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Gynecological Care and the Health System

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INTRODUCTION

Healthcare delivered at the hospital level is closely related to the functioning of the whole health system in a country and these systems are very complex. The World Health Organization (WHO) defines health systems as 'all actions in a society that are primarily intended to improve health'[1]. Further, WHO categorizes health systems into six building blocks: governance and leadership, financing, the health workforce including education and employment, procurement and provision of medical products, vaccines and technology, information including health management information systems, and service delivery[2] (see Box 1). The characterization of these different aspects will be described in more detail below. Apart from the formal health sector with the public, private-for-non-profit [non-governmental organizations (NGO) or mission hospitals] and private-for-profit health facilities, health systems include the informal sector including traditional healers and traditional midwifes.

Looking at the complexities of health systems at the local level in a more structured way can help to improve the quality of care offered. Using the elements of the six health system blocks can help to structure health planning, such as for gynecological care. For example, setting up a program for screening of cervical cancer needs more than just the training of health workers and information to the community. Planning needs to include sustainable financing, leadership and responsibility, organization of service delivery, reliable provision of testing equipment, establishment of monitoring and evaluation procedures and many more elements. This chapter aims to give an introduction into the complexities of healthcare delivery and to sensitizing health providers on issues outside immediate healthcare provision. The example of 'introduction of a program for cervical cancer screening' will be used throughout this chapter as a guide through different aspects of the health system.

HEALTHCARE ORGANIZATION AND ITS RELEVANCE FOR GYNECOLOGICAL CARE

Determinants and elements of health systems

Health systems are not limited to the formal healthcare systems as described above. Values and principles, culture, the country's context including financial resources available for the health sector, number and education of health professionals and many other factors determine the care provided to the population[3]. The diagram in Figure 1 describes factors and elements for the example of cervical cancer care. Healthcare provision and outcomes are determined by:

- *Values and principles*, such as the status of women and the recognition of cervical cancer as an important disease.
- *The context*, including the epidemiological context such as prevalence of sexually transmitted diseases (STIs) and prevalence of cervical cancer.

Box 1 The six health system building blocks[1]

- Governance and leadership
- Financing
- Health workforce
- Medical products, vaccines & technology
- Information
- Service delivery

- *The health system*, including the availability and functionality of referral systems and availability of specialist cancer centers.
- *Leadership and governance*, including advocacy for non-communicable diseases and the careful and informed planning of cancer prevention and treatment programs.
- *Resources*, such as the overall health budget, but also the number of specialists in cancer care and gynecology.
- *Service delivery*, such as availability of cancer screening programs at the different levels of healthcare and health promotion activities for prevention and screening programs.

The graph can be used for all disease conditions and can be very helpful for planning, implementation and monitoring. A framework like this can help to realize how much care at a district hospital is closely connected to many other health system functions. It can help to sensitize health providers to the fact that much more is needed than only delivering care at hospital level. For example, collecting good health data to advocate for recognition of health needs for women and non-communicable diseases is an important part of providing health services. Health data are essential for leadership and governance in health.

Delivering care for gynecological diseases might also include building alliances with NGOs and patient interest groups. The values and principles of health policies might not yet sufficiently take up the needs of women. In many settings in low- and middle-income countries, primary care is focused on children or care around delivery, but less on the needs of older women, outside the childbearing age. Women's organizations might play an important part here in sensitizing the public concerning other women's problems.

Organization of healthcare

In most low- and middle-income countries healthcare delivery is built around a three-tiered system, with the individual, family and community as the first level, primary health facilities (often called dispensaries or health centers) at the next level and referral hospitals (district hospital, also sometimes called secondary level) as the highest level (Figure 2). In addition, tertiary level hospitals might provide more specialized care and are often engaged in training, education and research.

Furthermore, healthcare systems are mostly organized around district health systems based on the idea that planning and providing healthcare close to the people is more effective. Decentralized decision-making and planning for health has been part of many health reforms; however, the extent to which funds are available at district level varies a lot between countries.

A health district comprises a defined population, several primary healthcare facilities, and a referral level hospital. There is great variation concerning
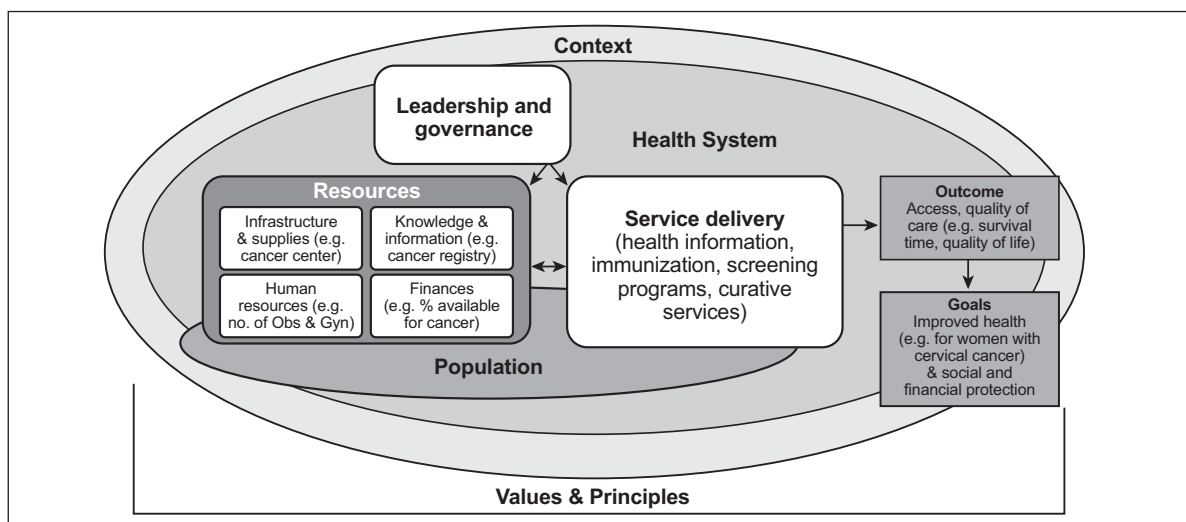
Figure 1 Determinants of the health system. Adapted from Van Olmen *et al.*[3]
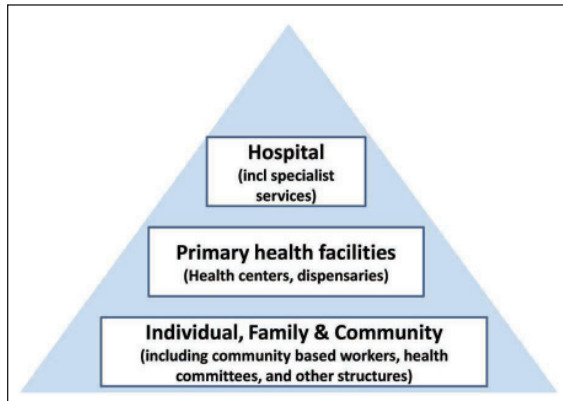
Figure 2 Healthcare pyramid

the population living within one district and the number might range from 50,000 to 500,000 people, depending on the density of the population. WHO defines a district as follows: 'A district health system based on primary health care is a more or less self-contained segment of a national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether rural or urban. It includes all institutions and individuals providing health care in a district, whether governmental, social security, non-governmental, private, or traditional'[4]. The number of district hospitals and primary health facilities in a district differ greatly. There is common understanding that primary healthcare facilities should be available within a radius of 5 km (approx. 1 h walk) from home, which determines the number of facilities per district. All the three levels of healthcare are important for gynecological care.

Community level

At community level health promotion, preventive healthcare and a few selected curative services such as malaria treatment is offered to a varying degree. Many countries use community health workers for such services. Outreach activities are well established in some countries particularly for vaccination services. Gynecological care at community level might include information and referral for STIs (e.g. by peer health educators), community-based distribution of contraceptives, health promotion for cervical cancer screening or others.

Primary level facilities

At primary healthcare facilities, basic care for most prevalent health conditions should be offered. Provision of contraceptives, post-abortion services and prevention and treatment of STIs are part of the essential care package commonly offered at primary level. Other interventions such as cervical cancer screening or prevention and care for other common gynecological diseases and malignancies might be added depending on the resource level in the country, the burden of disease and the education of the health workers.

Referral or district hospital

The referral or district hospital should offer diagnostics, operative and more advanced curative care. Again, the level of healthcare provided depends largely on financial and human resources as well as the education and training level of health professionals. For gynecological diseases, no clear guidelines or minimum packages that ought to be offered have ever been established, but basic operative care for several acute but also chronic gynecological and obstetric conditions are unanimously seen as essential activities of a district hospital as well as diagnostic services like ultrasound.

What can and should be offered at the district hospital needs to be carefully considered. Specialized care is often only available in the countries' capital and thus is not accessible for rural and poor patients, as distance and costs are likely to be prohibitive. Therefore offering some advanced surgical care at a district hospital also for vesico-vaginal fistulas and cancer treatment will be important to increase access for the rural poor.

Most important for care of many gynecological diseases is a good collaboration and communication between the different levels of the healthcare pyramid. Functioning referral systems are characterized by clear guidelines for (1) when to refer, (2) predefined forms and standards for referral notes and (3) feed-back from hospital to primary level, and established communication structures such as telephone communication and transport (see key elements in Box 2).

Technological advances, particularly mobile phones, are increasingly used to improve referral and communication between the levels. This provides great opportunities for further improvement.

Box 2 Key elements of a functioning referral. Adapted from Murray *et al.* 2001[5]

> Key elements of a functioning referral
> - Designated referral system with people trained on the use
> - Adequately resourced referral level
> - Communication and feedback system
> - Designated transport
> - Agreed use of definitions, terminology, coding and classifications
> - Exchange between levels and teamwork
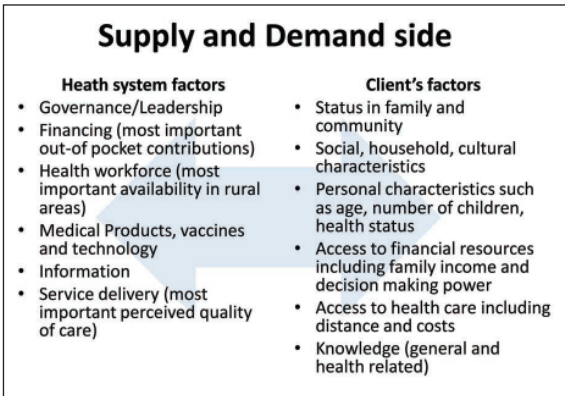
Figure 3 Supply and demand side factors

Tertiary level including specialized hospitals

The tertiary level, including specialized hospitals, might play a role in advanced treatment for cancer such as radiotherapy or chemotherapy, which cannot be offered at the district level. Thus the tertiary level is important to complement care. As mentioned above, highly specialized care from tertiary level is often not accessible for rural poor patients. Thus, it is important to consider whether this kind of care should be brought to district level through outreach activities by tertiary care specialists. Examples might be fistulae treatment or major gynecological operation for cancer disease.

OVERCOMING BARRIERS TO HEALTH SERVICE UTILIZATION: SUPPLY AND DEMAND SIDE FACTORS

Health system and organization of healthcare is mostly concerned with healthcare provision or the 'supply side' and often overlooks that people also need to 'demand' services. The health system factors have been described above. For demand creation four supply-side factors might have an immediate effect:

1. Financing and the amount of out-of-pocket contributions.
2. The availability of health workforce, particularly qualified staff in rural areas.
3. Availability of medical products.
4. Service delivery, particularly the perceived quality of care.

Many of the clients' factors (Figure 3) are known as determinants of health status. But these factors also affect the use of health services. These demand-side factors have been well described in the maternal health literature[6,7].

Health programs commonly address three main barriers of access to healthcare:

1. The lack of knowledge by including sensitization and health promotion to programs.
2. Distance by increasing the number of health facilities.
3. Reducing financial barriers.

However, although much is published on describing barriers and factors preventing clients from using services, little is known about the effectiveness and cost-effectiveness of interventions to overcome them[8]. Financial barriers can be fees, drugs, transport costs and others. Direct costs and indirect costs are commonly distinguished; direct cost include the patient fees, drugs and supplies bought by the patients whereas indirect cost include transport, the costs for a family member to stay with the patient and or costs for somebody taking care of children at home. Often, these indirect costs are far higher than the direct fees for a treatment, and they are much related to distance and the duration of the stay.

Other factors like the status women have in their family and community or social determinants of the household and community are much less amendable through simple health intervention. These factors demand changes in the society, which are difficult and take a long time. Thus, to overcome barriers to healthcare on the demand and supply side very different aspects need to be taken care of. In Box 3 there is an example, along with Figure 3, of what to consider when establishing a cervical cancer program.

Box 3 Examples on possible intervention on the demand and supply side to reduce barrier to cervical cancer screening

Supply side

Hospital leadership supports the program and distributes resources to the service.

Screening and treatment is offered at a fixed and reasonable fee including consumables.

Sufficient providers are well trained on screening and operative care.

Testing materials are continuously made available.

The quality of care is good, care is offered regularly, and providers are friendly.

Demand side

Women are well informed and their status is high enough to make decisions.

Culture makes it possible to talk about the problem and to gain support from family members for screening and treatment.

Women have access to family income.

Screening services are close to where women live, treatment at an acceptable distance.

Cervical cancer is a recognized disease in the community.

INTEGRATION AND LINKAGES

Comprehensive and integrated care is an essential element of good quality of care. Many argued that an integrated comprehensive service may better meet the need of the population, increase uptake of services and improve health outcomes.

The idea of comprehensive integrated care was put first on the international agenda at the Alma Ata Conference 1978 and the declaration of 'Health for All in the Year 2000' where comprehensive, decentralized, community-oriented primary healthcare with explicit links to other sectors such as education, water and sanitation was advocated[9]. This was also the start of a lively debate on the benefits of vertical or horizontal healthcare in the poorest countries. Projects or programs which were not integrated in the rest of the formal healthcare system and with a top-down leadership style were called 'vertical'. An example might be a standalone family planning service offered in special clinics and supported by a project with its own supervision system and provision of equipment and family planning commodities. Horizontal services might be described as a structure where all services are offered in a clinic, supported by the same support structure (supervision, provision of drugs, equipment etc.) as the overall system. When thinking about vertically or horizontally organized healthcare or integration, it can be helpful to differentiate integration in the context of:

- Governance arrangements
- Organization, e.g. supervision
- Funding
- Service delivery.

Moreover different levels can be distinguished as the central, intermediate and peripheral level (Figure 4)[10]. Integration at the service delivery level may include the delivery of services:

- By the same provider
- At the same day in the same health facility but by different providers
- By incorporating effective linkages between the different services.

It may include preventive and curative care and may include integration of community interventions, primary health facilities, hospitals and specialized services[11]. All health services today combine vertical and horizontal elements, but the balance between programs in these elements varies considerably. Specialized clinics, such as free-standing family planning clinics, have been mostly abandoned, but many services are still not offered every day even at primary health facilities. Specialized services might be useful to some extent for organizational reasons at district hospital level, but should in principle be avoided at the primary service level, to ensure comprehensiveness and continuity of care.
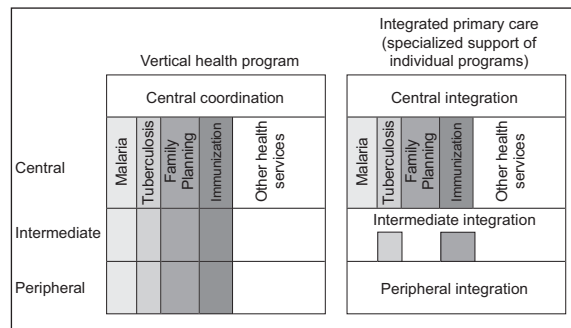

Figure 4 Framework of vertical health programs and integrated primary healthcare. Adapted from Hart *et al.*[10]

Integration of services has been seen as effective, in particular, if the same target group is concerned. In gynecological care this applies to care for STIs, especially HIV, family planning, and most other gynecological problems. Integration of care might be very beneficial to increase uptake of services. Women coming for a variety of gynecological problems may profit from counseling and information on STIs, cervical cancer, family planning and many other issues. Integration is also said to improve the quality of care. And maybe − most importantly − in resource-poor settings integrated services might be more cost-effective both for the healthcare system and for the clients. A hospital or health center will save working hours of staff members if a package of several compatible services are given at the same time as steps in the consultation such as welcoming the patient, asking about problems, history taking or gynecological examination. This applies for example to family planning, prevention and treatment of STIs and cervical cancer screening. Moreover, packaging and integrating different interventions saves time in training, supervision and other support functions. And, for women, integrated services can save money in the form of saving travel costs and time spent.

GETTING TO THE COMMUNITY AND TO THE WOMEN IN NEED

From community participation to people-centered care

Community participation was one of the main principles of the Primary Health Care strategy presented at the Alma-Ata conference in 1978 by WHO and UNICEF and adopted by 150 member states and was defined as: 'a process by which individuals and families assume responsibilities for their own health and welfare and those of the community, and develop capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid . . .'[9]. Thus, the need to give health information and involve communities, families and individuals in healthcare has been recognized for at least three decades. Community participation reaches from simple information sharing up to full empowerment of the community (Figure 5).
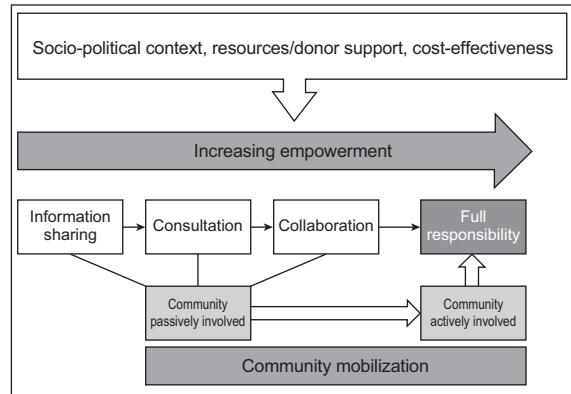
Figure 5 Conceptual aspects of community participation: modes of involvement

Many activities in the past have mainly focused on informing the population on health services and to promote the use of health services. Newer developments try to give the community more responsibility and power. Community committees and community health boards are structures used in more and more countries to actively involve community members in health planning and resource allocation.

Taking this further, the WHO health report 2008 titled *Primary Health Care Now More Than Ever*, advocated for 'Primary care: putting people first' and introduced the term 'people-centered care' as the basis of primary healthcare[12]. Important aspects of people-centeredness were defined as 'health care that deals with people as individuals with rights and not as mere targets for programmes or beneficiaries of charity'. The report further defines a few elements of people-centered care being (1) the focus on health needs, (2) providing comprehensive, continuous care and (3) recognizing people as partners managing their own health and that of their community (Box 4).

In gynecology, people-centered care might include several program aspects and service delivery:

Seeing a person as an individual but not merely as a target of a predefined health intervention: this might change the way consultations are organized and conducted. Health providers need to recognize that women have their own ideas and concepts concerning causes of disease and which treatment is best. Biomedical explanations might not always be acceptable, particularly for severe diseases. Health workers need to know about common disease explanations in the very area they work. Moreover,

Box 4 Elements of people-centered care (adapted from WHO 2010)

- Seeing the person as an individual and not as a mere target of health programs
- Comprehensiveness of healthcare
- Continuity of care, throughout the lifespan and from community to specialized care
- Having a trusted provider as an entry point and for follow-up

consultations need to give enough room and time so that patients can express their concerns. Counseling might need to bridge the gap between traditional and biomedical thinking to enhance collaboration and adherence to treatment. Privacy, dignity and respect are essential for all consultations, and in particular gynecological examinations.

When planning for a cervical cancer screening program it might be important to first consult communities and investigate perceived needs and traditional concepts, instead of designing and intervening according to purely epidemiologic patterns and resulting targets.

Comprehensive care: this includes integration and linkages between services. Very specialized and not-well-linked out-patient services might be a barrier for comprehensiveness. Patients often come for more than one health condition or might use a specialized consultation to get advice for other health problems. An example is women with lower abdominal pain who are often treated in specialized STI services. Lower abdominal pain might have several other causes and the visits might also be used for attention to other health problems, such as infertility.

Options might be either to establish a good internal referral system within a hospital so that patients can be seen by several specialist health providers if necessary on the same day and without major waiting time or to have well-trained multi-purpose health workers able to treat several conditions. Another example is postnatal care where immunization of children should be given at the same time as family planning services to the mother. Depending on the resource level cervical cancer screening could also be offered if culturally acceptable.

Continuity of care: this is defined as care throughout the lifespan from childhood to old age and from community to specialized care. A well-established referral system linking community to higher level care is important to improve continuity of care. To improve continuity throughout the lifespan a women should ideally be followed by the same provider at the primary healthcare level throughout pre-pregnancy, pregnancy, delivery, post-natal care, immunization and under-5 care, family planning, other gynecological services and later outside the reproductive age. This would help to establish a good relationship as the health provider will know about previous health problems and also about preferences and the overall situation of the family. Thus at primary health facilities, care should be offered as much as possible as non-specialized consultation and by multi-purpose health workers. Continuity of care and comprehensiveness is also best provided if a primary care provider, preferably a family doctor (or in many settings a primary care nurse), is the primary entry person into the health system. By this the patient and the family can establish a good relationship with the health system and have a trusted provider as an entry point as well as for follow-up.

HEALTH PROMOTION AND COMMUNITY SENSITIZATION

Health promotion and community sensitization are an important part of every health intervention. Women need to know about a disease, signs and symptoms as well as prevention and treatment options. But health promotion also extends to healthy behavior and healthy settings, thus incorporating the social determinants of health[13].

Health education was an essential part of the primary healthcare strategy declaration of Alma Ata in 1978. The importance has been reconfirmed in several international conferences, which gradually evolved to more global thinking with a greater emphasis on social determinants and consideration of different policy options to promote health. In the Ottawa declaration from 1986 health promotion was defined as having three pillars, advocacy, ability and mediation[14].

When planning a for a health promotion intervention it might be useful to differentiate between demand for and supply of healthcare (see also Figure 3). What is described by the community as 'felt and expressed need' is likely to differ within social groups, age groups, men and women, wealth groups and educational level as it depends on what

is known about a disease as well as its epidemiological pattern.

Different approaches can be used for health promotion, to inform target groups and community members. These include: cognitive behavioral approaches, motivational interviewing, theatre in health promotion, peer education, mass media campaigns, social marketing, community development, development of healthy settings and healthy public policy[15] (see Box 5).

All these approaches and methods have their distinct advantages and disadvantages. Some will be applied by health workers such as motivational interviewing; others need the collaboration with mass media or advocacy groups. Financial and human resources needed to implement the different approaches vary. Some might cost little for a single event, but will only reach a limited part of the population such as theatre in health promotion; others such as mass media campaigns or healthy settings imply large incremental costs and much effort in planning and implementation, but are less cost-intensive in the long run.

For smaller initiatives complementing health interventions at district level three approaches are mostly used: (1) motivational interviewing (as a part of personal counseling), (2) theatre in health promotion and (3) peer education. Much experience with these approaches and methods has been generated in the field of HIV/AIDS prevention and care. Analysis of this local experience might constitute a helpful basis for planning. In family planning programs, mass media campaigns and social marketing have been widely used. Well-known social marketing programs in many countries are implemented by Population Services International (PSI) and often include contraceptives, condoms and prevention of malaria by promotion of bed-nets.

Development of healthy settings is an approach most relevant for hospitals. The baby-friendly hospital initiative promoting early breastfeeding is an example. The initiative accredits hospitals if they conform with a number of criteria including a written policy on breastfeeding, having trained health workers to support mothers in breastfeeding, and adherence to the international code of marketing of breast-milk substitutes. The examples also point to the multitude of factors, which are important to promote healthy behavior, starting from international and national policies,

Box 5 Approaches in health promotion. Adapted from MacDowall *et al. Health Promotion Practise*[15]

Cognitive behavioral approaches to health promotion Individual-based strategies with emphasis on the identification and modification of people's health-related behaviors and thoughts

Motivational interviewing in health promotion A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence

Theatre in health promotion Use of theatre and drama in health promotion and social change, often linked to interactive workshops

Peer education Teaching or sharing of information, values and behaviors between individuals with shared characteristics such as behavior, experience, status or social and cultural background

Mass media campaigns Use of different mass media (television, radio, newspapers, mobile phones and others) to transmit health messages

Media advocacy Using mass media to highlight health problems and to advocate policy solution

Social marketing Use of ideas and techniques of the commercial sector to influence consumer behavior

Community development A method and a philosophy in health promotion using principles of participations, empowerment, ownership and learning

Development of healthy settings Health promotion by implying policies, structural or system change within organization

Health promotion policy Health promotion through public policies

recognition of the importance by the leadership at the hospital, training of health workers and finally counseling and support by health staff. Relevant in this context are also the Vienna recommendations on health promotion hospitals which include:

- Promotion of human dignity, equity, solidarity, and professional ethics.
- Orientation towards quality improvement.
- Focus on a holistic approach.

- Care centered on people.
- Effective and cost-effective use of resources.
- Good linkages within the healthcare pyramid.

Project planning and budgeting for health promotion

There are several different theoretical and technical approaches to project planning, most important logical frameworks promoted by different donors and NGOs (see short description in http://www.jiscinfonet.ac.uk/InfoKits/project-management/InfoKits/infokit-related-files/logical-framework-information). Most of the planning matrices differ only slightly. Essentially, health promotion will use recommended steps in planning and management which are listed in Box 6 below. The following description will work you through the steps by using the example of cervical cancer screening.

Box 6 Steps in planning for health promotion. Taken from MacDowall *et al. Health Promotion Practise*, 2006[15]

Task 1: Identifying the need the health promotion project will address
Task 2: Stakeholder analysis and engagement
Task 3: Building a project team
Task 4: Defining aims and objectives
Task 5: Planning the project's activities
Task 6: Developing a project budget
Task 7: Identify assumptions and risks
Task 8: Getting the approval for the project plan

Task 1: Identifying the need that the project will address

It is important to specify clearly what the health promotion project is about and which needs it will address. Skipping over this step by just simply assuming that there is a health need risks resources being badly used. People might not 'demand' services as they are not aware of the severity or how the disease progresses. In the case of a cervical cancer screening promotion project, the following areas are important:

- Assessing the literature on estimated occurrence of cervical cancer in the area.
- Assessing local health information data to estimate how many women seek care.
- Investigating local concepts of the disease and common explanatory models.

In addition, ethical issues and health service constraints need to be taken into consideration during this planning phase.

Task 2: Stakeholder analysis and engagement

In most settings today, many stakeholders will be involved or will have something to do with a health promotion project. Stakeholders might include: the target group and interest groups, the formal and informal health sector, and NGOs or major donors.

Knowing partners and key stakeholders is important to build alliances for implementation but also for sustained financing. A stakeholder analysis can also assist in identifying forces which could potentially have a negative impact on the project. Stakeholder analysis and engagement includes brainstorming and mapping of potential stakeholders, visiting and interviewing the different partners, inclusion of partners in planning workshops and sharing of results and project reports. Ideally stakeholder engagement should continue throughout the project. Sufficient time and resources need to be available for this.

For planning of a cervical cancer screening promotion project, stakeholders might include NGOs working with family planning, STI or post-partum care, the education department if youth are intended to be reached, the head of the gynecological department, and others.

Task 3: Building a project team

The structure of the team will to a large extent depend on the scale of the health promotion project. Small local health promotion projects can be run by a group of people who join forces for a while and does not demand the establishment of a formal project structure. Still, leadership needs to be clear and tasks should be clearly defined, regardless of the size of the group or the amount of work to be carried out. More complex and larger projects will need a clear management structure or a steering committee. Developing a project team also requires capacity building.

For implementation of a cervical cancer screening promotion project to support a single screening service at the local hospital, a small informal team of health workers and NGOs might be appropriate. But one should not forget that health promotion for cervical cancer screening could have many different components such as developing a promotion

program using drama groups (Box 7), information and education in family planning, STI-services or post-partum care, health promotion in school, and advocacy on the importance of cervical cancer screening among health workers as well as other aspects. A larger project with many different strategies clearly needs a good project team where leadership, tasks and responsibilities are clearly defined and written down.

Box 7 Health promotion using drama groups

Theatre is a method for both education and social change. Theatre for health promotion has the opportunity to present a health topic in an entertaining and pleasant way which is much appreciated if the group has a good reputation. Drama groups often reach many people, old and young, men and women. Drama groups can in particular affect attitudes and might influence intention to use health services, but they are not primarily designed to transmit knowledge. The major disadvantage of using drama groups for health promotion is the costs. Close rapport and interaction can only be achieved with small audiences, so few people are reached.

 Theatre for health promotion needs careful planning. First, the drama group needs to be sufficiently trained on professional drama and presentation skills: make it as professional as possible. They also need to have sufficient knowledge on the health topic they present and the content and messages need to be elaborated together with health specialists. Drama group performances should be accompanied by health workers who have good participatory and technical skills so that he can engage after the performance in a dialogue with the audience.

Task 4: Defining aims and objectives

This task is closely connected to the first task. Everybody will agree that getting aims and objectives clear is essential, but smaller initiatives often do not give enough care to this step.

Whereas the overall aim of the project can be broad and not specific for the actual project, specific objectives should be clearly defined. For example, a specific objective could be 'reaching young women aged 20–30 with health information on cervical cancer screening using drama groups'. Specific objectives need to be accompanied with clear measurable indicators. For the example an indicator could read: '20 drama group performances on cervical cancer screening for 20 youth groups in Wanda district during a period of two months (Jan to February 2014)'. Indicators should be SMART:

- *Specific*: with clear, defined outputs.
- *Measurable*: can be measured with existing or easy implementable tools.
- *Agreed*: agreed in advance.
- *Realistic*: the target can be reached with existing resources and in the set time limit.
- *Time-bound*: clear time limits are included in the target.

Task 5: Planning the project's activities

This step follows the decision on aims and objectives logically. Some log-frames include activities in a lot of detail; other project planning tools promote the use of separate chronograms or Ghantt charts (Table 1).

It can be helpful to add to the chart the responsible person and the funds required for each of the activities. Tools like this can also assist in monitoring progress. Targets are often set before clear planning is done. Many projects do realistically foresee when they can start working effectively. Targets set in first preparatory meetings are often unrealistic, omitting the need for preparatory work, or the time it takes to realize funds. Objectives and targets should be adapted during the project planning process to avoid project documents with meaningless objectives and targets. But once the project planning phase is over, monitoring should go along the pre-defined objectives, targets and activity schedules.

Task 6: Developing a project budget

How project budget are done and how flexible they are depends much on funding agencies. Often budgeting is a 'reality check' and objectives and targets need to be revisited after the budgeting process. Developing a project budget demands

Table 1 An example of a chronogram or Ghantt chart for cervical cancer screening promotion program

Activity/months	Jan	Feb	March	April	May
Assessment of needs and stakeholder meeting	X				
Training of drama group		X			
Piloting in 2 villages			X		
Stakeholder meeting and adaptation of approach			X		
Conducting drama group sessions in 8 villages				X	X

much experience and knowledge of local context such as who gets which kind of remuneration, allowances rates or transport costs. The first task in budgeting is commonly to (1) divide activities into as many sub-activities as needed for budgeting, (2) get sufficient information on remuneration, allowances schemes and transport costs as possible and (3) calculate the budget for each sub-activity.

It is best to do the calculations in Excel to avoid mistakes, but should be accompanied by a narrative description. Budget summaries per major activity and per year are helpful for financial planning.

Task 7: Identify assumptions and risks

This step is again a kind of 'reality check'. Assumptions are factors outside the project that will nevertheless impact the project. An example might be that the health provider offering cervical cancer screening will continue to work throughout the project period. It is not difficult to imagine how important it is that cervical cancer screening is continuously offered to ensure credibility of the health promotion project.

A risk is a potential hazard, which needs to be taken into consideration. A risk might be for example that key project staff leave the project. Good project planning respects risks and puts mechanism in place to mitigate them, for example always training two staff members on the same activity so that they can replace each other.

Task 8: Getting the approval for the project plan

Finally, the project planning document needs the approval from the funding organization and key stakeholders. If the project involves research a research permit for the respective research activity might also be needed. The funding organization will look in particular into the aims and objectives as well as the overall coherence, in particular whether timelines or budgets are realistic.

CONCLUSION AND REMARKS

This chapter was written with a view to sensitizing healthcare providers delivering care in gynecology at the district hospital on a few important health system aspects. Health providers often overlook the complexity of health systems. Aspects of referral to higher level and cooperation with the community are important for prevention and care. Careful consideration of integration and linkages of services can improve use of services and client satisfaction with services offered.

Delivering care is not enough; clients in need must also be reached. Health promotion is essential for achieving the goal of better health for women – prevention is essential, care and treatment alone will not reach best levels of health.

INTERESTING WEBSITES AND FURTHER READING

Health systems

Alliance for Health Policy and Systems Research: http://www.who.int/alliance-hpsr/resources/9789241563895/en/

WHO, Western Pacific Region: http://www.wpro.who.int/nr/rdonlyres/5ba80b95-dc1f-4427–8e8b-0d9b1e9af776/0/eb.pdf

Linkages and synergies

The WHO homepage has several documents for further reading on synergies and linkages, particularly in the field of reproductive health/family planning and HIV: http://www.who.int/reproductivehealth/publications/linkages/en/

Health promotion

MacDowall W, Bonell C, Davies M, eds. *Health Promotion Practise*. (In Series Understanding

Public Health edited by N. Black and R. Raine). Maidenhead, UK: Open University Press, 2006

WHO homepage on health promotion: http://www.who.int/topics/health_promotion/en/

German Health Practice Collection. Best practise homepage gives several examples of health promotion projects from various countries, mostly in the field of HIV prevention and reproductive health: http://german-practice-collection.org/en/successful-programmes/publications-at-a-glance

The Breast Health Global Initiatives to promote screening for breast cancer in low-income settings: http://portal.bhgi.org/Pages/Default.aspx

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