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ABSTRACT

Background: About 88%, 8%, 36% and 28% of the ministries of health in African countries do not have long-term health plans (LTHPs), health policies (HPs), strategic plans (SPs), and operational plans (OPs), respectively. Eight per cent, 38% and 54% of the countries with OPs rated their formulation as 'excellent', 'satisfactory' and 'needs improvement', respectively.

Objective(s): To provide a rationale for an OP; to describe its contents; and to explain the process of developing it.

Design: Descriptive study.

Setting: Operational plans in the WHO African Region.

Interventions: Non-intervention descriptive study.

Main outcome measures: Operational plan (OP) for health.

Results: An OP framework and process that could be adapted by countries is proposed.

Conclusion: An adequately formulated OP will contain objectives, targets, expected results, activities, required resources, and a monitoring and evaluation plan (consisting of responsibilities, monitoring indicators, evaluation indicators, data sources - for verifying indicators, and periodicity). In the next two decades, we envision that all the UN agencies and other health partners working in Africa will cooperate with individual countries to develop (or strengthen) LTHPs, HPs, SPs, and OPs of the Ministries of Health (national, provincial and district level).

INTRODUCTION

Alice: Which way should I go?

Cat: That depends on where you are going.

Alice: I don't know where I'm going!

Cat: Then it doesn't matter which way you go!!

Lewis Carroll, 1872

Through the Looking Glass

An operational plan (OP) is a course of action which relates to *how* to solve identified problems. Its development presupposes the existence of a sound long-term health plan (LTHP), health policy (HP) and a medium term strategic plan (SP). The LTHP provides a long-term vision for improving the health of communities. It answers the question: "Given the prevailing environment (strengths, weaknesses, threats, and opportunities), *where* are you going?" The HP expresses the political commitment for implementing the LTHP. It addresses the question: "Is there political will, and hence,

necessary resources for operationalising the LTHP?" SP relates to *what* shall be done to operationalise the LTHP. They respond to the question: "How do you get there?" And finally, the OPs implement the SPs. The LTHP, HP and SP provide a sense of direction to Ministries of Health - providing a mission statement, clarity about the scope of operations, and a set of goals and objectives - without which the ministry, like Alice, is adrift. The three policy plans are indispensable reference documents during the OP development process. Given the frequent changes in occupants of various high level Government offices in different African countries, it is critically necessary to involve the national civil population and other health development partners in the whole process of developing the three policy plan documents. This will ensure that such changes in occupants of Government offices, do not negatively impact on the continuity in the implementation of policy plans. To date, top management in Ministries of Health have made a strategic mistake of relegating the policy planning process to planners. We believe that deciding the future health course of a nation is the task of

the top MoH management (for example, Ministers, permanent secretaries and directors of medical services) - a task that cannot and should not be delegated. We agree with Goodstein and Nolan(1) that the proper role of technical staff (including MoH planners) in this process is to serve as a resource to the management planning group, conduct research, generate data, and develop alternative ways of implementing the action steps that emerge from the policy planning process. Detailed discussions of the three policy plans is beyond the scope of this paper. However, we shall devote our attention to a discussion of the rationale for having an OP, its contents and how to formulate it.

For effectiveness and efficiency, we envision a shift in this millennium from narrowly defined programme-based planning to planning broadly based on integrated programmes (for example, health systems; communicable diseases surveillance, management, prevention and research). A typical District Health Management Team (DHMT) would have an OP document consisting of as many OPs as the number of integrated programmes.

RATIONALE FOR AN OPERATIONAL PLAN

There are a number of reasons why each DHMT needs to have well formulated OPs. First, they provide a framework for action that is embedded in the mind-sets of the national health policy-makers, DHMT, district health management board, and all other concerned parties. Such a framework systematises planning by providing a DHMT with a basis for assessing situations similarly, discussing the alternatives in a common language, and deciding on actions (based on shared values and understandings) that need to be implemented in a reasonably short period (e.g. 1 to 3 years). Second, they enable the DHMT to unleash the energy of the district behind a shared vision (as reflected in the national LTHP, HP and SP) and a shared belief that the vision can be fulfilled. Third, development of the OPs and the implementation process increase the capacity of the Ministry of Health to implement the SPs completely on a timely basis. Fourth, the development of the OP and the implementation process help the MoH develop, organise, and utilise a better understanding of its clients (actual and potential) and the environment in which it operates, as well as its own capabilities and limitations. Fifth, the development of OP provides an opportunity on at least an annual basis to constantly adjust to current events (e.g. disease patterns, changing roles of the state, change in political regimes, and other macroeconomic scenarios) and actions by other actors in the health sector. Sixth, the operational planning, monitoring and evaluation processes should provide the proper incentives to DHMTs to effectively and efficiently deliver health care. Seventh, the OP helps DHMTs and individual managers to gain better understanding of the parameters involved in their decisions and, thereby, better assess the risks that they must take. Eighth, the development of the OP and

monitoring process enable the DHMTs (and indeed the MoH) to gain a better understanding of how the macroeconomic, technological, political, health (disease patterns), financing, degree of governmental presence, degree of other providers presence, donors and internal (distinctive strengths and weaknesses) environments should be monitored. Ninth, given the imperfections in health care markets, the OP development process can be used in pursuit of efficiency goals. The latter benefit would only accrue if the officers in charge of formulating OPs carefully link the budgetary allocations to expected results. For example, if expected result A saved Y disability adjusted life years (DALYs) at \$k, whereas expected result B saved more DALYs at the same or a lower cost, then the latter should receive more resources.

CONTENTS OF THE OPERATIONAL PLAN

The OPs of the national Ministry of Health (MoH) will consist of horizontally and vertically integrated OPs of the districts. Thus, the MoH Headquarters will have to collect, review and integrate OPs developed by DHMTs in all the districts. In addition, the headquarters would review all budgets embodied in the District OPs to ensure that they are adequate for implementing the OPs. If the OPs are too optimistic, given the available resources, it may be necessary to ask concerned DHMTs to scale them down.

Prior to developing OPs, the DHMT needs to establish priorities. Typical questions include the following:

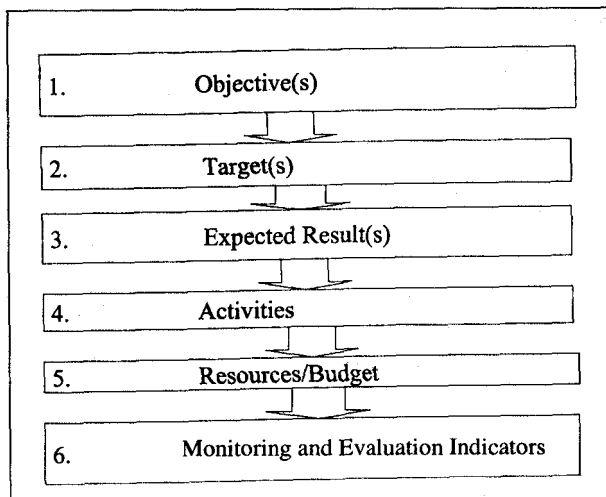
- What are the health problems in the district? What are their magnitudes, relative impacts, and vulnerability to attack by known and available means? This entails a health situation analysis.
- What is the full set of integrated programmes (i.e. relevant to the district)? This would entail grouping health problems into broad bands, e.g. health systems; communicable diseases surveillance, management and prevention; health promotion issues; etc. Planning in terms of broad integrated programmes obviates unnecessary duplication of effort and the ensuing wastage of scarce resources.
- Which integrated programmes should get more attention early in the implementation and which can wait until later? This will depend on the assessed cost-effectiveness of intervening into various integrated programmes.
- Within the priority integrated programmes, are some health problems more important than others? If yes, which ones should get more attention early in the implementation and which can wait until later?

The priority setting process ought to be guided by economic evaluation(2).

The next task would be to develop an OP for each integrated programme established to be a priority. Each OP will contain the following planning elements (Figure 1).

Figure 1

Operational plan (OP) components



- a. **Objective:** This is the end result that a programme, a project or an institution seeks to achieve(3).
- b. **Target:** This is a quantified specific objective to be reached within a given time frame(3). Thus, by definition, targets ought to be realistic and measurable, and should reflect the expected date of completion. There should be at least one target for each of the objectives specified for each area of work.
- c. **Expected result:** This is an observable and/or measurable product, service, effect or outcome produced by an activity or a set of activities using the allocated resources(3). There should be at least one expected result per target.
- d. **Activity:** This is a set of tasks needed to produce an expected result(3). There ought to be at least one activity per expected result.
- e. **Resources/budget:** This is the monetary value of the inputs allocated to each activity. The allocation of the resources should be guided by proper costing of the relevant planned activities. In addition, the resource allocation should be proportional to the expected impact on people's health (that is, both quantity and quality of life). In other words, the limited budget for an integrated programme should be invested in those expected results whose impact on health status, at the margin, is highest.
- f. **Monitoring and evaluation plan:** This includes monitoring and evaluation responsibilities; monitoring indicators; evaluation indicators; data sources (for verifying status of indicators); and periodicity of monitoring and evaluation. PAHO(4) defines an indicator as a variable with characteristics of quality, quantity and time used to measure, directly or indirectly, changes in a situation and to appreciate the progress made in addressing it. The indicators should be valid, reliable, sensitive and specific to facilitate monitoring, as well as evaluation of effectiveness and

efficiency. It is important to note that we monitor the implementation of planned activities and evaluate the degree of achievement of the expected results.

PROCESS OF DEVELOPING DISTRICT OPERATIONAL PLANS

We envision that the process of developing an OP document will involve seven steps.

STEP 1: Minister of Health, Permanent Secretary or Director of Medical Services Issues a Memo to all DHMTs Chairpersons

The purpose of this step would be to:

- emphasise the importance of the OP development;
- disseminate the guidelines for preparing the OP;
- officially delegate responsibilities to the DHMTs; and
- convey the deadlines the activities related to the OP.

STEP 2: DHMT to Hold an OP Preparatory Meeting with all OP Managers

The objectives of step 2 would be to:

- confirm long-term and medium-term national and district health priorities, objectives, targets and expected results as stipulated in the LTHP, HP and SPs;
- define and prioritise the broad integrated programmes relevant to the district;
- allocate the district health budget to the priorities;
- disseminate and explain the OP guidelines;
- assign responsibilities for the OP development exercise (will mainly entail nomination of focal points for the areas of work); and
- draft a schedule of activities related to OP development.

STEP 3: Managers of the Integrated Programmes OPs

In step 3 the Managers for the Integrated Programmes OPs will:

- identify the relevant long-term and medium-term national and district health priorities, objectives, targets and expected results as outlined in the LTHP, HP and SPs related to their area of work; and
- formulate or reformulate various OP elements, including objectives, targets, expected results, activities, budgets, and monitoring and evaluation plans specific to their areas of work.

STEP 4: Peer Review of Integrated Programmes OPs

The purpose of step 4 is to ensure:

- the individual OPs are consistent with LTHP, HP and SPs;
- there is no duplication of planning elements across areas of work;
- adequacy (including linkage) and relevance of planning elements;

- adequacy of resources allocated to the activities; and
- resource allocation to various expected results is consistent with the magnitudes of expected health returns.

STEP 5: Send Draft District OP Documents to MoH HQ

The purpose of step 5 is to ensure:

- that the district OPs are consistent with LTHP, HP and SPs;
- synergy across areas of work;
- adequacy and relevance in the formulation of planning elements (including costing of activities); and
- equitable distribution of resources across districts.

STEP 6: Finalisation of the OP Documents at the District Level

The goal of step 6 is for DHMTs:

- to review OPs to incorporate comments from MoH HQ; and
- to prepare Monitoring and Evaluation Plans.

STEP 7: Approval of OP Documents by the Director of Medical Services, Permanent Secretary and Minister of Health

The deadline for approval of the OP documents by the Minister of Health should be a month before the parliamentary approval of the national budget. The readers should refer to BOX 1 for a hypothetical OP example.

BOX 1: Operational Plan for a Hypothetical 'Women's Health' Integrated Programme

1. Objective

To eliminate domestic and sexual violence against women, and existing harmful traditional practices, particularly female genital mutilation.

2. Target(s)

By end of 2005, DHMT will have reduced the incidence of domestic and sexual violence against women and existing harmful traditional practices by 80%.

3. Expected Results

- 3.1* All health facilities with copies of the women's health national policy and legislation.
- 3.2* All health facilities in the district with a plan of action on 'womens health'.
- 3.3* A databank on womens health established at the district headquarters.
- 3.4* All health facilities with one community nurse trained in clinical psychology, domestic and sexual violence traumor management, and counselling.
- 3.5* All health facilities in the district with an operational women's health consultation unit.

*4. Activities**

- 4.1* Print and distribute copies of the women's health national policy and legislation to all facilities in the district.
- 4.2* Organise a three day DHMT and DHMB workshop for developing a plan of action for womens health.
- 4.3* Print and distribute womens health plan of action to all health facilities in the district.
- 4.4* Contract a local consultancy company to undertake studies on prevalence and incidence of domestic and sexual violence againt women in the district.
- 4.5* Establish a databank on womens health at the district headquarters.
- 4.6* Organise a four week workshop in the district for community nurses on clinical psychology, domestic and sexual violence trauma management, and counselling.
- 4.7* If not already available, construct and equip womens health consultation rooms in all health facilities in the district.

*It is critically important that resource requirements are costed at the level of the activities and aggregated for each expected result.

5. Resource Requirements

Expected Result 3.1: Pesa \$10,000

Expected Result 3.2: Pesa \$25,000

Expected Result 3.3: Pesa \$25,000

Expected Result 3.4: Pesa \$30,000

Expected Result 3.5: Pesa \$150,000

6. Monitoring and Evaluation

6.1 Monitoring and evaluation responsibilities

District Health Officer of Health (the Chairperson of the DHMT) will be ultimately responsible. However, s/he will be supported by the officers in-charge of women's health at the health facilities.

6.2 Monitoring indicators

Existence of evidence that:

- copies of the women's health national policy and legislation to all facilities in the district.
- a workshop for developing womens health a plan of action was organised.
- womens health plan of action was printed and distributed to all health facilities.
- prevalence and incidence of domestic and sexual violence againt women in the district.
- a workshop was held in the district for community nurses on clinical psychology, domestic and sexual violence traumor management, and counselling.

6.3 Evaluation indicators

- The incidence and prevalence of domestic and sexual violence.

- Percentage of health facilities in the district with copies of the women’s health national policy and legislation.
- Percentage of health facilities in the district with copies of women’s health plan of action.
- Percentage of health facilities in the district implementing the womens health plan of action.
- Evidence of a databank on womens health at the district headquarters.
- Percentage of health facilities with at least one community nurse trained in clinical psychology, domestic and sexual violence traumor management, and counselling.
- Percentage of health facilities in the district with an operational women’s health consultation unit.

6.4 Data sources

Monitoring and evaluation data would be obtained from: health facility women clients surveys, the databank on women health, and monthly health facility reports.

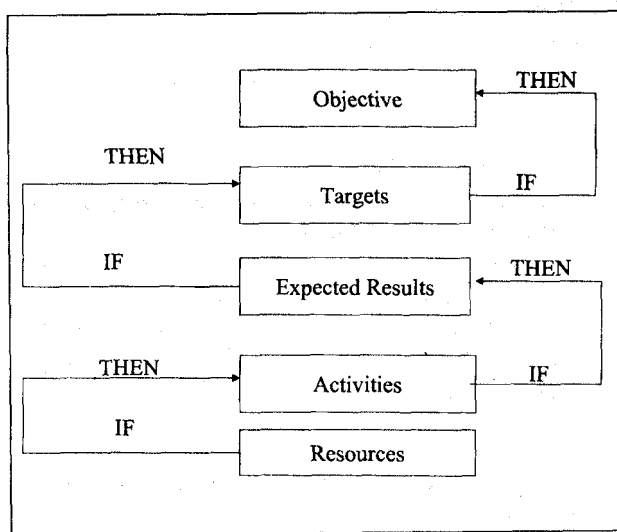
6.5 Periodicity

Formative Evaluation: End of each year of the OP period.
Summative Evaluation: End of the OP period.

The DHMT ought to carry out two forms of assessment (i.e. assessment of relevance and adequacy) while developing their OPs. The former entails verifying whether the planning elements (i.e. objectives, targets and expected results) are consistent with the national health priorities as stipulated in LTHP, HP and SPs and with each other. The latter (adequacy) is an evaluation of the extent to which sufficient attention was paid to the formulation of the OP objectives, targets, expected results, activities, resources and evaluation indicators. At issue is whether the planning elements in their totality can make a difference in the health situation (Figure 2).

Figure 2

Logic of an OP: a set of linked hypothesis



CONCLUSION

We could not agree more with the Office of Analysis and Strategic Planning of PAHO(4) that “If an health care manager cannot or does not formulate, in advance of the time required for action, his/her (plan of action) in writing and in detail, s/he cannot for sure know what s/he is doing.” Well-formulated district health OPs are a necessary condition for the achievement of district and national health missions and goals. The LTHPs, HPs and SPs are necessary to guide the development of sound OPs. Thus, the countries in the African Region which do not have those documents need to urgently make arrangements for their development. In the new millennium, we envision that all the UN agencies and other health partners working in Africa will: cooperate with individual countries to develop (or strengthen) LTHPs, HPs, SPs, and OPs of the Ministries of Health (national, provincial and district level); make complementary investments in building technical and administrative (institutional and systemic) capacities for evaluating the implementation of OPs; coordinate their support to countries to obviate wasteful duplication of effort and ensure synergy; support only health activities contained in the OPs; avoid the temptation of “parachuting” into countries to develop OPs for countries, because that will only serve to propagate the chronic disease of economic, intellectual and technological dependency. Instead, there ought to be genuine desire to work together with countries to build national capacity for planning, implementing, monitoring and evaluating their programmes.

We recognise that some countries have different organizational infrastructures, with one or more layers existing between the national and district levels. In those countries, the steps specified in this article could be adapted to accommodate the specific roles that could be played by these intermediate layers in the formulation of the OPs.

We also recognise that the nomenclature may differ in certain countries with regard to the various planning elements. What is important is that a hierarchy exists among the existing elements to enable the formulation, implementation, monitoring and evaluation of realistic OPs.

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