World Health Organization

Strategizing national health in the 21st century: a handbook

Chapter 6

Operational planning: transforming plans into action

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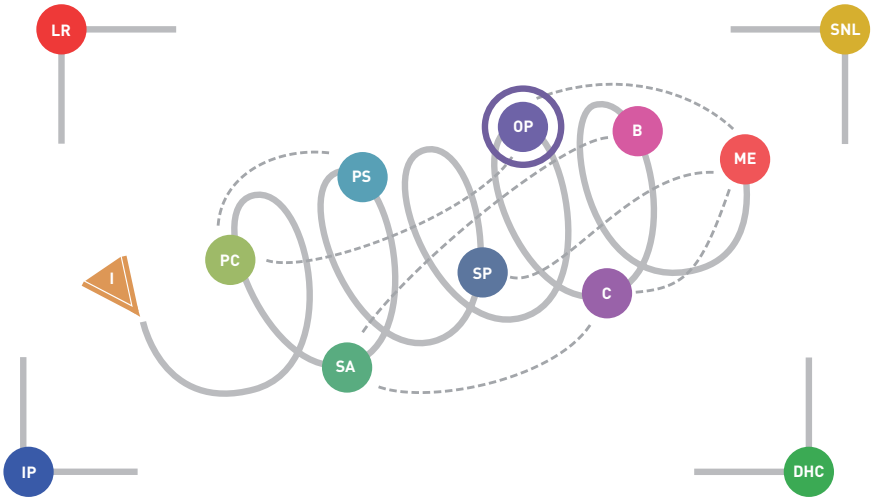

I	CHAPTER 1	Introduction: strategizing national health in the 21st century
PC	CHAPTER 2	Population consultation on needs and expectations
SA	CHAPTER 3	Situation analysis of the health sector
PS	CHAPTER 4	Priority-setting for national health policies, strategies and plans
SP	CHAPTER 5	Strategic planning: transforming priorities into plans
OP	CHAPTER 6	Operational planning: transforming plans into action
C	CHAPTER 7	Estimating cost implications of a national health policy, strategy or plan
B	CHAPTER 8	Budgeting for health
ME	CHAPTER 9	Monitoring, evaluation and review of national health policies, strategies and plans

Cross-cutting topics relevant to national health planning

LR	CHAPTER 10	Law, regulation and strategizing for health
SNL	CHAPTER 11	Strategizing for health at sub-national level
IP	CHAPTER 12	Intersectoral planning for health and health equity
DHC	CHAPTER 13	Strategizing in distressed health contexts

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Contents

Acknowledgements iv
Overview v
6.1 What is operational planning? 1
6.1.1 Concepts and definitions 1
6.1.2 Strategic planning vs operational planning 3
6.1.3 Operational planning and budgeting 5
6.1.4 Participation and inclusiveness of operational planning 5
6.2 Why is operational planning crucial to strategizing for health? 7
6.3 When should operational planning take place? 7
6.4 How does operational planning work? 10
6.4.1 Some operational planning issues to consider 10
6.4.2 Steps in operational planning 15
6.5 Who are the main actors involved in operational planning? 23
6.5.1 Planning is best done best by those who will be carrying out the plans 23
6.5.2 Multi-stakeholder playing field 23
6.6 What if...? 27
6.6.1 What if your country is decentralized? 27
6.6.2 What if fragmentation and/or fragility is an issue in your country? 29
6.6.3 What if your country is heavily dependent on aid? 30
6.6.4 What if your country has strong vertical health programmes? 31
6.7 Conclusion 33
6.7.1 Key take away messages for the central health planning authority 33
6.7.2 Main points for operational planners to keep in mind 33
References 34
Further reading 35

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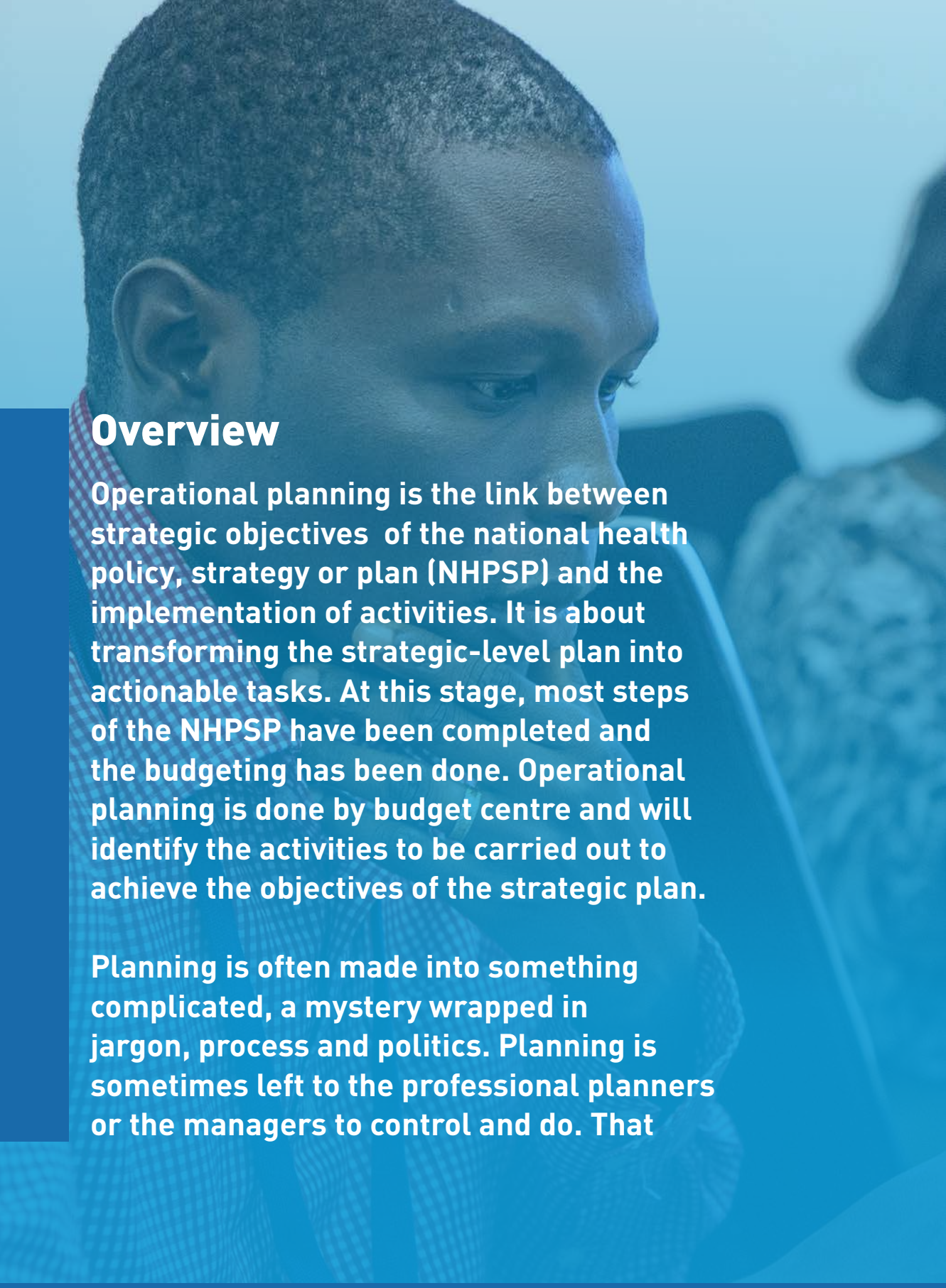
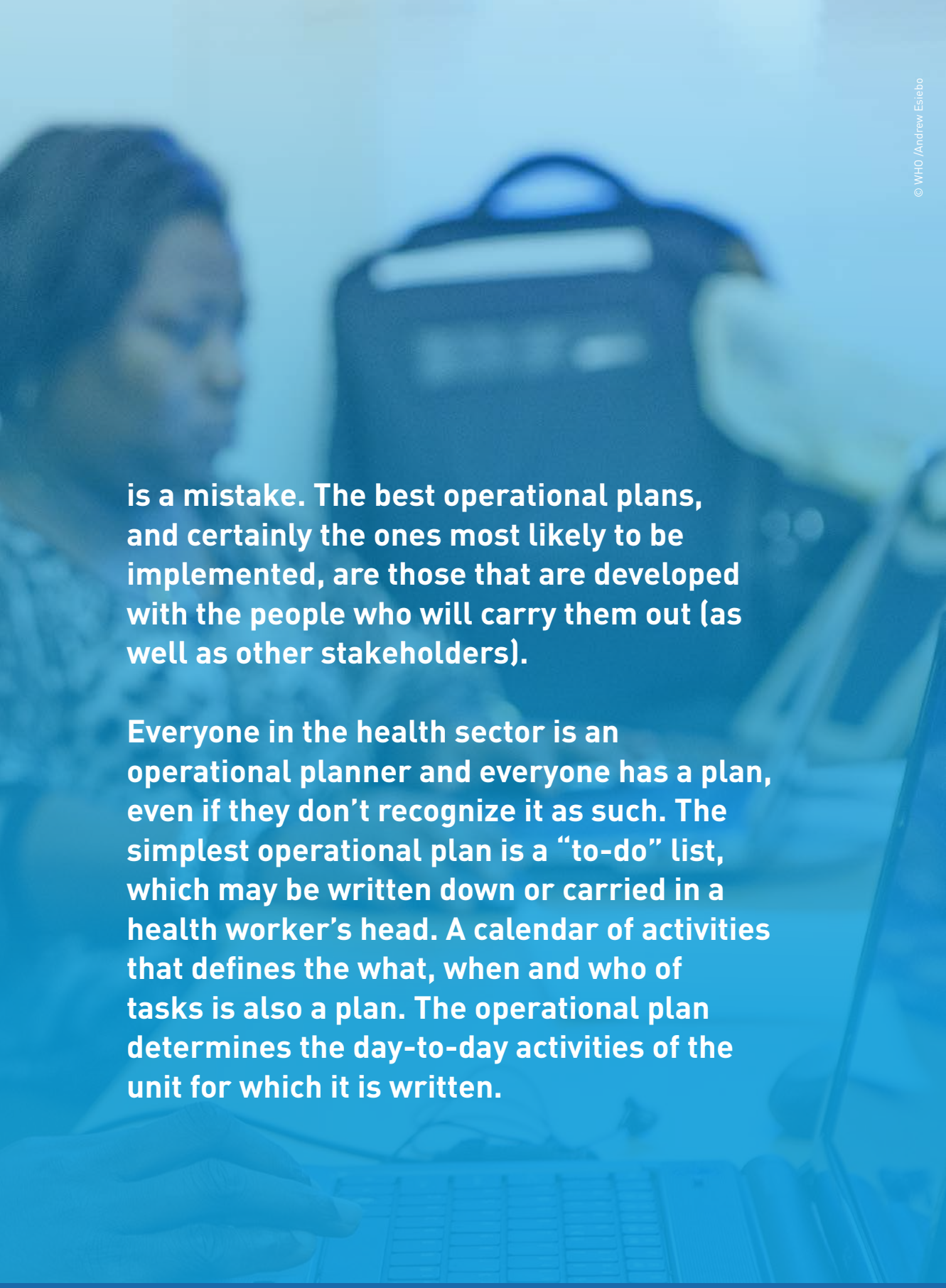


Overview

Operational planning is the link between strategic objectives of the national health policy, strategy or plan (NHPSP) and the implementation of activities. It is about transforming the strategic-level plan into actionable tasks. At this stage, most steps of the NHPSP have been completed and the budgeting has been done. Operational planning is done by budget centre and will identify the activities to be carried out to achieve the objectives of the strategic plan.

Planning is often made into something complicated, a mystery wrapped in jargon, process and politics. Planning is sometimes left to the professional planners or the managers to control and do. That



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is a mistake. The best operational plans, and certainly the ones most likely to be implemented, are those that are developed with the people who will carry them out (as well as other stakeholders).

Everyone in the health sector is an operational planner and everyone has a plan, even if they don't recognize it as such. The simplest operational plan is a "to-do" list, which may be written down or carried in a health worker's head. A calendar of activities that defines the what, when and who of tasks is also a plan. The operational plan determines the day-to-day activities of the unit for which it is written.

Summary

What is operational planning?

Operational planning is typically based on a NHPSP that defines the vision, goals and objectives for the health sector. Operational planning is managerial and shorter term, as opposed to strategic planning, which usually has a 5–10 year horizon, sometimes even longer. Operational planning deals with day-to-day implementation and often has a one-year time horizon.

An operational plan is a practical plan of activities to undertake that are in line with the overall NHPSP, but is concrete enough for practitioners at each level of the health system to know what they are responsible for.

Operational planning takes place when most other steps of the planning cycle are completed, at the level of budget centres.

Why is operational planning crucial to strategizing for health?

Operational plans are necessary to concretize NHPSPs. They provide a framework for action based on the strategic vision given by the NHPSP. The operational planning process has the potential to greatly assist stakeholders in gaining a better understanding of the NHPSP target population and its needs, as well as stakeholders' own capabilities and limitations in implementation. Especially when defined jointly, an operational plan is critical for the clarity it offers as to what needs to be done, by whom, how, and with which monies.

When should operational planning take place?

The health operational planning process should be synchronized with the budgeting process of the financing entity. This typically means a complete operational plan with budgets done on a yearly basis. This can be on a two-yearly basis in settings that are very stable from a political or social point of view. Operational planning can be done even more frequently, for example every six months or even three months, in situations where insecurity and instability force decision-makers to adapt activities to a rapidly-evolving context.[1]

1 For more information, please see Chapter 13 "Strategizing in distressed health contexts" of this handbook.

How does operational planning work?

An operational plan should typically include:

1. a description of activities and a statement as to which major objective of the NHPSP it falls under;
2. the timing and sequencing of those activities;
3. a quantity of activity;
4. the person(s) responsible for the activity;
5. the resources required, including financial resources, and the origin of those resources;
6. a method of measuring progress (monitoring).

The following steps are necessary for sound operational planning:

1. taking stock of the situation (where are we now?), including identification of stakeholders (who is involved?);
2. setting operational priorities;
3. putting together the operational plan (what are we going to do?), including the operational budget;
4. implementation of planned activities (how are we going to do it?);
5. monitoring and evaluation of the operational plan (what have we accomplished so far?);

Who are the main actors involved in operational planning?

Ideally, all of those who are responsible for an activity in the health sector will be involved in operational planning, either directly or through having their interests represented by someone involved in the formal planning process. Key stakeholders are the national and local health authorities, health service providers and health system end users.

Anything else to consider?

- decentralized environment;
- fragile environment;
- highly aid-dependent context;
- strong vertical programme.

6.1 What is operational planning?

6.1.1 Concepts and definitions

"Planning is a method of trying to ensure that the resources available now and in the future are used in the most efficient way to obtain explicit objectives."[1]

Another way to see operational planning, taken from a business consultancy, is "the process that determines the day to day activities of the business".[2] This point of view is transferable to the public sector. An operational plan is about doing. It defines what actions will be taken. Implementation planning, activity planning, and work planning are alternative terms used for operational planning.

An operational plan is a practical plan of activities to undertake that are in line with the overall NHPSP, but it is concrete enough for practitioners at each level of the health system to know what they are responsible for. In other words, an operational plan will describe the tactics that must be employed as the preferred method for achieving certain objectives, or targets. A simple example of a target might be "90% of pregnant women receive four antenatal care visits". A tactical (or specific) objective would choose whether the preferred method of reaching this target is through outpatient consultations at maternal and child health clinics, during outreach activities, through community health workers, or some combination of these methods or tactics.

Operational planning is undertaken by "budget centres" (or "cost centres"), ideally when the overall health budget is formally known. A "budget centre" is an accounting term used to describe a department, division, or other subunit for accounting purposes; usually, a budget centre has some level of autonomy in activity implementation. With regard to health sector planning, this can refer to a unit within a ministry of health (MoH), a parastatal institution, a sub-national entity, or any other establishment for which the income and expenses are separated out and monitored. It can also be a contracted facility or group of facilities (which could be in the private sector). The level of budget details may vary with private entities, but all facilities working in the health sector – public, private for-profit and private non-profit, need to do operational planning exercises; at the very least, all stakeholders need to be aware of what the others are doing.

An operational plan is a practical plan of activities to undertake, concrete enough for practitioners at each level of the health system to know what they are responsible for.

That being said, all units that have activities and budgets should have an operational plan. There will be cases where several units (such as health centres) together form a budget centre; the contrary holds true as well – a large well-funded programme may end up being several budget centres. In the former case, it might mean that a "sub-unit", for example a health centre, might still need to do a separate operational plan for its own purposes; in the latter case, the large programme might have to do a separate, unified operational plan for it to work off of. Either way, the principles of operational planning as elucidated in this chapter apply.

The operational plan of units that do not provide direct services, such as units at a central MoH,

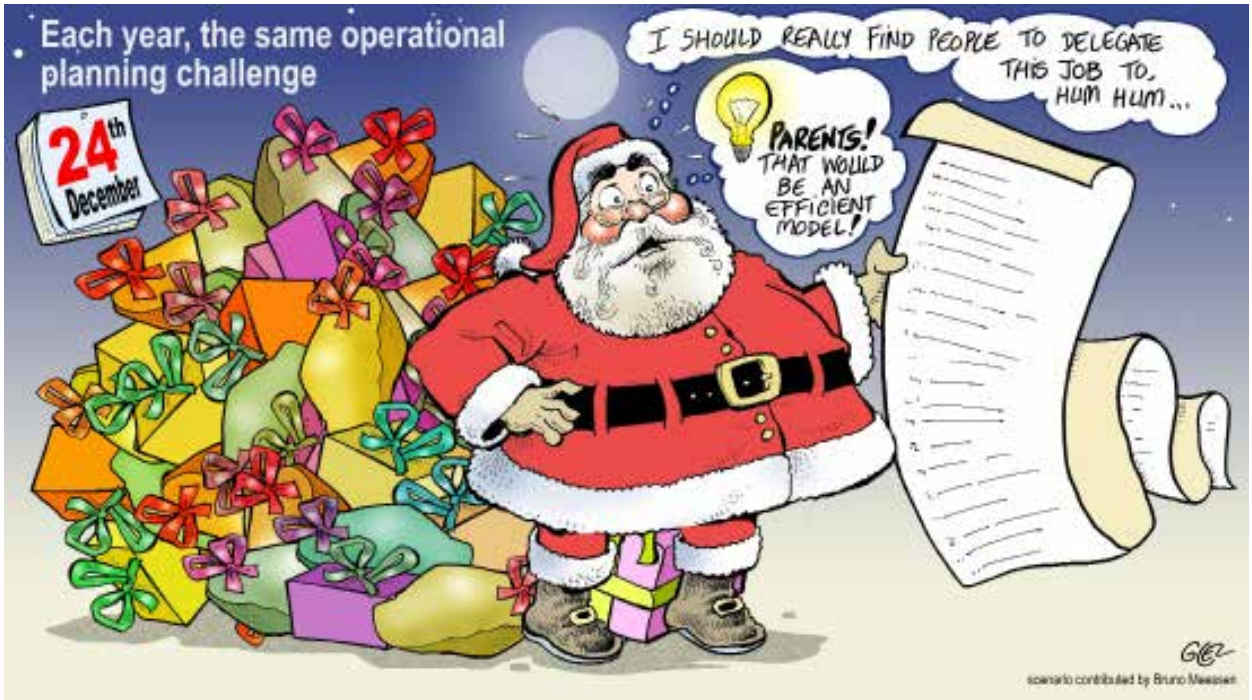
should include the activities undertaken to technically support those units that are providing direct services. An important decision is whether MoH units include the actual service delivery carried out by health facilities or district teams in their plans. There is a strong inclination to do so, but it can lead to a proliferation of planning exercises, and also lead to double counting of activities. In a well-organized system it is preferable for the operational plan to only include activities actually performed by the unit that is planning. For example, in a malaria control programme, the central malaria unit would not include the distribution of bednets to community members in their operational plan if members of a district health team do that distribution.

Operational plans are sometimes described as something that is needed for lower levels of the health sector, typically sub-national structures such as regions or districts and individual facilities such as hospitals and health centers. That is true, but incomplete. All who carry out activities benefit from having an operational plan. The planning unit of a MoH needs an operational plan to define what it will do on a day-to-day basis to implement the plan. Each department at a central MoH needs an operational plan, not to set strategy, but to determine activity. Even a minister's office needs a plan of the activities it will carry out to provide stewardship for the sector.

If the unit undertaking the operational planning is a sub-national entity, the specificities of planning is linked to the decentralized level and is addressed in the "what if" section 6.1.3.

A formal operational plan at a minimum should include:

1. a description of activities linked to the overarching strategic objectives (normally contained in the strategic plan);
2. the timing and sequencing of those activities;
3. a quantity of activity;
4. the person(s) responsible for the activity;
5. the resources required, including financial resources, and the origin of those resources;
6. a method of measuring progress (monitoring).



Damien Glez; scenario by Bruno Meesen

Fig. 6.1 Operational planning

6.1.2 Strategic planning vs operational planning

Strategic health planning refers to the long-term vision, goals and objectives for the health sector. Operational planning is managerial and shorter term. Strategic planning usually has a 5–10 year horizon, sometimes even longer (see Table 6.1). Operational planning deals with day-to-day implementation and often has a one-year time horizon. The time frame is usually the same as the budgeting cycle of the organization or government. Strategic plans, once completed and agreed, tend to stay relatively constant throughout their agreed term. Operational plans, on the other hand, should be dynamic, open to change if situations change or targets are not being met, and remain open to regular revision as circumstances change. Examples of changing circumstances requiring a change of plan would be an unexpected epidemic or a natural disaster, changes in the resources available, or clear signs that goals are not being met.

The flexibility of operational plans is absolutely central to the implementability of the NHPSP. The NHPSP gives the strategic orientation for

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the sector, which serves as a basis for the content of operational plans. The operational plans should "operationalize" the strategic plan and can only adequately do so if they can be modified along the way, as and when situations change and new context-specific learning can be applied. An example illustrating this point is the interaction between Cambodia's second Health Sector Strategic Plan (HSP) and Annual Operational Plans (AOPs). The AOPs for the health sector, which became mandatory in 1999, are put together through a combination of bottom-up and top-down processes, and are further broken down into quarterly action plans and monthly workplans.[3,4] The last HSP 2008–2015 was not altered during its duration, as its objectives were aligned with the Millennium Development Goals; however, the AOPs were constantly modified when corrective action was necessary, based on regular supervision and monitoring results.

Table 6.1 Key characteristics of strategic and operational planning

	STRATEGIC PLANNING	OPERATIONAL PLANNING
VISION	Long term	Short(er) term
FOCUS	Strategic direction for the health sector	Concrete activity implementation
TIME FRAME	3- to 5-year document	1 year, sometimes shorter time frame
FLEXIBILITY	Less likely to change during its term	Can more easily be adapted and modified according to changing circumstances

6.1.3 Operational planning and budgeting

Ideally, the sector budget ceiling as well as the exact allocations to the budget centres should be clear before putting together an operational plan. If the public budget negotiation process is still not completely concluded at the time of operational planning, the approximate sector budget allocation as well as the NHPSP disaggregated costing can be used as an approximate ceiling within which to plan.[II]

The structure of the operational plan will be heavily dependent on the type of budgeting used in the country. Ideally, it can be developed based on the specific objectives for the operational unit, as this is usually most useful from the point of view of the unit. However, if operational plans and budgets need to be submitted using line-item budgeting, one of the two options below can be used.

(a) The operational plan can still be done by specific objectives but an additional step will be necessary to "translate" the budget lines linked to activities and objectives to line items (sometimes called a "chart of accounts"). Several iterations will be necessary here if the exact amounts of each of the line items are fixed and inflexible, in order to make the objective-driven budget match the line items. If the line item amounts are not fixed and there is flexibility within the budget centre's allocation of funds to change the amounts linked to the line items, then the line-item budget can be more easily molded to the needs of the operational unit's objectives.

(b) The operational plan is created from the beginning according to line items. The risk of not ensuring a link between the country's budgeting system and the structure of the operational plan is that resource allocations may not match the needs nor the capacity of the operational unit. If there is room for flexibility in the line item allocations, at least ensuring that those allocations meet the objectives of the operational plan is possible, but will entail an extra workload for health planning stakeholders in securing allocations by line items that tally up to the necessary resources per objective.

6.1.4 Participation and inclusiveness of operational planning

Operational planning is a method of formally organizing activities through a process that involves key stakeholders, with the results of the process shared with all involved. The process is meaningful in and of itself to encourage and solicit participation and input of major stakeholders of the (local) health system. The absolute criticality of broad and inclusive participation cannot be emphasized enough, all the more so for operational planning (vis-à-vis strategic planning) because the decisions made regarding what to include into the operational plan concretely and directly affect those who will be carrying out the decisions. Success or failure will depend largely on the buy-in, understanding and willingness to implement the plan by health sector stakeholders; hence, those very stakeholders must be consulted and heard. Many countries have well-functioning, recognized participatory bodies (health committees, management committees, etc.) that can be used as a vector to ensure that all interests are represented in the decision-making process.

While operational plans are a guide for day-to-day action, they are not a detailed description of every action taken; the correct amount of detail is vital to ensure the planning process is not burdensome.

II For more information, please see Chapter 7 "Estimating cost implications of a national health policy, strategy or plan" and Chapter 8 "Budgeting for health" in this handbook.

Box 6.1

Inclusive planning in Senegal: regional health sector reviews[5]

"[We have been able to focus] more on the communities in need, in their own environment, by putting in place much-needed regional health sector reviews," said Dr. Farba Lamine Sall, Director of the Minister of Health's Office, Senegal.

In 2014, the Senegalese Ministry of Health was looking to improve coordination among national, regional and local health administrations. It was decided to put in place regional health sector reviews (RHSRs), in addition to the annual health sector review, the idea being to more closely involve the health community, civil society and implementers on the ground, as it was usually not feasible to involve them all at the annual health sector review.

Over a period of two years, the RHSRs have been formally institutionalized as a means to monitor sub-national operational plans. In addition, the RHSR has proven to be a key instrument for allowing greater and more meaningful participation from different players in the local health system, since much of civil society and various population groups are represented at regional, rather than national, level. Also, most of the practitioners on the ground were more motivated to actively participate in the regional – rather than national – reviews, as the issues discussed directly affected their daily lives.

The Senegalese MoH has noted better quality operational plans from the regional level since 2014, and a more profound understanding of national-level stakeholders for challenges in the different regions. All in all, monitoring of operational plans, and the subsequent adjustments made to operational plans in the regions, have proven to be essential means to increase community and population participation and make the participation more useful and meaningful.

6.2 Why is operational planning crucial to strategizing for health?

Operational plans are necessary to concretize NHPSPs. They provide a framework for action based on the strategic vision given by the NHPSP. They are the only instrument that allows for a formulation of implementation modalities, and an identification of financial and other resources needed and of the timelines against which the tasks must be achieved. Without an operational plan to make the NHPSP more tangible, stakeholders will not be clear about their own roles and responsibilities, and implementation will suffer. Especially when defined jointly with all relevant health sector stakeholders, an operational plan is critical for the clarity it offers as to what needs to be done, by whom, how, and with which monies.

The operational planning process has the potential to greatly assist stakeholders in gaining a better understanding of the NHPSP target population and its needs, as well as stakeholders' own capabilities and limitations in implementation. The operational plan provides an opportunity on at least an annual basis to constantly adjust activities and actions according to need and circumstance, also by other actors from other sectors.

The process can help increase transparency and avoid confusion about what is expected, and guide the implementation of activities. It is a useful tool for both the manager and the person being managed. Each worker should know where he or she fits in the overall plan and what is expected.

6.3 When should operational planning take place?

Although an operational plan may have activities described for a year, the exact timing of most activities need to be planned on a shorter time period, often quarterly or even monthly. For example, it may be possible to describe a certain number of primary health care activities per month to cover a district, but fixing the exact dates of the activities needs to be done closer to the time of actual implementation.

Operational plans are necessary to the NHPSP planning process because they provide a framework for action based on the plan's strategic vision.

The operational planning process should be synchronized with the budgeting process of the financing entity. This typically means a complete operational plan with budgets done on a yearly basis. This can be on a two-yearly basis in settings that are very stable from a political or social point of view. Operational planning can be done even more frequently, for example every six months or even three months, in situations where insecurity and instability force decision-makers to adapt activities to a rapidly evolving context.[III] Close cooperation between the finance and health sectors – and indeed other relevant sectors – is ideal.

Typically, operational plans with budgets are done on a yearly basis to ensure that the planning process is synchronized with the budgeting process of the financing entity. They can be done more frequently in situations in insecurity or less frequently in a very stable context.

The central health planning authority should provide operational units clear guidance on dates that planning milestones must be met and the processes for approval of the plans. It is helpful if guidance can be given as to the estimated length of time that is required for preparation of the various steps in the process. A checklist with due dates is extremely useful (see Box 6.2).

III For more information, please see Chapter 13 "Strategizing in distressed health contexts" in this handbook.

Box 6.2

Example operational planning checklist from a Cambodian Provincial Health Department Office[6]

TASK	WHEN	WHO	CHECK
Task 1: Attend the MoH Annual Performance Review Meeting	End of February	PHD Director	
Task 2: Provincial workshop for annual review and setting provincial objectives and targets	March	Provincial Health Technical Advisory Team (PHTAT), PHD staff, referral hospital management team, health centre chiefs, partners	
Task 3: Provide technical support to the referral hospitals and health centres	March and April, during development of annual operational plans	Directors of PHD, key staff of PHD technical bureau, key staff of PHD finance bureau	
Task 4: Appraisal of PHD, referral hospitals, and health centre annual operational plans	May, as soon as operational plans developed	Directors of PHD, key staff of PHD technical bureau, key staff of PHD finance bureau	
Task 5: Preparation of the provincial 3-year rolling plan and the provincial annual operational plan	May, as soon as operational plans developed	Directors of PHD, key staff of PHD technical bureau, key staff of PHD finance bureau	
Task 6: Meeting to review the provincial 3-year rolling plan and the provincial annual operational plan based on feedback from the MoH	Early August, as soon as PHD received feedback from MoH	PHTAT, PHD staff in charge of national programs activities, referral hospital management team, health centre chiefs, partners	
Task 7: Meeting to finalize the provincial annual operational plan	December	PHTAT, PHD staff in charge of national programs activities, referral hospital management team, health centre chiefs, partners	
Task 8: Monthly Meeting of PHTAT with referral hospitals and health centres	Every month of the next year, while operational plan implemented	PHTAT, PHD staff in charge of national programs activities, referral hospital management team, health centre chiefs	
Task 9: Provincial quarterly review meetings	The first week of each quarter	PHTAT, PHD staff in charge of national programs activities, referral hospital management team, health centre chiefs, partners	
Task 10: Attend the MoH Mid-year Performance Review Meeting	August next year	PHD Directors	

One problem encountered in some countries is constant change to the guidance and formats of planning. Typically, central health planning authorities may find that the format of the operational plans are not perfectly adapted for monitoring and evaluation purposes, or for tracking the use of resources for a particular programme or for better access to specific earmarked funding. They may therefore change the format of the operational plan from one cycle to the other (from one year to the other). It must, however, be kept in mind that every change requires time and effort to adapt to it. The change must be a significant improvement to justify the disruption it causes. The pursuit of perfection should not drive out planning processes that are good enough.

It is wise for the unit undertaking operational planning to try to finish work at least a week or two before the deadline, leaving ample time for a leisurely review and fine-tuning, as necessary. Last-minute planning often leads to mistakes.

6.4 How does operational planning work?

Central-level guidance to the different budget centres and operational units on operational planning should typically include information on timing for completing the different steps, information on the stakeholders expected to be involved in the planning process, and a guidance framework, often a matrix, that includes at a minimum:

A formal operational plan should include: a description of activities linked to the strategic objectives; the timing, sequencing, and quantity of those activities; the person(s) responsible for and resources required for the plan; and a method of measuring progress.

1. a description of activities and a statement as to which major objective of the NHPSP each falls under;
2. the timing and sequencing of those activities;
3. a quantity of activity;
4. the person(s) responsible for the activity;
5. the resources required (including financial) and the origin of those resources; and
6. a method of measuring progress (monitoring).

The guidance must also include instructions concerning the degree of decision-making authority that lies with the budget centre. Is the operational planner required to follow goals, objectives, budgets, and tactics that are determined by a central authority? Or, can the budget centre set its own goals, objectives, budgets and tactics? In most situations, the reality is somewhere in between these two extremes. The national health planning authority should give guidance as to where the balance lies in that particular system.

In addition, major policy orientations based on the NHPSP should be detailed and explained right at the beginning of the operational planning process, in order to orient the content of the operational plans.

6.4.1 Some operational planning issues to consider

Operational plans are still needed even if there is no useful strategic plan

There are times when the strategic planning process is less effective, and clear and reasonable guidance is not available. In such circumstances, an operational planning exercise is still necessary and useful as a management tool for health managers or health care workers who have responsibilities to fulfil.

Level of detail needed in an operational plan

A word of caution on the amount of detail needed is in order. Operational plans are a guide for day-to-day action. They are not a detailed description of every action taken. When too much detail is required, the planning process becomes burdensome and uses excessive amounts of time. The plan can become so large that it is not useful. A plan for immunization services might include an activity to maintain the cold chain in all of the health centres in a district. It will not include every step taken to maintain a refrigerator. However, a cold-chain technician might have a to-do list that does detail those steps, but it would not be part of the district plan. If maintaining the cold chain has been a problem, however, an operational plan might include developing a to-do list for cold-chain maintenance. Finding the correct amount of detail requires common sense and experience.

Flexibility

Operational plans must be iterative. They are subject to change depending on feedback on results that come from monitoring and ongoing field experience. If something is not working, it is often necessary to change what is being done. Depending on the circumstances, those changes do not always have to wait for the end of the formal planning period (see Box 6.3 on medium-term rolling plans).

Box 6.3

Medium-term rolling plans

In some settings, an intermediate or medium-term plan is also developed, which is usually three years in duration, and can be seen as a bridging plan between the NHPSP and the operational plans. Medium-term plans are commonly associated with a medium-term expenditure framework (MTEF), which is discussed in detail in a separate chapter.[IV]

MTEFs have been popularized by the international financial institutions and ministries of finance. In countries where a medium-term plan is developed, there may be a rolling plan process, where on a yearly basis, the operational plan for the coming year is refined, and an additional year of planning is added so that there is always a three-year plan in place.[7] The idea is to make the operational planning process less heavy and more connected with the budgeting process.[8]

Critique of MTEFs has been mainly focused on planning and reporting requirements from international development partners who have heavily supported the MTEFs. It is true that in settings with large donor monies in the health sector, MTEFs have helped give more clarity to development partners' financial and technical commitments. For example, in Benin, some development partners found it difficult to commit beyond three years. A three-year rolling plan was thus more feasible for many partners to commit to. In recognition of this, Benin's 10-year NHPSP (Plan national de développement sanitaire, 2009–2018) was divided into three-year rolling plans with MTEFs.

On the other hand, it has been acknowledged that MTEF processes have contributed to greater linkages between operational planning and budgeting and have helped countries to adjust their plans to be more realistic and feasible.

IV For more information, please see Chapter 8 "Budgeting for health" in this handbook.

Bottom-up or top-down process

A major decision is whether operational planning will be a bottom-up process, a top-down process, or some combination of the two. In most cases, it ends up being the latter.

A top-down process works best in a highly-structured civil service or business setting with strong central budgetary and supervisory controls. Instructions can be sent and the plans have to be completed, as instructed, before any of the resources flow. It should work like clockwork, but rarely does. Nevertheless, even if the organization is highly centralized, there are advantages in letting units and individuals develop their own plans within the limits of that highly centralized structure. Operational plans that are dictated from above frequently do not reflect on-the-ground reality and therefore lead to poor performance.

The pathway for operational plan approval should be clear, both with regard to who can approve and the deadlines for when decisions are to be made.

However, a bottom-up process can be lengthy, requires much training, and large numbers of human resources, and their time, to prepare and consolidate. Whether it is feasible is a judgement that depends on local capacity and local priorities, but such processes frequently become delayed and bogged down.

An alternative is a local operational planning process based on clear guidance from a national health planning office. Such a process usually works better if there is input from the national level during the planning process, before local plans are far advanced. This input can take the form of written guidance, the physical presence of planners to facilitate the planning process, or workshops to familiarize local planners with the national plans and priorities. It can also include remote support such as emails and teleconferences, something that is becoming more feasible as technology improves. The art of planning involves finding the proper balance between these methods.

Finalization and approval of the operational plan

A particularly important issue is to provide guidance on the process of finalization and approval of the operational plan, including clear criteria for acceptance of plans. A clear pathway for approval should be described, both with regard to who can approve and the deadlines for when decisions are to be made. In the real world, there are often multiple layers of approval, and it can become quite confusing unless it is clearly specified who has the right and responsibility of approval and when that is to occur. An even more difficult issue is what to do with the entities that miss submission and approval deadlines (see Box 6.4). Complexity cannot be avoided, but it is only fair that operational planners be given a clear roadmap of the approval process.

Aggregating plans

Another issue to consider is where the aggregation of operational activities is done. Will activities be aggregated at district level and then passed up to a regional office, if it exists, and then on to the national level? Or will activities be aggregated by programme? The decision will depend on how the budget centres are organized and which entities need a separate budget that will be monitored for expenditures and outputs. For example, the district malaria team's operational plan can be aggregated at the district health plan level; the operational plan can also be sent to the national malaria office and aggregated there. Aggregating by programme, i.e. organizing budget centres by programme, is often felt to be more satisfactory by the individual programmes, but is at risk of leading to a plethora of plans– one for each individual programme – which may not be coherent with each other.

Box 6.4

What happens when local units do not complete or submit their operational plans?

Does failure to submit mean no funds or decreased funds? Does it mean that the plan will be identical to last year? Or does it mean reorienting resources towards those teams that do meet the deadlines? The unfortunate truth is that those district teams that are weakest or least experienced with developing plans are frequently in districts that have the greatest health needs. Indeed, more remote geographical areas with poorer or hard-to-reach populations may potentially be understaffed and under-resourced because of the classical challenges of deploying and retaining health staff in these areas or establishing proper communication channels such as internet connection etc. They may therefore be in a weaker position to develop and submit their plans on time. Rather than a punitive approach towards those who miss planning deadlines, it may be better to allocate resources to assist the weaker teams in developing their plans. It is not particularly fair, or a wise public health decision, to take resources away from high-need areas because their public health teams have less experience or capacity in planning.

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6.4.2 Steps in operational planning

Similar to overall strategic planning, the steps in the operational planning process include:

(a) taking stock of the situation (where are we now?), including identification of stakeholders (who is involved?);

(b) setting operational priorities;

(c) putting together the operational plan (what are we going to do?), including the operational budget;

(d) implementation of planned activities (how are we going to do it?);

(e) monitoring and evaluation of the operational plan (what have we accomplished so far?).

Shorter operational planning cycles that group some of the above-mentioned steps together and longer cycles that split up multiple steps can be considered, but they all contain the same or similar steps. Examples of different cycles can be found in many sources.[9,10]

The operational planning cycle places less emphasis on costing and budgeting compared to the overall national health policy and planning cycle, with more emphasis on the implementation. This is because the overall budget should already have been developed and the budget centre doing the operational planning has its specific budget lines which need to be planned for. Hence, the costing and budgeting is done at a much smaller scale, and is less complex, than in the strategic planning cycle. That being said, if national-level costing is not done well and is based on gross assumptions, a more detailed cost estimation exercise at operational unit level may be useful, also in view of providing valuable feedback to national-level costing and potentially influencing resource allocation decisions. On the other hand, operational planning will of course put more emphasis on the implementation, which is the primary objective of an operational plan.

In the following sections, each operational planning step is described in more detail. As many of the steps mirror the overall national health policy and planning cycle, the possible methodologies for each step are not described in detail, as they are elaborated upon in other chapters of this handbook and can be applied here as well.

Similar to the steps of strategic planning, the operational planning process should take stock of the situation, set operational priorities, put together the operational plan and budget, plan for the implementation of activities, and monitor and evaluate the operational plan once implemented.

(a) Taking stock of the situation (where are we now?), including identification of stakeholders (who is involved?)

Taking stock of the situation from the point of view of a budget centre need not be as extensive as the situation analysis for the NHPSP. It should build upon it, examining more closely the specific issues relevant to the budget centre and its mandate. In addition, it is important to look particularly at any significant differences from the analysis in the national plan. This need not be a problem per se but must be flagged, explained and made clear. Examples of this might be if a certain district has a health problem, such as guinea worm, that is present in that district, but not in the rest of the nation.

What is worth investing in at operational unit level is a tailored stakeholder analysis, examining the local playing field in more detail. The analysis done at central level may be too broad-based to be directly applicable for each operational unit. Local stakes may be very different from central-level stakes and interests.

(b) Setting operational priorities

At budget centre level, the prioritization exercise is focused on activities, ideally linked to the overarching priorities already set in the NHPSP. Based on the national-level situation analysis and any additional context-specific complementary information produced by taking stock on the local situation, a ranking of the different recommendations can be made which then leads to a first draft priority list. Through several rounds of dialogue, health sector stakeholders' key operational priorities will crystallize. Part of the discussions on operational priorities will include sequencing of activities, based on level of priority accorded to that activity (even if the final timeline happens in the next stage of actually developing the operational plan).

Based on the national-level situation analysis and any additional context-specific complementary information, a ranking of the different recommendations can be made which then leads to a first draft priority list.

Any local evidence will be crucial to ensuring that local operational priorities reflect realities on the ground. Other national and international evidence will, of course, also be examined where relevant, but context specificity is so vital here that any data and information from other contexts should be discussed with regard to adaptation to a specific setting.

(c) Putting together the operational plan (what are we going to do?), including budgeting

As explained above, operational planning is usually documented through the use of a predetermined planning matrix or grid provided by the national planning authority. There are many models for this.[11-13] If no template is available, at the very minimum, the elements described in section 6.4 should be included.

Crucial guidance from the central health planning authority to operational planners includes an outline of the operational plan, which should ideally be linked to and follow the headings of the NHPSP. This will allow activities of the operational plan to be clearly identified as contributing to NHPSP objectives. If the NHPSP was developed in a bottom-up manner, then much of the input to the NHPSP will have come from the various operational units anyway, which means that matching NHPSP and operational plan headings should not be particularly difficult. Otherwise, the operation plan headings are often organized around the main local priorities without any distinct link to anything beyond the local. If the operational plan is for a particular programme, reference should be made to the strategic directions of the NHPSP.

Ideally, as mentioned in section 6.1.3, the operational plan headings would also correspond to the budget line items ("chart of accounts") of the financing authority, for example the ministry of finance at the national level and the district treasury office at district level.

Frequently there is poor alignment between the health planning process and the national and sub-national budgeting processes.[14] In actual practice, health planning stakeholders often find the headings from the national chart of accounts to be ill suited to strategizing for health. The temptation to ignore the national chart of accounts should be resisted, even if they do not seem appropriate for an operational plan. A compromise is to do a "translation exercise" by adding another column to the operational plan matrix for the national budget line items so that the operational plan can be sorted to reflect the NHPSP or the national budget line items as appropriate. Another column can also be added for "source of funds", in situations where there are multiple sources of funds that must be accounted for separately, such as funds from different government levels or from external donors.

The pivot table function of a spreadsheet, if that is what is used for the matrix, can be used to provide an operational plan (see Box 6.5) in a format that is suitable for the operational planner or for the planner/accountants from the district treasury, or other development partners. The national health planning staff should help the local planning staff put together the most adequate matrix and technically support the process in areas where it is needed.

Box 6.5

Example of a hypothetical operation plan using the pivot table function of a spreadsheet

Original table of activities for the operational plan

ACTIVITY	COST (IN MILLION USD)	ACQUIRED COSTS (IN MILLION USD)	SOURCES OF FUNDING	MOBILIZATION (IN MILLION USD)	EXECUTION RESPONSI-BILITY	T1	T2	T3	T4
Activity 1.1 Create new district health centres in peripheral districts	300	300	World Bank	10	Ministry of Finance	x	x		
Activity 1.2 Acquisition and deliv-ery of enough vaccinations to cover district population	200	200	GAVI	50	Ministry of Health		x		
Activity 1.3 Re-train district and regional health staff in proper immunization techniques	100	80	Foreign donor	20	Regional Health Admin-istration	x			
Activity 1.4 Community engagement by health work-ers to improve immunization awareness	100	50	Ministry of Finance	40	District Health Administration	x	x	x	x
Activity 1.5 Design and deliver traveling clinics for vaccines to underserviced areas	200	100	Ministry of Finance	20	Ministry of Health			x	
Activity 1.6 Record rates of immunization while performing annual census	100	70	Ministry of Finance	10	Ministry of Housing				x

Pivot table showing the distribution of activity cost by responsible entity

Sum of Cost (in million USD)

ACTIVITY	DISTRICT HEALTH ADMINISTRATION	MINISTRY OF FINANCE	MINISTRY OF HEALTH	MINISTRY OF HOUSING	REGIONAL HEALTH ADMINISTRATION	GRAND TOTAL
Activity 1.1 Create new district health centres in peripheral districts		300				300
Activity 1.2 Acquisition and delivery of enough vaccinations to cover district population			200			200
Activity 1.3 Re-train district and regional health staff in proper immunization techniques					100	100
Activity 1.4 Community engage-ment by health workers to improve immunization awareness	100					100
Activity 1.5 Design and deliver traveling clinics for vaccines to underserviced areas			200			200
Activity 1.6 Record rates of immu-nization while performing annual census				100		100
Grand Total	**100**	**300**	**400**	**100**	**100**	**1 000**

Central planners should identify the category of activities and level of detail that they want to see reflected in operational plans, especially in view of bottom-up aggregation of the plans (for example delivery of health services, training activities, management activities, etc. will all need to be coordinated or supported by the central level, sometimes just to ensure that there is no duplication). Clear guidance should also be provided on the methodology and the level of detail needed on the resource calculations for the described activities. The same goes for the selection of resource persons and focal points for activities and the level of details required for the timelines.

The above guidance will ensure that operational plans developed by different units are coherent, comparable and can be aggregated.

The spreadsheets in such situations, particularly if they are long and involve multiple levels of activities and funding sources, can become complicated and difficult to manipulate. Ideally, such complexity is handled within an efficient budgeting and planning database programme. A good database management system can make it easier to enter and extract information, store data over time, make comparisons across activities from different plans and years, etc. In practice, such programmes are often difficult to initiate and expensive to maintain, but if they function well, they are superior to using spreadsheets. But, spreadsheets can be used to manage the planning matrix if proper guidance on their use is given and care is taken in the initial set-up. It is the responsibility of the central health planning authority to provide guidance and capacity building on the issue of proper formats and IT platforms in their setting. It is advisable to avoid each budget centre having their own formats and IT methods.

Another decision to be made is whether the operational planning will be done using an incremental approach, with the new plan based on making changes and adjustments to what activities were carried out in the past, or whether an attempt should be made to plan from a blank slate or matrix. There are theoretical advantages to looking at everything anew, but if it is known that certain services will continue, there is no reason to pretend that you can plan them starting from scratch. Don't waste the precious time of health workers.

Another decision to be made is whether the operational planning will be done using an incremental approach, with the new plan based on making changes and adjustments to what activities were carried out in the past, or whether an attempt should be made to plan from a blank slate or matrix.

In many situations, it can be a recommended approach to start with looking at what has been done in the past. Then look at what is new as far as demographics, epidemiology or the resource base, including human resources, infrastructure and financing, are concerned. Then make adjustments to the operational plans based on what is new in the situation. The rolling 2- to 3- year plan is meant to be particularly well suited to adjust to incremental change. A calendar of deadlines and deliverables can be provided from central health planning authorities to operational planners to allow submission of draft versions of operational plans that can be reviewed and refined. The iterative process will help reconcile an operational plan based on the needs of the implementing units with the resources that are available for implementation.

(d) Implementation of planned activities (how are we going to do it?)

For actual implementation, individual managers should be encouraged by their team leaders to break their planned activities into individual sub-steps that make sense. Operational plans identify the activities that are required to meet the plan's objectives. Managers will then need to identify the concrete to-dos that will allow the team to implement these activities in a given timeline. Not every detailed step needs to be approved and planned by the overall in-charge, but in many respects, each detailed step needs to be thought through by the person who has the direct responsibility for that activity. Operational plan implementation is thus perhaps more about management than about planning.

Operational plan implementation is perhaps more about management than about planning.

For example, a district health plan may list as an activity a fixed number of outreach visits in a fixed number of remote villages per month. The responsible officer will list the steps necessary to actually perform the agreed number of outreach visits – for example, "arrange transport", which involves the tasks "organize car and driver, purchase fuel". Other steps could be:

- identify staff;
- forecast supplies (tests, vaccines, preventive medicines, health education materials, etc.) and ensure they are available at the time of the visits;
- organize coordination meetings;
- etc.

An important aspect of this work is to ensure coordination between different activities: for example, that all staff are not on outreach activities at the same time, that there are not multiple orders of the same kind of supplies but that orders are placed in bulk, and so on.

(e) Monitoring and evaluation of the operational plan (what have we accomplished so far?)

Monitoring and evaluation (M&E) are frequently written together. They are closely related, but they are two different activities.

Monitoring operational plans typically refers to the continuous assessment of whether planned activities are occurring and whether the expected results are being achieved. Monitoring is usually internal, something performed on a continuous or regular schedule by those who are actually doing the activities. It consists of comparing activities actually performed and the outputs actually achieved with what was planned. For example, monitoring will tell you that the planned number of outreach visits to remote villages has not taken place, or that the attendance of the outpatient clinic is declining or, on the contrary, has dramatically increased. Monitoring should be an activity listed in the operational plan in order to ensure it is done and that the resources needed are available. The frequency of monitoring should be defined to allow implementers to correct the course of action. Monitoring will also tell you if something unusual is being reported, such as increased numbers of cases of a certain disease, and therefore action needs to be taken, and perhaps changes made to the operational plan.

If monitoring shows that the implementation of planned activities is behind schedule or that some important outputs are not reached (for example, a decrease in utilization of services), managers need to investigate the reasons for such a situation in order to take adequate corrective measures. For example, they may find that activities are not happening because the funds have not been received on time, because the expected health staff have not

been deployed in the area, because medicines or vaccines are out of stock, etc. Other challenges to timely implementation are more complex to understand: the target population may be reluctant to use the services or certain categories of stakeholders may be unhappy and resisting the implementation arrangements. Ideally, managers should try to understand the underlying reasons for such bottlenecks; for example, if the necessary supplies are out of stock, is this because the orders have not been placed on time, or because there were delays in supply? This should be done in collaboration with those who are directly responsible for implementing the activities and in a supportive manner. After examining underlying reasons for slow or delayed implementation, managers can apply corrective measures. Depending on the underlying cause of the problem, these may consist of increasing productivity, reallocating the necessary resources to meet the initial targets, etc. Correcting the course of action may require some amount of dialogue and negotiation; for example, pharmaceutical suppliers may be approached to discuss and solve delays in supply of medicines.

Some implementation bottlenecks may be addressed by managers who are directly responsible for the formulation and implementation of operational plans. Other kinds of bottlenecks are not directly under their control. Typical problems of this kind are delays in disbursement of funds to replenish the budgets of implementing units or perverse incentives created by provider payment methods used by national health insurance organizations. In such cases, the issue should be taken up with central health planning authorities and corrective actions should be taken by them or with their support.

Evaluation seeks to determine the impact of activities, typically after a fixed period of time. It will tell you whether the targets have been met both efficiently and effectively. The implementers themselves can and should evaluate their own performance, usually at the end of the implementation period. And, of course, evaluations are also often done by external evaluators.[V]

Following up on activity implementation should not only be done at local level (including community level); feedback to the national level at least once a year, for example, during the annual health sector review, is just as important.

V For more information, please see Chapter 9 "Monitoring and evaluation of national health policies, strategies, and plans" in this handbook.

Box 6.6

Is a specific operational planning workshop necessary?

Operational planning can be organized through a planning workshop, by operational staff at their worksite, and/or as a topic of discussion at one or a series of meetings with the district health coordinating body.

There are several options with regard to how to organize the operational planning: the common planning workshop, or planning by operational staff at their desks or worksite, or it can be made a topic of discussion at one or a series of meetings of the district health coordinating body. Of course, there is an option for a combination of these possibilities. If the workshop option is chosen, then a decision has to be made whether the workshop is held peripherally, or the involved parties are called to a central location for planning. The latter is often more convenient for the centrally located stakeholders (MoH and external donors). Doing the planning closer to the actual site of implementation, for example in the district, is more consistent with the principle that the best plans are done by those who will implement them.

In many situations, there have been a proliferation of planning processes, often consisting of workshops, involving the same participants. For example, separate workshops for disease control programmes, multilateral and bilateral agencies active in health, and the national planning process have been a common occurrence. This is to the detriment of work on the ground. It is particularly a problem in settings where health worker pay is low and workshops have become a source of income supplementation. Having said that, there are also numerous positive examples of countries where planning exercises were used to strengthen coordination between partners and to strengthen the implication of key actors in decisions related to health system strengthening. In the Democratic Republic of the Congo, for example, when the district model was implemented in the late 1980s, a three-week training package for district management teams was used as an opportunity to jointly develop an operational plan for each district.

A workshop can be useful for team-building and introducing new concepts. There are very few workshops that actually produce a plan, particularly if the planning process is not far advanced before the workshop is held. So, the participants have to take their initial draft back to the office and complete the planning matrix at their desks. Therefore, if a planning workshop is chosen, considerable work should be done on completing a draft before the workshop. Likewise, follow-up activities to support staff in completing their plans should be considered.

Operational planning is probably best done through a mix of on-the-job work, using a clear matrix with clear instructions, with the final product discussed and vetted through a meeting or workshop.

6.5 Who are the main actors involved in operational planning?

6.5.1 Planning is best done best by those who will be carrying out the plans

To some degree, everyone who is responsible for an activity in the operational plan should be involved in the planning for that activity. However, operational planning is often done by managers. That said, the most successful managers will have meaningfully engaged the staff that they supervise in developing the plan. In addition, other partners and stakeholders who are affected by the implementation of the plan should have a say in the operational plan itself.

For example, in the case of an operational planning exercise of a MoH unit, it would mean having consulted partner institutes and state agencies (bureau of statistics, inspector-general's office, etc.) and those working on health in other sectoral ministries of government offices (health advisor in the prime minister's office, health advisor in the ministry of finance, etc.). For a national disease-specific programme, it might mean consulting civil society organizations (CSOs) that have a large stake in how the operational plan is implemented.

In the case of operational planning at a district level, the entire district management team will need to be involved. Furthermore, representatives of community members, representatives from each health unit in the catchment area, and representatives of CSOs that are active in the health sector in the area should participate in the planning exercise. Private practitioners might also be included if they are willing, especially if their services are being included in some of the activities or they are partially financed by public funds.

Operational planning is best done by those who will be carrying out the plans, both by managers and staff and with other stakeholders who are affected in the implementation of the plan.

6.5.2 Multi-stakeholder arena (see Table 6.2)

Negotiating the agreements between the various departments, programmes, donors and non-state actors requires a lot of effort, good will, and political support at the highest level in many cases. Dialogue at all levels is important, but especially with implementing partners, which can be CSOs, community groups or religious organizations. For example, if immunization tactics include mobilization through religious leaders, then discussions with them must take place in order to negotiate their role and responsibilities in the operational plan.

Having a wide variety of stakeholders on board also implies that all parties are transparent about their budgets. This can be immensely helpful to avoid confusion and double reporting. Even though it is strongly discouraged, some stakeholder financial contributions may be separate from the online budget. In this case, a separate column in a table or spreadsheet

for these contributions can make the overall financial situation clear to everyone.

Operational planning involves many stakeholders, and thus negotiating between the various government departments, programmes, donors, and non-state actors.

In the era of the Paris Declaration,[VI] most agencies, and governments, are becoming more willing to share information. They should be encouraged to do so. New developments in information technology can support this effort, for example through shared online planning dashboards that relevant stakeholders can access.

Finally, when drawing up any operational health plan it is also necessary to identify stakeholders outside the government sector and decide to what degree their activities are included in the district operational plan.

VI The Paris Declaration on smart aid: five principles for aid effectiveness (http://www.oecd.org/dac/effectiveness/45827300.pdf, accessed 28 September 2016).

Table 6.2 Key stakeholders and their roles in operational planning

ACTOR	ROLE
MoH	▸ Ensures link between strategic and operational planning ▸ Provides clear guidance on operational planning (templates, tools, modalities, etc.) ▸ Technically supports budget centres in their operational planning processes ▸ Synthesizes and aggregates operational plans to feed into national health planning exercises
State and parastatal agencies (e.g. bureau of statistics, inspector general's office)	▸ Lead operational planning for their respective budget centres ▸ Liaise with MoH for guidance and technical support ▸ Ensure that all stakeholders relevant to the work of the budget centre are adequately involved in the operational planning process
Other sectors (e.g. education, labour, etc.)	▸ Where intersectoral action is needed to reach a specific objective or target, the relevant other sector(s) must be brought into the budget centre's operational planning process
CSOs	▸ Provide data, information and knowledge ▸ Ensure that CSO activities are aligned with and part of the relevant budget centre's operational plan
Regional/district health authorities	▸ Lead and coordinate at local level the operational planning process ▸ Bring all stakeholders on board into the operational planning process, ensure coordination between different activities ▸ Provide supervision and guidance for lower levels of the health system ▸ Implement operational plan ▸ Liaise with national level for guidance and coherence in plans across the country
Community groups	▸ Represent the community in operational planning dialogue ▸ Provide feedback on health services and system ▸ Work with local health authorities to implement operational plan, pointing out any bottlenecks and challenges when necessary
Private sector	▸ Participate meaningfully in district-level operational planning exercise ▸ Strategize with stakeholders how the private sector can contribute and work towards operational planning targets
Development partners	▸ Technically support budget centre where necessary to convene and coordinate operational planning exercise ▸ Actively participate in operational planning evidence examination, dialogue and debate ▸ Provide monies for implementation

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6.6 What if...?

6.6.1 What if your country is decentralized?

Shift in roles and responsibilities

The operational planning process in a decentralized setting must identify who is responsible for governance of the health system at whatever level the plan is being prepared. The operational plan must be developed in a manner that involves and can be understood by and sold to that entity, be it a local government council, a faith-based organization tasked with providing health services, or external funding agencies.

That being said, local government councils may have priorities that do not make sense to public health managers, and may not always reflect population needs. There are examples where public health programmes, such as primary health care, are neglected by local councils, while politically popular projects, such as building new hospitals and health centres, are given undue attention. The operational planners in a decentralized system will need to become educators and negotiators as well as public health professionals if they want to succeed.

It is also important to note that central-level planning authorities may also not have the right answers to a local health system's most pressing needs. Different types of experiences and knowledge will reside with different people and institutions, at different levels of the health system. Bringing those views and realities together in a process of frank dialogue will most likely yield the most pragmatic and effective results.

It is important that national health authorities be involved in the planning process before all the decisions are made and the resources have been committed. In countries that opt for decentralization after having had a long history of highly centralized services, this requires a large shift in attitude on the part of central-level planners, from command and control to guidance and facilitation. It is a shift that many have difficulty making.

In some countries, even ones that are highly decentralized in theory, grants from the central government are often earmarked for certain aspects of health, such as the core package of primary health care services or public health packages. It is important for the central authorities to define what decision-making freedom lies with the local government and the local health office.

Central authorities must reconcile and bring together various operational plans and ensure alignment with the overarching NHPSP. Clear guidance on the standards and services that decentralized levels of the government are expected, or required, to provide, is necessary here. In addition, the MoH should ensure that sub-national health authorities have key roles to play in the strategic national-level planning process – harmonization and alignment of local operational plans with overarching NHPSPs is then more likely to occur.[VII]

VII For more detailed information on planning in a decentralized context, please see Chapter 11 "Strategizing for health at sub-national level" in this handbook.

Keep in mind that newly decentralized authorities may not immediately have the necessary capacities and experience to adequately conduct the operational planning. Especially at the beginning of a decentralization process, heavy technical support and guidance should be provided and central-level authorities should set aside time and resources to build capacity at sub-national levels. The MoH should ensure that its guidance and support is temporary only and that over time, sub-national levels will completely take over.

Box 6.7

District health profile

A district health profile can be a useful tool at local level to establish an understanding of the health situation locally and build from there to do operational planning according to local needs. At a minimum, a district health profile will contain:

1. basic geographical information, including a map and catchment area;
2. demographic information, including population broken down by sex, age and ethnicity where relevant;
3. epidemiological information;
4. resources available, including health workers, facilities and finances; and
5. baseline service delivery information such as immunization rates, water and sanitation coverage, numbers of hospital beds, and outpatient visits, among others. Additional socioeconomic information on topics such as education, the state of the local economy and most common livelihoods, ethnicity, and special problems – such as conflict or environmental disruption – may be useful. The district health profile should not be excessively time-consuming in preparation.

When describing the district health profile it is important to decide how to account for, or at least acknowledge, health providers outside the government health sector. These may be formal providers, such as private practitioners and pharmacies, or informal providers, such as traditional healers and itinerant drug sellers. If there is dual practice, where government workers also work privately, that should also be acknowledged in the profile. Even if not a formal part of the operational plan, these types of practices have a large influence on the total amount of services provided in the health sector. Ideally, they would be part of the plan, although that is unrealistic in many, if not most, settings.

The amount of analysis done by each district or unit will depend to a large degree on the amount of autonomy or decision-making authority it has, and also to a certain extent on the amount of variation from the national norms. It is important to ensure that relevant data are collected at district level to allow data analysis at regular intervals for operational planning purposes.

6.6.2 What if fragmentation and/or fragility is an issue in your country?

Fragile states often refer to states that are in the midst of a conflict or disaster, or recovering from one. In such a situation, the operational planning process is even shorter term, often needing to be reworked in a matter of weeks or months, rather than a full year. Also, the services will focus on those things appropriate for emergencies. In such a context, flexibility and an eye for the likely political and economic evolution of the situation is crucial. Indeed, in fragile contexts, the environment and health situations are constantly evolving; this constant evolution calls for new actors with specific skills in emergency or disaster response to act in the field. This frequently creates a confusing overlap of responsibilities, with multiple agents, both internal and external, entering the service provision field. As difficult as it is in an emergency, it is key that a few talented and experienced individuals take on the role of coordination and planning. Ideally, the lead in this process is the government health care system, aided by external partners, not the reverse.[VIII] The most important aspect is that a solid process is put in place to track the changing situation and the new actors who come into play, and to engage multiple stakeholders in a productive dialogue. The operation plan must be flexible to adapt to these factors rapidly and effectively.

In some contexts, when the crisis is in its acute phase, stakeholders will most likely focus the majority of efforts and resources on vertical health programmes for the population subgroups in most need. However, if a crisis situation becomes more protracted and chronic, it is advisable to rely more on existing national or local structures, and their set-up to provide all types of health services for the whole population, and seek to strengthen them. In such a case, systematic involvement of local actors should be emphasized in order to ensure sustainability of jointly planned activities and smoothen the transition back to normalcy. In post-Ebola Guinea, for example, the three-year health systems recovery plan was designed based on input from 38 district operational plans, demonstrating the MoH's strong emphasis on sub-national levels as the operational unit of implementation. It should also be noted that the health systems recovery plan was explicitly made the first phase of the 10-year national health plan, instead of it being a separate or parallel plan – evincing the MoH's resolve to keep existing plans, structures and stakeholders as the foundation of the health system.

Operational planning in fragile states requires a shorter-term framework and an ability to be flexible in the midst of political and economic evolution.

Another major challenge in fragile states is human resources for health, as they tend to be more unstable, with health workers and their families often missing or on the move. The operational plan should include means of protecting the safety of health workers and their families to the extent possible.

VIII For a more detailed discourse on health planning in a fragile state context, please see Chapter 13 "Strategizing in distressed health contexts" in this handbook.

6.6.3 What if your country is heavily dependent on aid?

In some countries, the majority of funds for public health services come from sources outside the country. Even though these resources should all come from donors who follow the principles and practices of the Paris Declaration, it may unfortunately not reflect reality. This has been demonstrated in cases where third-party financers reserve the right to approve the part of the operational plan that they are financing before funds are released. This may occur not only with external donor support, but also when a national disease control programme reserves the right of approval for sub-sections of the plan.

Health planning stakeholders need to be informed in a transparent manner of the resources that can be expected and obligations that come with those resources.

An operational planner at local level needs to be informed in a transparent manner of the resources that can be expected and the obligations that come with those resources with regard to activities, time deadlines and reporting. Donor-funded services, especially those implemented by the district team, should be part of the district operational health plan. It may be necessary to add an additional column to the planning spreadsheet or database to reflect funds from sources other than the government budget. Ideally, the reporting would be on the same schedule as the government reporting, but that is not always possible. A means of easing reporting is planning in three-month blocks, so that one can mix and match the various reporting dates of the government and donors, if they are different. The central health planning authority can greatly aid districts or other operational health units in providing a format for planning that can be easily sorted for reporting activities by donor and by reporting period.

This means that it is essential to have a planning matrix or database that allows individual programmes, and their donors, to extract the information they need to monitor activities and keep resources flowing. If not, they will either bypass the general health planning process, or add programme- and donor-specific planning exercises, separate from the general health plan, neither of which is desirable. The planning processes must try to accommodate the reasonable needs of all stakeholders.

In fact, there have been cases where individual donors, or their implementation units, call in members of district health teams for planning exercises for their individual interest, separate from the over-all district operational plan or NHPSP. These individual programme plans have often been developed as a separate exercise from the unified district health plan with separate dates, budgets and lines of authority. There has been some progress on unifying the different planning exercises, but it is far from universal. Managers should try to avoid fragmented programme-driven or donor-driven plans and aim at integrating them in a unified district plan as much as possible.

The planning process becomes even more complicated if the operational plan has to be produced in more than one language. This can happen in situations where external partners require a copy of the plan in an international language, or when the country does not have a single national language. It is preferable to allow people to work in their own language for planning, but it can leave a large and difficult translation issue as deadlines are approaching. If translation is needed, time and resources will need to be allocated. It is important that it be an accurate translation so there are not multiple versions of the plan in circulation, something that can lead to a loss of confidence in the transparency of a health system.

6.6.4 What if your country has strong vertical health programmes?

The discussion in this situation is essentially the same as the discussion that occurs with donor dependence, but is also relevant when funding for vertical programmes comes from domestic sources. It is helpful if the central health planning office and the heads of the various vertical programmes, have agreed on formats and timetables for planning and reporting.

A key decision is whether reporting on activities will go through the general health programme and be consolidated as an entire health plan, or whether it goes through the individual vertical programmes and is consolidated by them and then reported to the broader health sector.

When there are relatively few vertical programmes it is manageable to have the reporting go through them. When there are multiple programmes, it becomes progressively more burdensome and problematic for lower-level implementers.

However, central health planners cannot be excessively dogmatic on this issue, particularly where funding flows are specifically earmarked for certain programmes. A task of the central health planning authority is to help the lower level operational planners cope with multiple programmes by providing clear guidance on a national strategic direction (as spelled out in the NHPSP) for the health sector, with norms for the health district and its facilities, and tools and procedures in place to implement those norms. Otherwise, it is likely that some vertical health programmes, at least those that are well-funded, will just ignore the general health planning process.

Guidelines on how to include vertical programmes in the operational plans should be provided, where to fit their activities and funds into the matrix, and how to ease the reporting requirements. If at all possible, planning processes for the vertical programmes and the overall district health plan need should be unified in both time and place.

If the national planning processes do not make it easy to have a unified district operational health plan, a proactive district health management team can do it, to at least a partial extent, on their own. A proactive district management team can gain trust and recognition if the process of integrating the various plans is participatory (and using existing coordination mechanisms), accountable and transparent for everyone.

Searching for synergies between different programmes in the health sector has been a common topic of discussion.[15] Where the national authorities have been unable to build a guidance framework, the local level can do it, mainly because it is often the same individuals or team who are implementing the various vertical programmes. In such cases, putting resources (human or material) from vertical programmes in common and integrating activities is possible at the level of the operational plan.

Coordination and cooperation in developing a unified plan can be achieved. Then the various component plans can be grouped out of the matrix and sent off to the approvers as required. It is not an ideal situation, but one that can produce a positive benefit for the community. For example, mosquito nets can be delivered during immunization outreaches with mutual benefit to both programmes. Sometimes the operational problems can be solved on a local level more easily than in the capital.

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6.7 Conclusion

Operational planning, as the term indicates, "operationalizes" a strategic plan that defines the vision, goals and objectives for the health sector. Operational planning is managerial and shorter term, and deals with day-to-day implementation. It is where concrete activities are planned for at the operational level.

The operational planning process has the potential to greatly assist stakeholders in gaining a better understanding of the NHPSP target population and its needs, as well as stakeholders' own capabilities and limitations in implementation. Especially when defined jointly, an operational plan is critical for the clarity it offers as to what needs to be done, by whom, how and with which monies.

In this chapter, the core content of the operational plan is discussed, as well as the steps in the plan development process. The various roles and responsibilities of stakeholders are also examined. For two of the principal stakeholder groups, the main take away messages are below.

6.7.1 Key take away messages for the central health planning authority

(a) Operational health planning is the connection between strategic objectives and activity.

(b) The best operational plans are written by the people who carry them out.

(c) The central health planners have an obligation to provide clear guidelines to operational planners with regard to operational plans. It is important that deadlines are known, formats are clear, the degree of decision-making authority is known to all, and the approval process is transparent.

(d) A clear guidance framework, with orientation on the content, in an easy to use form of information technology should be provided by the central planning unit.

(e) The central health planning unit should aim to facilitate and assist operational planners rather than taking over the process.

(f) The weakest operational planning units should not be penalized for not producing their plans. Rather, adequate resources should be dedicated to support them in the operational planning process.

6.7.2 Main points for operational planners to keep in mind

(a) Everyone is an operational planner.

(b) Operational plans are a necessary management tool.

(c) Operational planning should involve a wide range of people rather than be dictated by the manager/boss. At the minimum, all those who are expected to implement the plan should be involved in the process.

(d) Operational plans should be open to revision as circumstances change.

(e) Coordination and cooperation can occur at the local, operational level, even if the methods for doing so are not yet well worked out at the centre.

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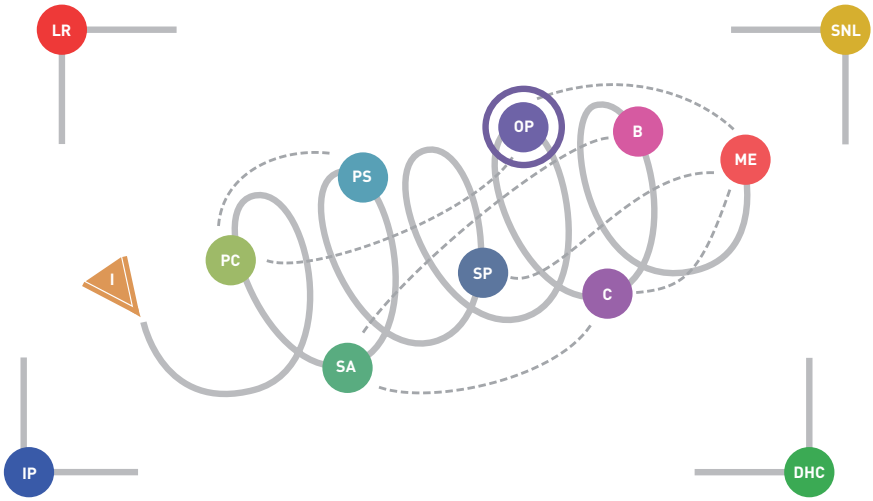
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