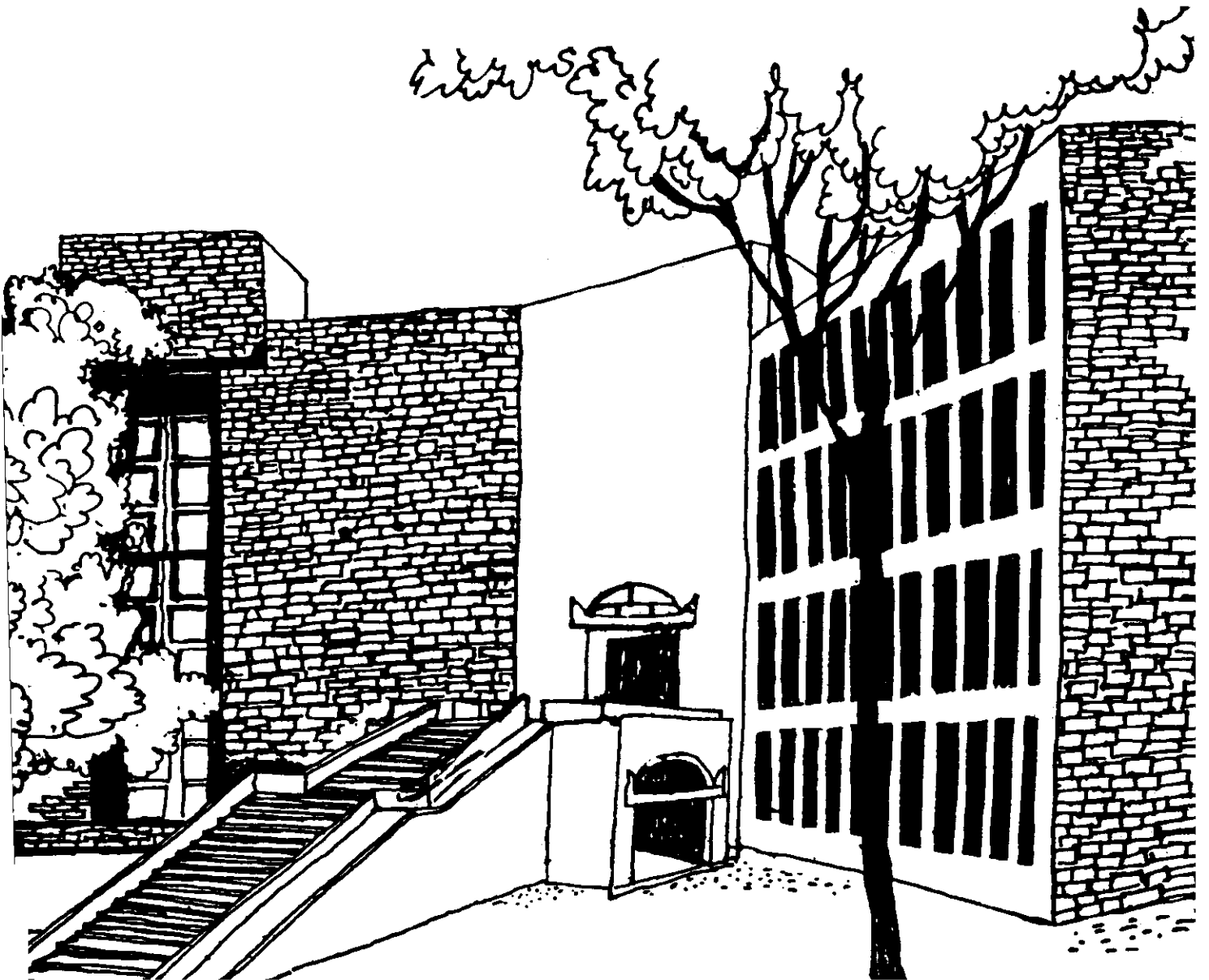




# Working Paper



MICRO-LEVEL PLANNING METHODOLOGY FOR  
PRIMARY HEALTH CARE SERVICES

By

J. K. Satia  
D. V. Mavalankar  
&  
Bharti Sharma

WP1047

1992  
(1047)

W P No. 1047  
August 1992

The main objective of the working paper series of the IIMA is to help faculty members to test out their research findings at the pre-publication stage.

INDIAN INSTITUTE OF MANAGEMENT  
AHMEDABAD-380 015  
INDIA

**Summary:**

This paper describes a micro-level planning methodology for primary health care services which has been developed and tested in India. As compared to current top-down, target-based planning, the methodology uses village level data on client needs to formulate micro-level plans aimed at improving service coverage.

A quick sample survey to assess service need, coverage-gaps and reasons for non-utilization of services form the basis for identifying village level variations and developing village profiles. From such disaggregated analysis of data general interventions for overall service-coverage improvement and targeted interventions for selected villages are also identified. This system was tried out in 113 villages of three Primary Health Care centres of a district in Gujarat state of India. It demonstrated the feasibility and utility of this approach. However, it also revealed the barriers in the institutionalization of the system on a wider scale.

The proposed micro-level planning methodology would improve client-responsiveness of the health care service delivery system and provide a basis for increased decentralization and community involvement. By focusing attention on under-served areas, it would promote equity in the use of health services. It also helps improve efficiency by focusing the efforts on small group of villages which contribute to most of the service coverage gaps.

## **Introduction**

It is now widely recognized that rapid assessment methods can provide information on health status, impact, services and behaviour that can be fed into the health planning cycle at all levels (Vlassoff & Tanner 1992, Oyoo 1991, Selwyn 1989). Population-based health information assessing more clearly the service coverage-gaps in the entire population, and particularly among under-served, is needed for planning and programming the Health for all strategy ( Nordberg 1988). In addition, decentralized decision making and increased use of survey data in planning are mutually supportive processes.

This paper describes a micro-level planning methodology based on assessment of client needs, use of health services and reasons for non-use through a quick, household sample-survey. The procedure for data collection and coverage analysis are discussed. A framework for identifying interventions necessary to increase service coverage is proposed. These can form the basis for health service delivery planning at the local level. Experience with the methodology in three primary health center of a district in Gujarat state of India is also discussed.

## **Health System Planing in India**

Service provision targets form the basis for most of the primary health care service delivery planning in India. These targets are derived at the national level from the desired progress to be made towards achieving

goals set for year 2000 in the National Health Policy (1982). The Ministry at the national level allocates these targets to the states, largely based on population norms. The states repeat this process with the districts which in turn allocate them to primary health centres. Broadly the government's primary health care service delivery structure in India is a primary health centre manned by a medical doctor and other staff for a population of 30,000, and a health subcenter staffed by a male and a female multi-purpose health worker for a population of 5,000. At the primary health centre (PHC), the targets are allocated to field workers in proportion to the population covered.

The targets, so set, form the basis for planning supplies and other activities as well as monitoring workers' and PHC's performance. An evaluation of implementation of immunization programme found that of the 43 districts surveyed, 33 districts claimed to have action plans. But these were mostly in the form of scheduling of immunization sessions, supply of vaccines, and distribution of targets. Only in 23 districts, the district officials were involved in preparing such plans in whatever form they were. In others, the district officers were mostly concerned with passing on the targets allotted to them from the state headquarters to the lower level. The workers are generally held responsible for achieving the targets allotted to them. Those found deficient in terms of their target achievement are threatened with punitive actions or occasionally transferred to other undesirable locations (Gupta et al 1990).

The population-norm based, target-driven planning is based on the principles of equity and accountability. But it has resulted in several problems which has attracted substantial criticism recently (Bose 1988). First, actual service coverage in different areas varies considerably, depending on the socio-economic conditions, worker motivation and skills. Consequently poor areas are the most ill-served. Second, the planning does not cater to local socio-economic and geographical variations. Third, the planning process does not involve local staff depriving them of initiative and motivation to improve health care service delivery.

#### **Micro-Level Planning Methodology**

Often health services planning is based on service statistics derived from worker records (Bhadkamkar 1984). However, these records are incomplete or inaccurate, especially where socio-economic conditions are difficult and/or worker performance is poor. But even more important, low service coverage only points to the problem. The interventions to reduce future service coverage-gaps and improve coverage would depend on identification of reasons for non-use of services and relating them to socio-economic conditions, worker characteristics and programme's operating practices. Micro-level planning methodology overcomes some of these shortcomings. Similar efforts in Micro-planning have been undertaken in other sectors (Aram 1989, NWDB 1990, UNESCO 1991).

## Methodology

Here we propose a methodology for micro-level planning which comprises of (a) a quick sample survey of villages to assess service coverage-gaps and reasons for non-use of services; (b) analysis of this data to assess the coverage gaps and relate them to determinants of performance (c) identification of interventions to reduce future service coverage-gaps. Village level intervention plans when aggregated will generate a strategy for the primary health centre.

The main features of the methodology are given in table 1. A schematic flow chart for the methodology is shown in figure 1. The planning cycle starts with a quick sample survey of the beneficiaries to assess coverage levels, gaps and reasons for gaps for key services. The required actions emerge from the reasons for non-use of services. From the levels of gaps and realistic appraisal of the local situation reasonable targets can be negotiated with the PHC staff. Action plans need to be drawn up to meet the targets. Monitoring of the action plans during implementation will be required to ensure achievement of targets. The repeat quick survey during the next planning cycle will help assess achievement of targets and coverage. As the gaps between need and served becomes narrow one can make the definition of need more rigorous to achieve higher and higher standards of service coverage.

## Data Collection

A sample survey of 1752 households in 113 villages of three primary health centres of Sabarkantha district in Gujarat was carried out to assess coverage of key primary health services currently being provided in the government's programme. These services include maternal health (tetanus immunization and provision of iron-folic acid tablets), Child health (immunizations and vitamin A), curative care for common ailments (fever, skin diseases and diarrhoea) and family planning (sterilization and spacing methods). A household was identified as needing one or more of these services in recent past using criteria given in table 2. For instance, all those households where women wished to space their next child and the youngest child was between 8-36 months of age were identified as needing spacing methods. Service coverage-gaps were estimated by counting those households which needed services but did not receive them.

A form for quick sample survey was developed. It included information on the household to assess eligibility for various services and use of such services. If there was a gap (non-use among eligibles), then the major reason for gap was also identified. The procedure adopted for data collection was to sample systematically every seventh household (14% sample) from the eligible couple registers maintained by the workers, and interview the woman resident if she is married and in the reproductive age-group. We experimented with data collection by workers, supervisors and independent investigators. The time for a household interview varies



depending on its eligibility for various services but averaged around 5 minutes. Our experience shows that supervisors are the optimal means of collecting data and with them it would take only about 10 days to collect this data from their field areas. Besides ensuring reliability of the data, the supervisors get an opportunity to come in contact with the client population and learn firsthand about their perception of the quality of programme operations. Thus they can help workers in developing village level plans based on the data collected. Such quick assessment fits well in to their role as supervisors.

#### Analysis:

The quick survey data can be analysed in several ways to generate useful information for coverage assessment and planning interventions. We have developed micro-computer based software to enter quick survey data, analyse it and produce various tabulations which provide useful information. Use of micro-computer expedites the analysis but the same analyses can be done by hand tabulation. Here we present some of the important analyses we tried out and their application to planning.

#### Analysis of Coverage-gaps

The coverage-gaps and reasons for non-use of services were summarized for each village and then aggregated at the worker and primary health centre level. Table 3 illustrates this analysis for one of the primary health centres.

The coverage-gaps for tetanus immunization, iron and folic acid tablets distribution and measles immunization were small (less than a fifth). While gaps were substantial (about one third) for DPT, BCG and polio immunizations. The main reasons for non-use of immunization services were supply related as mothers reported that workers did not visit their houses to give vaccinations. Fifty three percent of the respondents did not want more children (defined as in need for sterilization). Of those in need of sterilization 72% had accepted sterilization, 7% were practising spacing methods and the remaining 21% did not use any method. This gap, translated in absolute numbers, is about two and half times the current annual sterilization target of this primary health centre. Some common reasons for non-use of sterilization services were 'waiting for the child to grow', 'waiting for appropriate time', health-related reasons and fear of operation. 15% of the women wanted to space their next child and had their youngest child between 8-36 months (defined as need for spacing methods), of which 33% were not using any method. The main reasons for non-use were lack of felt need, dislike for and lack of knowledge of spacing methods.

Overall resistance to family planning was low, as indicated by a high proportion of respondents (68%) expressing no desire for more children or wishing to space their next child. Only 5 out of 41 villages were identified as expressing some resistance to family planning indicated by less than 50%

of couples wanting no more children or wanting to space their next child.

Most of the episodes of fever in the area were treated. But a fourth of diarrhoea episodes did not receive any treatment and a little more than a third of the skin problems were also untreated, both largely for demand related reasons. However, in nearly three-fourths of these cases of minor ailments, care was sought from private sector.

The causes for non-use for various services differ. Non-use of family planning is due to both demand and supply related reasons. The MCH services, in general, do not face demand constraints and improving availability of these services on a regular basis would lead to a reduction in coverage-gap. Curative care is sought from a convenient available source, either public or private. Therefore, interventions to reduce coverage gaps for these three types of services differ and, would require different strategies.

The major reasons for non-use and likely interventions to respond to these causes are given in table 4. Broadly the interventions to reduce overall coverage gaps fall into four categories:

- (a) Strengthening interpersonal and group communications capability, particularly for spacing methods and sterilization services because both have gaps which are demand-related. As immunization service-

coverage gaps were largely due to workers not visiting the households, it would be useful to direct communication so as to motivate mothers to seek these services at static facilities or designated village posts.

(b) Improving quality of care for the whole range of services, but particularly for sterilization and spacing methods to overcome fear and dislike.

(c) Better planning of outreach and provision of MCH services, particularly in those areas allocated to male workers for family planning, would result in a higher coverage of MCH services.

(d) Most people used private curative care for minor ailments wherever it was easily accessible. They also used government services where convenient. But in a few villages both private and public curative care are not conveniently available. In these places, workers may have to be specially trained and motivated to provide such curative care.

#### Variations in Service Coverage

Although health services are planned on an uniform basis, the resulting service coverage-gaps vary considerably. Table 5 presents overall gaps for two PHC for each service and number of villages with extremes of

gaps (number of villages with  $\pm 50\%$  of overall PHC gap). Gaps are much larger in PHC B which is situated in backward area than PHC A which is situated in a better area. About a fourth of the villages in both PHCs have service coverage gaps which are more than one and half times the over all PHC gap for most preventive services.

#### Reasons for Differential Service-coverage gaps

The reasons for service coverage gaps differ, as shown by the following case studies of three villages.

Moti Panduli is a tribal village with a population of around 1,200. the region is hilly and the hills are rocky and barren due to deforestation. People have built houses on hill tops which are less rocky and can be cultivated. The female worker is 25 years old and is married to younger brother of the village headman (Sarpanch). Her husband works in the secretariat at the state capital. Her health is poor and finds that the area is too vast and difficult to cover. The outreach is limited and people do not have faith in her technical skills because abscess were formed in several cases after DPT immunization. The coverage gaps vary from a third to three-fourths of needs for various services.

Village Odha, with a population of around 600, is around 6 kms from the primary health centre and 3 kms from the subcenter. The

population is both tribal and non-tribal. The households are somewhat scattered. The village is socio-economically backward but a few farms have irrigation facilities. The female worker is 24 years old and unmarried. She has been working in this subcenter for three years. As she has carried out her work diligently, coverage gap is negligible for most of the services. But as she is unmarried and this is her home village, she has made little efforts to educate women about spacing methods where the coverage gap is very large.

Village Isri is the primary health centre head quarter village with a population of around 1,600. The socio-economic conditions are reasonable. There is also a private doctor in the village. The female worker is 35 years old and has been staying in the village for a long time. Most people visit primary health centre MCH clinic for various services. The worker carries out some outreach activities and has developed a good rapport with the community. The service coverage gaps are small.

Village Moti Panduli suffers from unfavourable socio-economic and geographic conditions as well as poor worker competence emanating from selection and training practices of the programme. Village Odha also has somewhat unfavourable socio-economic conditions but worker is able to counter these effects. spacing method coverage still suffers as the worker is unmarried and local. Both of these features may be an advantage for some

health services but adversely affect others like family planning. The primary health centre village is often one of the most developed village of the area and also attracts good workers. Thus, the socio-economic characteristics of the village, worker characteristics and their rapport with the village communities, and programme's operating practices interact in a complex way to determine the performance and service coverage-gaps. Figure 2 proposes a framework to explain how these factors jointly influence program performance leading to service coverage and gaps.

#### Developing Village Profiles

From the data collected, it is possible to develop village profiles on five key dimensions each having three categories -- high, medium and low. These five dimensions are: (1) potential for sterilization depending on coverage-gap for sterilization; (2) need for systematization of spacing method services depending on spacing method coverage-gap; (3) Resistance to family planning based on the combined percent of couples not desiring additional children and those wishing to space with youngest child between 8 and 36 months; (4) need for systematization of MCH services based on variation in various MCH service coverage; and (5) needing additional key health services as those villages where coverage-gaps for all the services were low and additional services would be needed to improve health status further. Out of a total of 41 villages, 19 had high potential for sterilization, 16 had high need for systematization of spacing method services, 5 had high resistance to family planning, 28 required systematization of MCH

services and 15 were such that new services could be introduced. This analysis shows that within a PHC different villages require emphasis on different services. Such segmentation of villages based on key dimensions will help develop planning system based on village level needs.

### Targeting Villages

Although it is ideal to plan appropriate interventions for each village, the complexity may be too high. Besides similar factors may be influencing delivery of all the services in a village. By ranking the villages on coverage-gaps, it was found that around 7 out of 41 villages of PHC A with approximately a third of the population accounted for 60% of the service coverage-gaps for all the services except for sterilization where coverage-gaps were more evenly distributed, perhaps reflecting the emphasis placed on meeting sterilization targets in the programme. Similar pattern was observed in PHC B and C. This analysis showed that coverage-gaps are not uniformly distributed in all the villages of a PHC, but are highly concentrated in small subset of villages. Targeting such villages for improving service coverage would be an efficient strategy.

More rigorous statistical methods can be used to identify villages to be targeted having coverage-gaps much higher than average. The selection criteria can be devised to balance the risks of selecting a wrong villages against the risk of not selecting a village with high coverage-gaps (Rosero-Bixby 1990). But such rigour is not necessary for micro-level planning for



two reasons. First, the results are discussed with the respective health staff which serves as a validation for targeting. Second, a diagnosis is carried out to identify causes of high gaps. If such a cause(s) can be identified then actions need to be taken to address it irrespective of the severity of gap. In other cases where causes are not identifiable, further investigations would be necessary.

The reasons for poor service coverage in these villages differed. Several specific reasons were identified when the coverage data were shared with the PHC staff. For example in one village with low coverage the worker's position had remained vacant for around two years. Even the current worker in that village was not well accepted as she belonged to a lower caste and the village was predominantly high caste. In another instance, poor coverage was due to the fact that the worker was unable to visit that village regularly as it was far way from her headquarter village and other villages allocated to her. One village had predominantly tribal population which is socio-economically backward and would require special communications strategy to overcome demand barriers to services. Coverage-gaps in a village were high because the houses were scattered making regular outreach difficult. In villages allocated to a male workers for family planning activities the MCH services are to be provided by the female worker as per the program guidelines. Female workers have low motivation to visit such villages. Instead they concentrated on the villages where they responsible for both family planning and MCH activities. Thus

different factors -- socio-economic conditions, programme operations and worker characteristics -- seemed to influence performance in these villages and needed to be addressed appropriately to improve performance.

Reasons for resistance to family planning were more complex and would require coordinated actions from other developmental departments. To illustrate, in one village, mostly artisans lived who felt that more the hands available, more work could be done. It would be useful to introduce some labour saving devices in this village to decrease demand for labour. On the other hand, a village was dominated by prosperous agriculturalists, but where women had low status and were largely illiterate would require women's groups, literacy classes and other social activities to increase acceptance of family planning.

The reasons for low coverage-gaps for all the services in some villages also differed. In one village, a government dispensary had been operating for a long time and people availed of various health services from this dispensary. Although socio-economic conditions were poor in another village, the worker was sincere and had been able to provide most of the needed services. Socio-economic conditions were favourable in a village and people had demanded these services and received them. Thus in villages where present services are well accepted, causes of mortality, particularly infant, and morbidity would need to be investigated further to identify which health services should be added to improve health status

further. These villages also offer particularly favourable opportunities for sharing data with the community to promote its participation and encourage inter-sectoral coordination.

### Setting Need-based Targets

Thus interventions to future reduce coverage gaps are of two types: overall to improve coverage and targeting villages for specific actions. It is difficult to judge how far such an activity plan would succeed in addressing causes of non-use and improve service coverage. However, the data provides a basis for target setting involving the workers and potential for improving service coverage. Essentially the coverage should increase so as to cover all the need. For example, if half of all the women not desiring additional children and waiting for child to grow could be persuaded for sterilization then one can expect 255 operations and if a third of other demand related reasons could be overcome, then an additional 66 acceptors of sterilization can be expected in PHC A. Thus setting targets based on a micro-level plan would result in more realistic targets taking into account programme efforts, worker's expectations, the current gaps and reason for the gaps.

### Developing Primary Health Center Plans:

In theory, the micro-level plans can be developed for each village addressing reasons for non-use of services, and such plans can be aggregated to form health center plans. In addition to specific interventions

such plans would also include supervision and support activities. But in practice the process of developing health center plans approximates this ideal and is as follows. The information generated from the analysis of the quick survey is discussed with the health center managers and staff. Plans for intervention need to be based on what is realistically achievable in that planning cycle and should address major reasons for gaps in service coverage for the health center area. Some interventions that we are currently trying out at the health center level include improving communications skills of workers, strengthening work planning and out-reach, and improving technical knowledge. These interventions, involving all the health center staff, would suffice to improve performance in most of the villages having average coverage and thus will have effect on overall performance. But, specific intervention plans will be needed for villages which have very large or very small gaps. For example villages with large gaps in immunization would be targeted for 'pulse immunization' to increase the coverage very rapidly. Villages with high gap in family planning services would be targeted for demand generation activities such as information, education and communication campaign along with provision of quality services. Villages with high coverage (small gaps) of the existing services will have to be targeted for institutionalizing current services, increasing their quality and adding new services. Village level plans to operationalize these services will have to be worked out with details of visit schedules and work pattern during the visit. Supervisors will have to provide the required support and monitor implementation of such plans. Some interventions will require

flexibility at PHC level and support in form of training from outside agencies.

### **Conclusion**

We have described a micro-level planning methodology which essentially involves a quick survey to assess coverage-gaps and reasons for non-use. This data was collected for 113 villages in 3 PHC areas and an illustrative analysis of data was provided. This analysis led to identification of interventions necessary to improve service coverage and can form a basis for realistic and client-oriented village level planning for health services delivery.

Several lessons have been learnt during our attempts to implement the above micro-level planning methodology in these primary health centres. First, micro-level planning is feasible, not very costly and provides a vehicle for health service delivery planning. We found that it is feasible to collect the data in a reasonable period of time (around 10 days) by the supervisors. The workers and supervisors were able to follow the analysis and in most cases corroborated the findings of the survey. Occasionally they felt that for some villages survey showed results different from what they believed and this would require further checking. They also felt that following this methodology would help systematize the health services delivery and focus not only on what they should be doing but also where actions are required at higher levels.

Second, the proposed methodology can help in making services more responsive to client needs as well as reduce variations in service coverage.

The advantages of the proposed methodology are as follows:

(a) **Client orientation:** It assesses coverage levels directly from the clients and can assist in matching programme actions to client needs based on reasons for non-use of services.

(b) **Promote Equity:** By focusing on areas where coverage gaps are high, it would promote equity in use of health services.

(c) **Catalyse intra-organizational Communication:** It involves workers, supervisors and medical officers in a realistic review of their environment and performance, and encourages them to seek creative solutions and incorporate them in a plan. It would also serve as a basis for a dialogue with the district staff for necessary actions to improve performance. It would also promote dialogue with the community and other departments for increased inter-sectoral coordination.

(d) **Improve Quality of Plans:** By allowing better balance between demand-generation and service provision as well as setting more realistic targets, it would promote more efficient use of resources.

Third, this methodology is not applicable to areas which have very scattered population and have poor accessibility. Not only it is difficult to collect data, but the workers are also not able to visit homes on a regular basis. Some innovations in service delivery such as community-based link workers may be needed to ensure service coverage.

Fourth, the survey focused on service coverage. Many programme administrators felt that it should also assess some outcome indicators such as infant or child deaths rates and birth rate or proportion of higher order births. Although sample size at the village level (or even at primary health centre level for some indicators) is too small to provide reliable estimates, it would allow measurement of health outcomes at the district level. We have since revised the form to add this information.

But the most important lesson is that several hurdles need to be overcome before such a system can be institutionalized. There are several sources from which these hurdles emanate. Our sample survey of 38 medical officers of the district as well as our discussions with the district and state officials suggests that most of them feel performance can only be improved by additional resources and/or improvement in socio-economic conditions of the communities. Acquiring better technical or interpersonal skills or better planning and organization of the activities are not perceived as avenues for increasing service coverage. Thus they would need considerable help in reorienting their thinking for more efficient and

equitable use of resources. The primary health care programme also need to be reoriented away from strict target achievements to improving coverage, quality and content of services. Finally, appropriate financial and operating flexibility needs to be provided to the districts and health centre medical officers to be able to implement necessary actions to improve service coverage.

The hurdles faced in introducing micro-level planning methodology are somewhat similar to those experienced by others in introducing decentralization (WHO 1987). Berrest et al (1991) suggest that the key to the process of altering the power relationship between the center and periphery was the development of better information at the periphery. However, they also found that the power of information is limited. Structural, administrative control and actual budgetary control are more important determinants of decentralization. Nevertheless micro-level planning methodology suggested here can make a beginning towards decentralizing program operations. To overcome hurdles in implementing the plans so developed, actions would be required at the state and district levels. Only then micro-level planning can succeed in achieving its objectives.



## Acknowledgements

We would like to thank The International Development Research Centre, Canada for providing financial assistance for this study (Grant no: 3-P-88-295). Thanks are also due to P.P. Sassendran for research assistance; Renuka Bhavsar, Pragna Vyas, Dharmishta Joshi and Arti Dave for field data collection and NVSS Hari for programming help. We are grateful to health staff at various levels of Sabarkantha district of Gujarat State, India; this study would not have been possible without their close cooperation.

---

## REFERENCES

- Aram M. 1989. Microplanning at Village Level. New Delhi: National Institute of Educational Planning and Administration.
- Berrest T. Soebehti R. Rai N K. 1991. "Bottom up" planning in Indonesia: decentralization in the ministry of health, Health Policy and Planning 6:55-63
- Bhadkamkar S M. 1984. Management Information System and its application to health planning. The India J of Social Work 45(1):1-6.

Bose, Ashish, 1988. From Population to People. New Delhi: B. R. Publishing Corporation.

Government of India 1982 Statement on National Health Policy. New Delhi: Ministry of Health and Family Welfare.

Gupta J. P. and Murali, I. 1989. National Review of Immunization Programme in India. New Delhi: National Institute of Health and family Welfare.

National Wastelands Development Board, 1990. "Guidelines for Microplanning", Government of India.

Nordberg E 1988. Household health surveys in developing countries: could more use be made of them in planning? Health Policy and Planning 3(1):32-39.

Oyoo Ao, Burstrom B, Fersberg B, Mahhalo J 1991. Rapid feedback from household surveys in PHC planning, Health Policy and Planning 6:380-383.

Rosero-Bixby L, Grimaldo C, Raabe C. 1990. Monitoring primary health care program with lot quality assurance sampling: Costa Rica 1987. Health Policy and Planning 5(1):30-39.

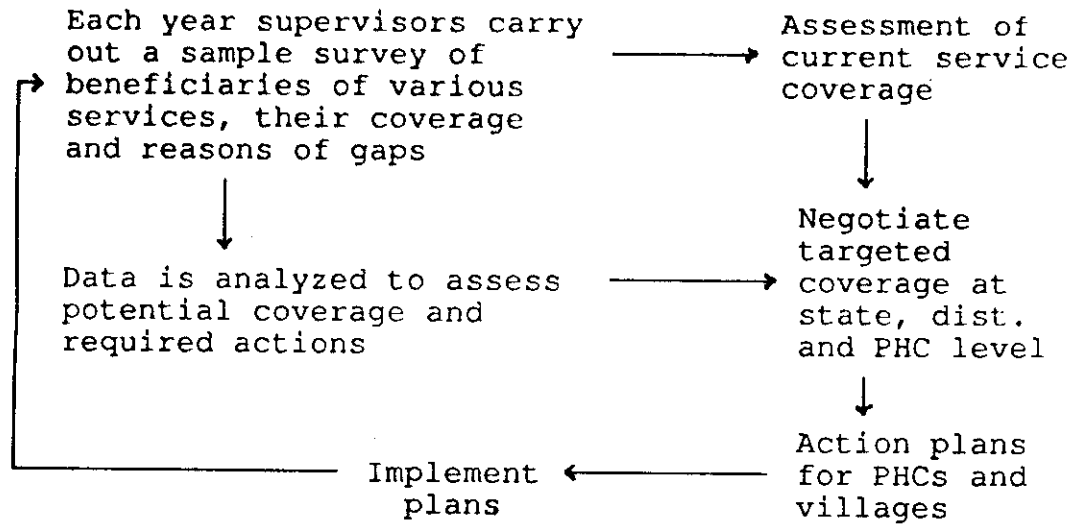
Selwyn BJ, Frerichs RR, Smith GS, Olson J. 1989. Rapid epidemiological assessment: the evolution of a new discipline - introduction. *International Journal of epidemiology*; 18(4)(suppl.2):s1.

UNESCO 1991, *Micro-level Educational Planning and Management: Handbook*. Bangkok: UNESCO principal regional office for Asia and the Pacific.

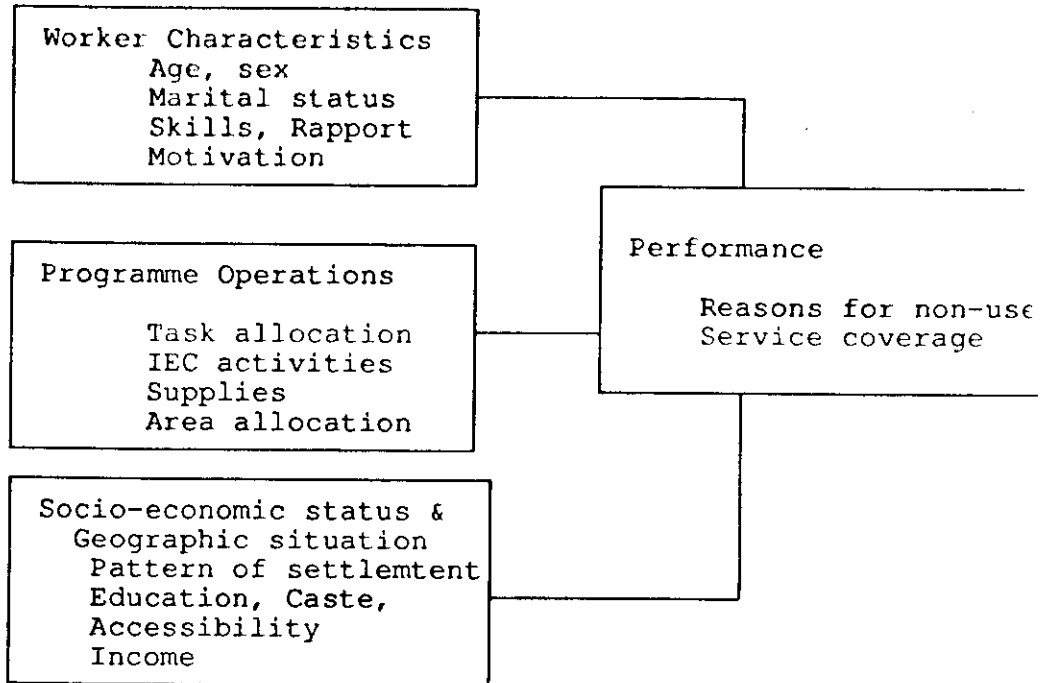
Vlassoff C, Tanner M. 1992. The relevance of rapid assessment to health research and interventions. *Health Policy and Planning*; 7(1):1-9.

WHO 1987, "The Process of Decentralization of the health System to the State Level and the Organization of Health Districts in Mexico", Ministry of health and WHO.

**Figure 1. A Schematic of Micro-Level Planning System**



**Figure 2. Framework Explaining Service Coverage-**



**Table 1. Main Features of Micro-Level Planning Methodology**

<b>Objective</b>	To assess village-level service coverage-gaps
	To identify reasons for non-use of services
	To prepare plans for increasing service coverage
	To prepare plans for targeted villages
<b>Team</b>	PHC medical officer, supervisors and workers
	Selected community members and other department officials of targeted villages
<b>Methodology</b>	Collect data through quick sample survey
	Analyze data to assess coverage-gaps and reasons for non-use
	Identify interventions to address major reasons for non-use
	Select villages to target and design interventions for them
	Prepare a plan for health service delivery
	Monitor using the plan
	Repeat the planning cycle annually
<b>Time</b>	10 days for data collection by supervisors and 3 days for planning meeting of PHC staff; 5 days for data analysis

**Table 2. Criteria Defining Those in Recent Need of Services**

Service Needed	Characteristics
Sterilization	Currently married women in reproductive age group who do not desire additional children
Spacing Methods	Women who desire at least one additional child, wish to space their next child and the youngest child is between 8 and 36 months of age
Tetanus imm. and Iron and Folic acid tablets	Pregnant women and women with children in age group of 0-6 months
BCG, DPT, and Polio	Children in the age group 0-12 months old
Measles and vitamin A	Children in the age group 9-24 months
Curative services	people suffering from specified common diseases in the previous fortnight

**Table 3. Service Need, Coverage, Gaps & Reasons for Gap in PHC A**

Service (% of total eligible couples)	Ster	Spac	IFA	DPT	Measles	Fever
Need	53	15	26	27	28	8
Served	38	10	23	18	23	7
Gaps	15*	5	3	9	5	1
<b>Reasons for Gap (as % of gap)</b>						
Client Refuses	3		15	6	5	
No Knowledge		11				
Up to God			10	10	11	
Waiting for Child to Grow	39					
Sterility	13					
Feel not needed	4	29				25
Waiting for Appropriate Time	11			19	3	
Poor health / Fear / Side effects	13	8		4	16	
Don't like		26				
Not contacted		3	10	1	3	12
Not given			45	33	8	
Home remedies						37
Out of station				12	11	
No Reason	12	21	15	10	46	12
No money						12
Other	5	2	5	5	5	2

Ster= sterilization, Spac= spacing method for family planning  
 IFA= Iron & Folic acid tablets for pregnant & lactating women  
 DPT, Measles = immunizations.

\* some of these couples were using spacing methods.



**Table 4. Main Reasons for Non-use of Services and Potential Interventions**

Service	Reasons for Non-use	Potential Interventions
Sterilization	Poor health	treat/refer
	Fear of operation	IEC
	Waiting for child to grow	provide spacing method and follow up
	Waiting for appropriate time	provide spacing method; organize service delivery
	No specific reason	Counselling / Exploration
Spacing methods	No knowledge	IEC
	Dislike of spacing methods	Improve quality of services
	Feel not needed	Counselling
	Not contacted	Organize outreach
	No specific reason	Counselling / Exploration
Iron-FA Tabs	Client refuses	Counselling
	No specific reason	Counselling / Exploration
	Feel not needed	Assess need/refer
	Not contacted	Organize outreach
TT- preg. women	Fear	IEC
	Client refuses	Counselling
	Not given	organize service delivery
	Not contacted	organize outreach
Immunization / vita. A	Feel it is up to God	Counselling
	Not given	Organize service delivery
	Client refuses	Counselling
Treatment for ailments	Feel not needed	Assess / Refer
	No money	Organize service delivery
	Not contacted	Organize outreach
	Feel not effective	Referral, Quality improvement

Table 5. Distribution of Villages By Service Coverage-gaps for PHC A & B.

Service	PHC A (41 Villages)				PHC B (24 Villages)			
	Gap %, G	No. With >1.5 G	No. .5G- 1.5G	No. <.5G	Gap %, G	No. with >1.5G	No. .5G- 1.5G	No. <.5G
Sterilization	28	9	18	14	39	2	20	2
Spacing	33	11	8	22	67	0	11	13
IFA	18	8	7	26	28	6	2	13
TT	17	14	9	18	32	7	2	12
BCG	38	11	15	15	29	8	9	7
DPT	32	15	11	15	35	6	7	8
Polio	32	15	11	15	35	5	11	8
Measles	17	12	9	20	53	9	9	6
Vitamin A	18	12	8	21	58	7	11	6
Fever	12	6	1	34	6	4	6	14
Diarrhoea	23	3	1	37	22	6	4	14
Skin diseases	35	3	2	36	35	5	7	12

Note: last three columns for each PHC shows number of villages with gaps more 1.5 times the PHC average gap, villages with gaps between 1.5 to 0.5 times the PHC gap and villages with gaps less than 0.5 times the PHC gap.