposed activities for these areas or groups. There is a need to develop an overall strategy or framework to serve the poor and unreachable and build evidence for it, i.e., in terms of identifying/mapping vulnerable groups and areas and plan according to their specific needs.

- The districts have proposed many innovative schemes to enhance service provision. However, these proposals need improvement in specifying the target population, details of activity, logistics and budget. In spite of the weaknesses, some of these schemes came up with very good ideas and are at various stages of acceptance by the State. Some of the proposed innovative schemes are presented in the box on the facing page.

- Greater clarity is required in preparing monitoring and supervision plans for the DHP. Districts need to specify methods, frequency and modalities of monitoring, roles and responsibilities of people to be involved in the process.

- More focus and clarity required in convergent activities vis-à-vis role of various stakeholders– mostly nutrition and PRI.

- District plans also revealed that latest policy or priority-related decisions have not reached the district planners uni-

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**Appraisal criteria for DHPs**

- Interventions prioritised to district specific situation
- MNH and IMR interventions evidence-based
- Actions to increase coverage of the poorest proposed
- Feasibility of innovations proposed
- Actions to promote convergence of health and nutrition proposed
- Detail monitoring and supervision plan
- Clear and appropriate output/outcome indicators proposed
- That the budget is within the given resource envelope
Some innovative schemes proposed in DHPs

**Baby friendly kits for mothers, Uttar Dinajpur**
The State has taken up this idea and developed a Hypothermia Prevention Kit (HPK) to be given to mothers delivering at public institutions. This is expected to encourage institutional delivery as also proper newborn care at home.

**Provision of Pregnancy detection and Urine tests at sub-centres, Uttar Dinajpur, Dakshin Dinajpur, Purulia**
The State PIP 2007-08 has included this new initiative. Under this, facilities for Pregnancy detection (preg colour tests) and urine test for sugar and albumin during pregnancy will be available at the sub-centre level.

**Covered Van Rickshaw to reach the unreached, Uttar Dinajpur, Purulia**
The district has proposed to buy covered van rickshaws to be stationed at sub-centres for providing services and also serve as emergency vehicles for difficult-to-reach areas. These rickshaws would be procured from the untied fund of a sub-centre. The district also proposes to use the vehicle for disseminating IEC and BCC messages to the community in these areas.

**Involving SHGs in health services, Uttar Dinajpur and Purulia**
Uttar Dinajpur district has proposed that they would use the services of local SHG members to follow up on pregnant mothers for receiving ANC and PNC services. Purulia has proposed to provide SHGs in villages with baby scales so that they can monitor and keep a record of the birth weight of babies in their areas.

**Some other good proposals which needs further detailing:**
- Mobile handset for ambulance drivers, Purulia (for ambulances operated under PPP)
- Special strategy for children of seasonal migrants, Birbhum
- IEC/BCC services through FM radio, local cable network, Birbhum
- Joint training of AWWs and ANMs on Nutrition Surveillance and Counselling, Malda
- Joint micro-planning on Nutrition at SC / GP level, Murshidabad
- Provision of RTI/STI services in blocks
- Counselling services in blocks for adolescents, RTI/STI, HIV AIDS
- Family life education / life skill education for adolescent girls in Murshidabad, Uttar Dinajpur and Birbhum
- Identification of newly-married couples with greetings cards along with messages on family planning and maternal health care in Uttar Dinajpur
- Blood group testing and RH typing for pregnant women at the sub-centre level especially for primigravida mothers in Coochbehar
- Nutrition testing clinic at sub-centres in Malda and Murshidabad; nutrition clinics at Birbhum PHCs.
formly. Grey areas include poor comprehension on the changed role of the TBA: as a community influencer and motivator than a service provider, ensuring access to quality EmOC services to prevent maternal mortality, strengthening the referral chain to minimise risks of pregnancy and delivery and care of neonates.

- District targets for constructing and upgrading infrastructure and facilities have to be synchronised with the State Plan, as this is mostly decided at the State level.
- Planning within the provisional resource envelope has to be improved, with only three districts near the mark. Ten districts exceeded their budget and five planned below their budget, including two of the identified priority districts.
- In some cases, certain sections in the planning template did not get adequate attention. Specifically, sections on RTI/STI, diarrhoeal and water-borne diseases, registration of births and deaths, urban health and AYUSH need more effort and focus. Activity planning and budgeting for these sections also needs strengthening.
Implementing and monitoring District Health Plans

Monitoring the plan process: Monitoring of the plan process at the State and district levels ensured that time schedules were maintained and plans were technically sound. The State core team monitored the process through visits to districts and selected blocks and GPs. These visits served the dual purpose of supervising the process and getting first-hand feedback of the field situation. The monitoring-feedback mechanism remained informal throughout but provided lessons about how to strengthen the DHP process in the next round.

In the districts, the district administration (DM or the ADM [Health]) or the chairman of PRI (Sabhadhipati of the Zilla Parishad) assumed responsibility for monitoring and periodically reviewed the progress during meetings of the District Health Planning Committee and Steering Committee.

Monitoring the DHP implementation: A monitoring plan complete with indicators has been embedded into the district and block planning templates. Based on this section of the plan the State has developed a user-friendly Microsoft Excel-based ‘Activity Monitoring Tool’ for the districts to monitor implementation of the activities in their DHPs. The State has also included monitoring of district health plans in their agenda for quarterly health reviews. The DoHFW intends to use the tool during the quarterly reviews conducted in the districts, and thereby institutionalise it. It being the first year, the preparation of the final plans and their subsequent approval got delayed, so not much of the plans could be implemented during 2007-09.

Quarterly Health Reviews

The DoHFW introduced a “Quarterly Health Review” in 2006 as a tool to monitor its programmes and to forge linkages between policymakers and implementers. Quarterly reviews are held at the division level. The State team is lead by the Health Minister and Principal Secretary Health. Members include Commissioner Family Welfare, Mission Director NRHM, Executive Director Samitis and other senior Health officers. In addition to key Health officials, the district teams also include the District Magistrate and the District head of PRI. The review includes a broad range of issues from coverage of services to progress on infrastructure development, to the status at various levels. The reviews are useful in bringing accountability to the system and providing first-hand information to policy makers. Linking the monitoring of DHPs to these reviews will boost their implementation.
Key outputs in year one

This monumental effort culminated in the development of Health Plans in each of the 18 districts. With approximately 40,000 people actively participating in the process, the first round of planning has helped to create an awareness on health issues among health staff and personnel and beyond. More importantly, the process allowed health staff at every level of hierarchy and even the far-flung corners of the State to contribute to the State planning process. The process itself has laid the foundation for a decentralised planning approach in the State that can be further built up and fine-tuned in further planning cycles. Specifically, it has been able to generate the following:

- **A planning framework** that can swing into action with short orientation
- **A set of planning tools**: Basic tools for planning are now available with the State and the whole State is oriented to use them. They can be modified to adapt to emerging needs as the planning cycle continues.
- **State resource pool**: A pool of resource persons have been created at all levels with the vision and skills to carry the activity forward. The resource groups will ensure continuity and further refining of the process, through learning-by-doing.
- **Stakeholders of Health**: The involvement of multiple stakeholders has been instrumental in giving health issues a broader perspective than mere service delivery. Sensitisation and the involvement of stakeholders in the health planning process has also generated greater awareness of health issues. However, this task is far from finished. Repeated rounds of planning should enhance the clarity of roles of every stakeholder in ensuring health for all.
- **Utilising data**: The importance of data has been driven home at all levels. The process encourages data compilation and situation analysis at all levels of planning in order to identify local priorities and issues. A few more planning cycles will embed a culture of critical analysis and prioritising within the health system that will eventually improve the quality and integrity of data in the health MIS.
- **Inter-departmental collaboration**: A dialogue has been started between health officials and their counterparts in other departments. This is a step towards gaining a better understanding of local situations and problems and planning synergistic action to overcome some of them.
The process for developing DHP 2008-09 started in November 2007. The experiences from the first round were used to further strengthen the process. Although the planning framework remained the same, a few modifications have been made to overcome some of the weaknesses in the planning process and the plans themselves.

- **Broadening the scope of facilitation**: The State realised that one round of planning across the State was not enough to develop capacity for high-quality, participatory planning; therefore it solicited external support for the planning process. Moreover it was felt that more facilitative resources are needed to sustain and build upon the process.

Several non-governmental agencies have been partnering the State in areas of health. So, for DHP 2008-09, the DoHFW opted to use four agencies to facilitate the process in the districts instead of one. Moreover, efforts have been made to encourage greater participation of local MNGOs and FNGOs and also identify local resource pools at least at the district level to provide continuous support to the process of DHP.

- **Enhancing the quality of facilitation**: The use of four agencies brought in additional resources for facilitation on the one hand but also posed the challenge of ensuring uniform understanding and facilitation. The team of facilitators were prepared for their tasks with a three-day intensive training programme. The training was to foster a clear understanding of the DHP process and its tools, to explain to them their own role and to inculcate some basic soft skills for facilitation.

Participatory training techniques and simulation exercises of the different steps of planning helped to develop an indepth understanding of the basic issues of the planning template. The facilitation kit included in addition to templates, facilitation guidelines, a document on facilitation skills and papers on cross-cutting issues including access and demand, convergence, decentralisation and nutrition.
These areas were selected since they had been poorly dealt with in the last planning cycle. An important aspect of the skill development programme was prioritising issues out of the planning templates.

- **Ensuring participation of stakeholders:** It is important to ensure participation of various stakeholders, not just presence. This year, the district administration has been asked to coordinate the process and joint orders have been issued from the State and district administration. These are meant to support the facilitators in the districts in their tasks.

- **Priority setting:** This was a major challenge in round one. A stronger emphasis on prioritising issues and actions has been built into the training plan both at the State and district levels.

- **Clear lines of responsibility:** Efforts have been made to establish clear lines of responsibility at all levels. At the State level, DoHFW has appointed one State nodal officer from the SPSRC and assigned two nodal officers from the State Core Team for each district. Districts and blocks have been asked to designate nodal officers who will liaise with the State.

- **Intra-departmental communication:** Improved communication between the

**Areas that need further integration and strengthening**

- Planning for institutions like the hospitals (State and Sub-divisional level)
- State Institute of Health and Family Welfare should also be integrated
- Urban Health requires conceptualisation and strengthening

State and the districts has been planned. State nodal officers will monitor the assigned districts regularly and provide feedback to the State NRHM Mission Director. Facilitating agencies will meet the State team once a month to provide progress reports.

- **Improving the quality of plans:** The weaknesses within the plans have been addressed in different ways. Districts have received feedback on their plans for 2007-08, and they have also seen the comparative position of their districts according to the appraisal criteria. The planning templates have been modified for better clarity especially in sections that districts had difficulty in filling out. Districts are encouraged to send in innovative ideas but this time a structured approach is proposed. This will be reviewed by a committee for feasibility and may be included in the State RCH or NRHM PIPs. The process has been streamlined to allow timely feedback.
• **Timely implementation and monitoring of DHPs:** the second cycle of DHP has been completed in time to feed into the State Programme Implementation Plans (PIPs) for RCH and NRHM. The State has also completed the process of perusal and appraisal of the plans in time. This ensures that the implementation of the DHP can begin in time for the financial year 2008-09. Further DHP implementation will be reviewed by the districts themselves and by the State during its quarterly reviews.

• **Further action on DHP in 2008-09**
  ~ Timely feedback to districts on approved activities under each head.
  ~ Invitation of detailed proposals in a specified format for innovative activities and a flexible fund kept at the State level to fund them.
# List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ADM</td>
<td>Additional District Magistrate</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante Nataal Care</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>AWW</td>
<td>Anganwadi Worker</td>
</tr>
<tr>
<td>AYUSH</td>
<td>Ayurvedic, Yoga, Unani, Siddha and Homeopathy</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<tr>
<td>BPHC</td>
<td>Block Primary Health Centre</td>
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<tr>
<td>CMOH</td>
<td>Chief Medical Officer of Health</td>
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<tr>
<td>DHP</td>
<td>District Health Plan</td>
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<tr>
<td>DM</td>
<td>District Magistrate</td>
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<tr>
<td>DoHFW</td>
<td>Department of Health and Family Welfare</td>
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<tr>
<td>DWCD</td>
<td>Department of Women and Child Development</td>
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<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>FNGO</td>
<td>Field Non-government Organisation</td>
</tr>
<tr>
<td>GOI</td>
<td>Government of India</td>
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<tr>
<td>GoWB</td>
<td>Government of West Bengal</td>
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<tr>
<td>GP</td>
<td>Gram Panchayat</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HPK</td>
<td>Hypothermia prevention kit</td>
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<tr>
<td>HSIDI</td>
<td>Health Sector Development Initiative</td>
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<tr>
<td>ICDS</td>
<td>Integrated Child Development Scheme</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MNGO</td>
<td>Mother Non-government Organisation</td>
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<tr>
<td>MNH</td>
<td>Maternal and Neonatal Health</td>
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<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
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<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
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<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
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<td>PIP</td>
<td>Programme Implementation Plan</td>
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<td>PNC</td>
<td>Post Nataal Care</td>
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<td>PPP</td>
<td>Public-Private Partnerships</td>
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<tr>
<td>PRDD</td>
<td>Panchayat and Rural Development Department</td>
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<tr>
<td>PRI</td>
<td>Panchayati Raj Institutions</td>
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<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
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<tr>
<td>RH</td>
<td>Rural Hospital</td>
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<tr>
<td>RKS</td>
<td>Rogi Kalyan Samity</td>
</tr>
<tr>
<td>RTI/STI</td>
<td>Reproductive tract infections/ sexually transmitted infections</td>
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<tr>
<td>SC</td>
<td>Schedule Caste</td>
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<tr>
<td>SHG</td>
<td>Self-help Group</td>
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<tr>
<td>SPSRC</td>
<td>Strategic Planning and Sector Reform Cell</td>
</tr>
<tr>
<td>TAST</td>
<td>Technical Assistance Support Team</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>ToT</td>
<td>Training of Trainers</td>
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District Health Planning in progress