Guidelines for Setting Performance Targets at District Level

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Pakistan Initiative for Mothers and Newborns

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GUIDELINES FOR SETTING PERFORMANCE TARGETS AT DISTRICT LEVEL

1. Introduction

Under Local Government Ordinance 2001 of Pakistan, devolution of political power and decentralization of administrative and financial authority and responsibility to the districts has offered a renewed opportunity as well as challenge for strengthening the district health system for effective delivery of quality health services that are accessible, efficient and equitable. One of the main thrust of district health system strengthening is to improve district health system management.

In this context, target setting is a dynamic process and an essential ingredient of effective management for continuous performance improvement to achieve the desired health care outcomes.

This guideline provides a brief view of how to set performance targets at district level. This guideline is primarily meant for the district and tehsil level health managers. For further reading a bibliography is attached at the end of the document.

2. What is a target?

Targets specify time-bound desired or promised level of performance based on performance indicators. They may specify a minimum level of performance, or define aspirations for improvement.

Target is a commitment to achieve a specified level of performance over a specified timeframe. Therefore, target should be "SMART"

Specific – what is to be done related to district health systems objectives
Measurable – what is to be measured?
Achievable – yet challenging enough to motivate managers/staff to achieve it
Result-oriented
Time-framed - there is a clear timeline by which the target should be achieved.

It is necessary to understand the difference between target and indicators. Whereas the indicator defines how performance will be measured along a scale or dimension, the target identifies *the specific, planned level of result to be achieved within an explicit timeframe.*

3. Purpose of setting targets

The aim of target setting is to bring about improvement. Health system's performance targets are used to assess performance achieved compared with the expected performance and to make appropriate adjustments in efforts/interventions and resources accordingly.

Target setting in the context of district health system will help:

- Front-line managers to prioritize areas of improvement and, thereby, focus efforts and resources on priorities
- Motivate managers and staff to achieve specific performance milestones towards improving the health services in the district
- Create a sense of ownership among district managers and staff - if they are involved in target setting and some kind of incentive is associated with achieving the targets
- Put national and provincial objectives into district context, making them more understandable and meaningful for the district managers and staff

4. Pre-requisites for setting target

Target setting is just one aspect of performance management. It should never be viewed in isolation. Also, it is neither necessary nor feasible to set targets for every performance indicator. In order to set target, therefore, the following factors should be considered before selecting a performance area for setting target.

- There is a need to improve performance
- There is readiness and willingness to improve performance
  - There is a driving force that is encouraging the district health department to improve performance.
    e.g. District Government or District Health Department is concerned about certain health issues or services and give special emphasis to improve their performance.
  - There is capacity within the district health department to improve their performance
    e.g. district has satisfactory resource support or can mobilize support for achieving the target
  - District Health department is willing to implement interventions or put extra efforts for achieving the target.
- There is a monitoring system in place to monitor progress against the target

5. Steps for setting target

In consultation with staff, district health managers, MOICs, DHMT:

1. Decide which performance area you want to improve
   a. Identify the priority areas for improvement
   b. Know what outcome you are trying to achieve - clearly define the outcome
2. Identify the appropriate indicator/indicators for measuring that outcome
3. clearly define where you are and where you want to get to, i.e. set the target level for the specific indicator
   a. Review baseline
   b. Review trends and history
   c. Take account of national and provincial targets
   d. Expert opinion on what is possible or feasible with respect to a particular indicator and setting
   e. What is being accomplished elsewhere with similar program and setting, e.g. best performing district in the province (Benchmarking)
4. Develop an action plan for achieving the target
5. Monitor progress and revise inputs, interventions or target accordingly

Alternative approaches for deciding on target level

I. *Project a future trend, then add the "value added" by program/project interventions*

This involves estimating the future trend without any special effort or intervention, and then adding whatever gains can be expected as a result of the intervention. For this, historical data are required that can be used to establish a trend line.

II. *Establish a final performance target for the end of the planning period, and then plan progress from the baseline level*

This approach involves deciding on the program's performance target for the final year, and then defining a path of progress for the years in between. Final targets may be based on benchmarking techniques or on judgments of experts, program staff, and other stakeholders about expectations of what can be reasonably achieved within the planning period given the stage of program implementation, resource availabilities and constraints.

III. *Set annual performance targets*

This approach is similar to the preceding, except it is based on judgments about what can be achieved each year, instead of starting with a final performance level and working backwards.

5.1 Target setting steps with practical examples

5.1.1 Step 1: Deciding performance area for improvement and identifying outcome

The selection of priority areas depends upon the district needs, formative needs and community perceptions and demands. The priority areas may also be focused on health interventions of health services in the health facilities and at community level. District health managers may be interested to measure the efficiency and effectiveness of interventions that may be diagnostic, therapeutic, preventive and referral services. For example if district health authority identifies *Maternal and Newborn Health (MNH)* as the priority area, the desired outcomes of MNH interventions may be:

- Pregnant women registered for services in the district or catchment area of health facilities
- Pregnant women receiving the antenatal services
- Pregnant women receiving postnatal services
- Pregnant women protected against tetanus

5.1.2 Step 2: Identifying the Indicators for outcome

In the first step outcome of the interventions are objectively pointed out, but these outcomes have to be translated in some appropriate measurable terms known as ***"indicators"***. The pre-requisite for defining the indicators is the availability of data directly from source or it can be derived from the available data sources (see exercises annexure 1). Some MNH outcome indicators and their respective data sources are given as under:

Indicators	Data source
Percentage of pregnant women registered out of total expected pregnancies in catchment area of facility or district	Denominator is derived from catchment area population* and numerator is directly recorded in HMIS reports
Percentage of Low Birth Weight babies	Both denominator and numerator are directly recorded in LHW reports
Percentage of expected pregnant women received at least two TT doses	Denominator is derived from catchment area population* and numerator is directly recorded in EPI Monthly Reports

***** *Number of expected pregnancies will not be available from routine data source; it has to be estimated simply by dividing the catchments area population by 270 or other projectional methods*

The selected indicator should appropriately represent the real objective for which the target is set. Sometimes it may so happen that the staff, instead of working to improve their performance and achieve the real objective, may put more efforts to improve the indicator. For example, one indicator of improved antenatal care can be the percentage of pregnant women registered, because this would show the magnitude of the coverage of pregnant women coming in contact with the health facility and, thereby, believed to have received antenatal care. However, the health facility staff might not be providing the full range of antenatal checkup services to these pregnant women coming to the health facility, rather they are more concerned about the number of pregnant women that can be registered.

5.1.3 Step 3: Setting the target level

For clearly defining and setting the targets it is necessary to know the baseline and to set various benchmarks and the end-line to be achieved within feasible timelines. The baseline determines "where we are?", and setting the end-line will determine "where we want to go". This step needs review of baseline, trends and national /provincial targets for guidance. Seeking expert opinion and taking into account the other benchmarks must also be considered while setting the targets. Targets should not be set very low such that they can be achieved very easily and, therefore, do not motivate or inspire the staff to improve performance; targets should not be set very high such that they are unrealistic and, thus, become meaningless.

5.1.3.1 Review of the baseline

There must be some reliable data source for the baseline to start the target setting. In case of special projects, baseline surveys are usually conducted before the start of the interventions; then the magnitude and timeline are set for the project accordingly. If baseline surveys are not conducted then currently available data from routine data sources (e.g. MIS) can be used to determine the baseline. If routine data is also not available then other periodic sample surveys e.g. Multiple Indicator Cluster Survey (MICS 2004) can be used to determine the baseline.

Setting district targets provides opportunities for consideration of the ground realities. Districts may differ in their baseline levels for a selected indicator; according to the developmental profile of the districts for

instance the baseline for ANC and TT coverage of pregnant women were 12 and 53 respectively for Jafferabad as compared to 73 and 93 respectively for Rawalpindi (see table below). The districts may have different levels of resource availability or may be different in socio-cultural/geographical settings. Taking all these ground facts into consideration, the end-line targets for each district will also vary.

Table: Baseline for ANC and TT coverage indicators in various PAIMAN districts

Districts	% pregnant receiving antenatal care (ANC) by skilled attendants (2005)	% Pregnant ladies receiving 2 TT doses (2005)
DG Khan	47	53
Khanewal	34	69
Rawalpindi	73	80
Jhelum	72	93
Upper Dir	27	56
Bunner	29	55
Lasbela	21	52
Jafferabad	12	53

5.1.3.2 Review of national and provincial targets

District target setting must be inline with the provincial and national health goals and targets. The national, provincial and district targets are inter-related and the ultimate source of data for monitoring health services are the health facilities. Therefore, it is essential that before setting target at district level, the national and provincial service delivery goals and target must be taken into account. (see annexure 1: MDGs, PRSP targets)

5.1.3.3 Seeking expert opinions

Expert opinions are required to decide the magnitude and timeline of the targets as these are influenced by number factors such as political commitments, resources allocations, operational plans, seasonal conditions, community perceptions and effective supervision. Timeline for targets linked with the district's annual operational plans are usually

fixed on yearly basis. Timeline for targets used in strategic planning can be fixed on 3-year or 5-year basis depending upon durations of the strategic plan.

Hypothetical examples of targets after fixing timeline in various districts are given as under

ANC coverage targets with timeline for various districts

Districts	2005 Baseline	2006	2007	2008	Range 2005-8	Total achievement
DG Khan	47	50	55	60	47-60	13%
Khanewal	34	36	40	45	34-44	11%
Rawalpindi	73	75	79	84	73-84	11%
Lasbela	21	25	30	35	21-35	14%
Jafferabad	12	16	22	28	12-28	16%

5.1.4 Step 4: developing an action plan for achieving the targets

Once the priority area for performance improvement has been identified and the end-line target level of performance improvement measured through a suitable indicator has been set, the next step is to decide on what needs to be done in order to achieve that target, by what timeline, by whom and with what resources. The framework for defining these points is an Action Plan. Most action plans consist of the following elements:

- A statement of what must be achieved (the outputs or result areas)
- A spelling out of the steps or activities that have to be followed to reach this objective
- Time schedule for when each step must take place and how long it is likely to take (when);
- A clarification of who will be responsible for making sure that each step is successfully completed (who);
- A clarification of the inputs/resources that are needed.

A suggested structure of an action plan is as following:

Result Area: Indicator: Means of verification: Progress indicator:			
Activities	**Time frame (begin by, complete by)**	**Person responsible**	**Costs/inputs**
1.			
2.			
3.			
4.			

A sample action plan is given below:

Result Area:	Improving antenatal care in the district		
Indicator:	% increase in ANC registration		
Means of verification	HMIS from government health facilities		
Progress indicator	All WMO/LHV posts filled in the district		
Activities	**Time frame (begin by, complete by)**	**Person responsible**	**Costs/inputs**
1. Filling of the vacancies of Women Medical Officers and LHVs at BHUs and RHCs in the district	Jan 08 – June 08	EDOH	Advertisement cost – Rs. 9999 Salary cost – Rs. 99999
2. Special incentive package for lady doctors for appointment at hard to reach areas	Jan 08 – Dec 08	EDOH	Incentive package cost – Rs. 99999

Based on this action plan, the responsible person will then chalk out a day-to-day things-to-do plan specifying the various steps she/he needs to do in order to complete the task/activity given to her/him in the action plan.

5.1.5 Step 5: Monitoring the progress

The process of target setting is not complete until and unless the monitoring schedule is clearly laid down. Progress monitoring includes monitoring the implementation of action plan as well as changes in the performance indicator in comparison with the baseline and the end-line target. The progress monitoring provides the opportunity to revise the inputs or interventions if the progress towards achieving the target is not satisfactory.

The success of progress monitoring is linked with continuous availability and timely dissemination of the relevant data to the district managers. This, in turn, is linked with the selection of the outcome indicator (Step 2) and progress monitoring indicator. These indicators must be clearly defined at the very beginning and their data collection process should be unambiguous and consistent. Completeness of data reporting should be ensured. Similarly, data accuracy checks should also be performed from time to time to ensure data precision.

Given below is an example of monthly monitoring of newly registered cases for antenatal care number of HMIS reports submitted in a district. This example depicts the problem of incomplete reporting for monitoring the performance of ANC registration at the health facilities, and shows one way of overcoming that limitation.

Monthly progress monitoring of district Sukkur

Indicator	Oct-06 Baseline	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07
Pregnant women newly registered for ANC	1000	1381	1020	1095	1205	964	1184	798
Total Reports submitted	39	42	41	40	40	36	40	35
Average per HF	26	33	25	27	30	27	30	23

6. Annexure

6.1 Annex: 1- Targets setting exercises on selected indicators

Exercise 1: Setting ANC coverage target – based on benchmarking

For a district (e.g. DG Khan) with total population of 2018,000:

For a district (e.g. DG Khan) with total population of 2018,000:

No. of pregnant women in the district in one year (@ 3% of population)	= 60,540
Current level of women having at least one ANC visit	= 54% = 32,700 preg. women/yr = 2,700 per month
Level of at least 1 ANC visit in the best performing district of the same province (e.g. Rawalpindi)	= 86%
Therefore, target (benchmark) of at least 1 ANC visit in 2 years for DG Khan	= 86% = 52,000 preg. women/yr
Feasible target for the first year	= 70% = 42,000 preg. women/yr = 3,500 preg. women/month

Exercise 2: Setting EPI Targets – based on National Targets

National Target	= 80% of <1 yr children fully immunized.
For a district with population of 2018,000:	
No. of under 1 children (@2.54%)	= 51257
80% of <1 children	= 41005
Thus, yearly target for full immunization	= 41,000-51,000 <1 children
And, monthly target of full immunization	= 3,400 – 4,300 <1 children

Exercise 3: ***Setting target for Daily OPD Attendance at BHU and RHC – based on logical reasoning***

Daily OPD hours: 09:00 hours to 13:00 hours

= 4 hours (240 minutes)

Average time spent per patient = 5 minutes

(to ensure quality with proper history taking, physical examinations and consultation)

Therefore, maximum number of patients attended by 1 MO during OPD hours

= 240/5 = 48 patients (40 to be on conservative side)

Target Daily OPD Attendance = 40 patients / day per MO

Exercise 4: ***Setting target for institutional deliveries at DHQH/THQH***

Option A – based on deciding a yearly increase

Current baseline performance - Average number of deliveries in DHQH (from routine reports)	= 100 deliveries per month = 3-4 deliveries per day = 1 delivery per 8 hr shift
Target increase in yearly number of deliveries	= 20%
Therefore, target number of deliveries in 1st year	= 120 deliveries/month = 4 deliveries/day = 1-2 deliveries/8 hr. shift
Target number of deliveries in 2nd year	= 144 deliveries/month = 5 deliveries/day = 2-3 deliveries/8 hr. shift

Option B – based on deciding a 5 years target and then working yearly targets

Current baseline performance (from baseline survey) – percent of deliveries in DHQH	= 2% of all births = 1210 deliveries/yr
Current trend in deliveries by unskilled providers	= 75% of all deliveries
Target of deliveries at DHQH over 5 years	= 7% of all births
Yearly percentage targets of institutional deliveries at DHQH	1st year = 3% deliveries 2nd year = 4% deliveries 3rd year = 5% deliveries 4th year = 6% deliveries 5th year = 7% deliveries
Monthly target number of deliveries for each year (taking population growth rate into account)	1st year = 160 deliveries 2nd year = 215 deliveries 3rd year = 275 deliveries 4th year = 340 deliveries 5th year = 400 deliveries

Exercise 5: ***Setting target for number of Obstetric complication cases attending DHQH/THQH – based on identifying gap between the need and actual performance***

Expected number of obstetric complication cases in the district that require hospitalization (@ 15% of the total pregnancies)	= 9,100 cases in 1 yr
Current performance -cases admitted in DHQH/THQH	= 1,050 cases in 1 yr = 12% of the total obstetric complication cases
Gap	= 8,050 (88% cases)
Target - Reduction of gap by 50% in 1 year	= 4,025 additional cases treated at DHQH/THQH = 5,075 total cases per year = 425 cases admitted/month

6.2 Annex 2: Review of national and provincial goal and target

Although devolution gives autonomy for decisions but the district target setting must be in-line with the provincial and national health goals and targets. The national, provincial and district targets are inter-related and the ultimate source of data for monitoring health services at all these tiers is the health facilities. Therefore, it is essential that before setting target at district level, the national and provincial service delivery goals and target must be taken into account.

Ideally, there must be uniformity in district target that will help to consolidate the data for monitoring at district, provincial and national levels. The uniformity in defining the target/indicator must be ensured horizontally with the other districts and vertically with provincial and national indicators.

The time frame for achieving this target can vary from district to district depending upon the factors and circumstances for achieving those targets. For instance, if indicator for immunization against neonatal tetanus is '2 TT doses during the pregnancy' the target for achievement may be 40% for district A, 30% for district B and 35% for provincial level in one year.

Following are the National level MDG and PRSP targets that can be useful for identifying priority areas and setting district level performance targets in order to contribute to the achievement of national targets.

MDG Targets

MDGs and Targets	Indicators for Pakistan
Goal 4: Reduce Child Mortality	
Target 5. Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	■ Under-five mortality rate ■ Infant mortality rate ■ Proportion of fully immunised children aged 12-23 months ■ Proportion of children under 1 year immunised against measles ■ Prevalence of under-weight children (under 5 years of age) ■ Proportion of children under five who suffered from diarrhoea in the last 30 days and received ORT ■ Lady Health Workers' coverage of target population
Goal 5: Improve Maternal Health	
Target 6. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	■ Maternal mortality ratio ■ Proportion of births attended by skilled birth attendants ■ Contraceptive prevalence rate ■ Total fertility rate ■ Proportion of women 15-49 years who had given birth during last 3 years, and made at least one antenatal care consultation

PRSP Targets

D. HEALTH & POPULATION SECTOR INTERMEDIATE TARGETS

Indicator	Baseline Year	Projections for FY 2001-02 to FY 2005-06				
	FY 2000-01	2001-02 (Actual)	2002-03 (Actual)	2003-04	2004-05	2005-06
Utilization Rate of First Level Care Facilities/ Day (Curative only)	34	37	36	40	44	48
Population covered by Lady Health Workers.	30%	41%	44%	65%	75%	85%

Immunization coverage of children/ Pregnant Mothers	DPT-III: 76%	76%	69%	79%	79%	79%
	TT-II: 51%	51%	48%	54%	54%	53%
Percentage of births attended by skilled birth attendants.	13%	13%	14%	18%	19%	21%
Number of skilled female birth attendants. (MCH) (WMO, LHV, FMT, FHT, Mid-Wife)	96,254	101,823	110,376	117,500	124,000	131,000
The percentage of FLCFs not experiencing stock - outs of any one of five key supplies during the past month.	26%	28%	35%	35%	38%	38%
Number of FLCFs meeting staffing norms. MO, WMO, LHV/ FMT/ FHT	30%	34%	38%	42%	45%	50%
Availability of contra-ceptives from FLCFs	68%	83%	85%	85%	87%	90%
Contraceptives Prevalence Rate (CPR)			34.9%	37.2%	39.4%	41.7%

Source: Ministry of Health. Frequency: Annual

HEALTH & POPULATION SECTOR FINAL OUTCOME TARGETS

Indicator	Baseline Year	Projections for FY 2001-02 to FY 2005-06				
	FY 2000-01	**2001-02**	**2002-03**	**2003-04**	**2004-05**	**2005-06**
Population Growth Rate (%)	2.22	2.16	2.06	1.99	1.92	1.85
Total Fertility Rate per woman	4.31	4.20	4.09	3.98	3.87	3.76
Infant Mortality Rate (per 1,000 births)	85	82	77	70	65	63
Under five Mortality Rate (per 1,000 live births)		105	100	95	88	80
Child Mortality Rate (per 1,000)	20	19	18	16	17	15
Maternal Mortality Rate / 100,000		350-400				300-350
Proportion of children under five who are under weight for their age (%)		37				34
Proportion of population in malaria risk areas using effective malaria prevention treatment		20 %				25 %
Incidence of TB /100,000		177				133
%age of TB Cases detected and cured under TB DOTS		25				70

Source: Ministry of Health and Ministry of Population. Frequency: Annual

Immunization coverage of children/ Pregnant Mothers	DPT-III: 76%	76%	69%	79%	79%	79%
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6.3 Annex 3: Data source and target setting implications

Types of data	Implication in target setting	Merits/demerits
1. Routine data sources (MIS) Data from supervisory checklists	Defining, fixing and measuring the targets and its indicators. Direct implication on district level targets and indirect for provincial level targets	Data available at any time; regular system of data reporting No extra sources for target monitoring and evaluation Limitation for setting population targets
2. Periodic sample surveys	Defining the bench-marks/baselines for specific interventions Useful for setting national, provincial and district targets	May not be specific to the set targets Unpredictable time interval Needs extra resources Limitation in setting population based target
3. Population census	Population based targets, e.g. catchments area population and percentage population access Denominators for service delivery targets	Long inter-census interval needs continuous update of population Limitation of using population as denominator only to public sector service provision

Periodic Sample Surveys

Many sample surveys have been conducted and are being conducted in Pakistan by the mutual collaboration of national and international health agencies. Each sample survey had its own objectives, scope, spectrum and utility of information. The surveys are especially useful for bench-marking or providing baseline at a given point of times. The surveys are usually providing target indicator on community based interventions and are more useful in target setting and evaluation at provincial and national level. The surveys are based on national or provincial samples and are not specific to a particular district. The sample survey data is liable to statistical errors hence the data needs statistical manipulation before application to district level. Summary of various surveys in Pakistan is shown in below.

Periodic Sample Surveys in Pakistan

NAME OF THE SURVEY	YEARS	FINANCING AND COLLABORATING AGENCIES	BASIC OBJECTIVES AND AREAS OF COVERAGE
Pakistan Demographic Survey (PDS– 2001)	Sixties 1984 2001	Federal Bureau of Statistics (FBS) with collaboration of other agencies	Statistics of births and deaths, population increase and characteristics of population, impact of family planning and other socio-economic developments
The National Health Survey of Pakistan (NHSP)	1996	Collaborative project of Pakistan Medical Research Council (PMRC),FBS of Pakistan and NCHS, Public Health Services, of USA.	General health profile Morbidity profile, high-risk priority groups and to assess the utilization of public and private health sector
Pakistan Integrated household survey (PIHS)	1991 1995-96 1998-99	Federal Bureau of Statistics (FBS) with collaboration of other agencies	Family size, fertility rates, utilization of health services and other social issues
Household Integrated Economic Survey (HIES)	1990-91, 1993-94, 1996-97 1998-99	The operational activities of Household Integrated Economic Survey were carried on jointly with PIHS and HEIS by FBS	Household size and economic indicators
Multiple Indicator Cluster Suvey of Pakistan (MICS)	1995 2005	Ministry of Health Government of Pakistan with collaboration of UNICEF & Gallup Pakistan	To evaluate the mid-decade goals, Water and sanitation, Education, Nutrition ARI, Diarrheas diseases and Immunization coverage

7. Bibliography

1. Target Setting Guide – Jan 2004.

   www.buckscc.gov.uk/best_value/best_value_guides/index.stm. website accessed on 2 September 2007

2. NHS Management Executive. The health of the nation: local target setting–a discussion paper. Leeds: Department of Health, 1993.

3. WHO Regional Office for Europe/ European Centre for Health Policy. Setting targets for health. Definitions and experience in Europe. Handout for participants at the workshop: Health targets, health care and health policy in the European Union, Hannover, 28–29 April 1999.

4. The European Parliament. Measuring the appropriateness of health care. Analyzing Health Targets in Europe. Eurohealth; Volume 5 Number 3, Autumn 1999

5. Statistical Division and Central Health Monitoring Unit. Department of Health. NHS Plan Technical Supplement on Target Setting for Health Improvement. March 2001.

6. Water HPA van de, Hertoen LM van. Health Policies on Target: Review of Health Target and Priority Setting in 18 European Countries. Leiden. TNO Prevention and Health, 1998.

7. Local Government Plan 2000. Government of Pakistan, Chief Executive Secretariat, National Reconstruction Bureau, August 2000.

8. Establishing Performance Targets: Performance Monitoring and Evaluation TIPS; USAID Center for Development Information and Evaluation. 1996, Number 8

9. IDeA and Audit commission - Improvement through performance management, measurement and use of information. PMMI target setting guide. August 2005

10. Janet Shapiro: Action Planning Toolkit. CIVICUS – World Alliance for Citizen Participation. (www.civicus.org/new/media/Action Planning.pdf)

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