World Health Organization

Strategizing national health in the 21st century: a handbook

Chapter 5

Strategic planning: transforming priorities into plans

Frank Terwindt

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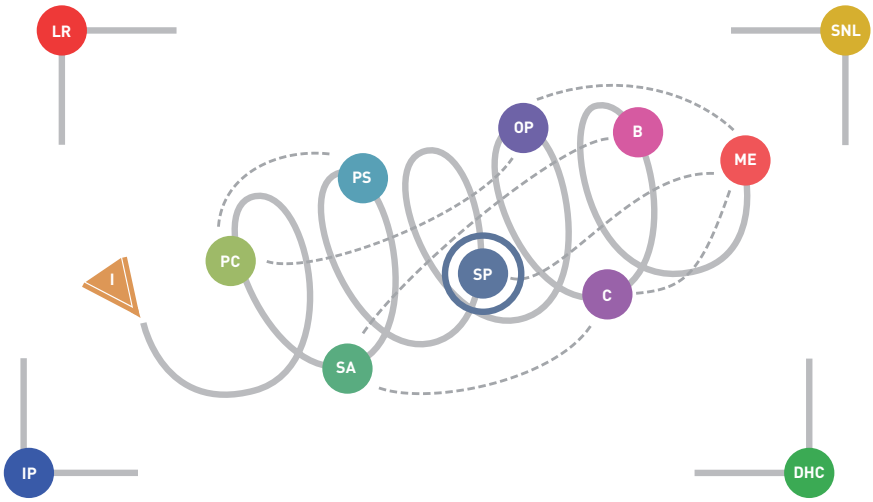

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Overview

In health, strategic planning aims at identifying, sequencing and timing medium-term interventions for the health sector in a comprehensive way. The end product is the sector strategic plan which guides the activities and investments that are necessary for achieving medium-term outcomes and impact.

In line with this definition, the purpose of strategic planning in health is to define a medium-term orientation and focus for the

development of the health system. Decision-making should be based on a thorough analysis of the current situation, lessons learned from previous plans, expected available resources and chosen priorities.

In this chapter, guidance is provided on developing a relevant NHPSP that is referred to, consulted and used. Steps are proposed to manage the NHPSP development process and common challenges and mistakes are pointed out with suggested solutions.

Summary

What is strategic planning?

In health, strategic planning aims at identifying, sequencing and timing medium-term interventions for the health sector in a comprehensive way. The end product is the medium-term sector strategic plan that guides activities and investments necessary for achieving medium-term outcomes and impact.

Why is it important to transform priorities into a plan?

Key reasons for transforming priorities into plans are:

- to concretize priorities;
- to keep focus on the medium to long term without deviating from the optimal path;
- to avoid fragmentation of the health sector;
- to help focus the policy dialogue on health sector priorities;
- to guide operational planning, resource allocation, and sector monitoring and evaluation.

When should operational planning take place?

In the context of ongoing comprehensive health sector development, strategic planning is an iterative process that should be conducted every 3–5 years (medium-term). The strategic planning exercise generally comes after the phase of priority-setting and precedes operational planning.

Who should be a part of strategic planning?

Strategizing for health will be more effective if a wide range of stakeholders are involved in it, and both the process and the product are truly owned by the country. To make the process effective, health sector stakeholders will need to come to a common understanding of the key issues and share institutional goals and expectations. Such an inclusive approach is likely to be more potent, not only in terms of planning the right vision and activities, but also in ensuring that implementation of the strategic plan is jointly undertaken by all actor groups.

How do we transform priorities into plans?

In this chapter, guidance is give on:

- preparation of NHPSP development;
- setting goals (or strategic directions) in line with commonly agreed priorities;
- setting objectives in the form of targets (and their baselines);
- formulating broad activity areas;
- providing orientation on NHPSP implementation;
- approval and dissemination of the NHPSP;
- NHPSP document structure.

Anything else to consider?

- decentralized environment;
- fragile environment;
- highly aid-dependent context.

5.1 What is strategic planning?

5.1.1 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 achieve explicit objectives.[1] Planning also includes organizing and preparing the necessary interventions for meeting those objectives.

In terms of timing, three types of planning can be distinguished in health sector development:

1. long-/medium-term planning, which is mostly used for strategic orientation;
2. short-term planning, which guides operational aspects of implementation;
3. ad-hoc plans/disaster preparedness plans, which are necessary in a situation of important unforeseen developments.

Three characteristics of strategic planning, different from those of operational planning, taken from entrepreneurial business theories, are:

1. a long-term, rather than a short-term, focus;
2. a comprehensive, "whole-of-business" perspective, rather than a collection of divisional business plans;
3. a concern to "fit" the business within the external environment expected to affect the business in the longer term.

In health, strategic planning aims at identifying, sequencing and timing medium-term interventions for the health sector in a comprehensive way. The end product is the NHPSP, which guides activities and investments necessary for achieving medium-term outcomes and impact. The details on implementation of the NHPSP, i.e. the most appropriate course of action to fulfil the goals or strategic directions of a NHPSP, are reflected in operational plans (see Fig. 5.2).

Strategic planning aims at identifying, sequencing and timing medium-term interventions for the health sector in a comprehensive way.

In line with this definition, the purpose of strategic planning in health is to define a medium-term orientation and focus for the development of the health system, based on a sector vision, policies, strategies and priorities. In essence, it is the development of the NHPSP.

In strategic planning, decision-making is based on a thorough analysis of the current situation, lessons learned from previous plans, expected available resources and chosen priorities.

Health sector strategic planning covers:

- delivery of comprehensive health services, including personal and non-personal, clinical and non-clinical services;
- support functions for health service delivery;
- health systems governance;
- health research;
- overall health systems development;
- reforms (institutional, organizational and administrative, including for decentralization);
- collaboration/coordination with other sectors.

5.1.2 Strategic planning in relation to other phases in the policy and planning cycle

Health sector strategic planning includes:

- sequencing and timing;
- attributing general responsibilities;
- linking interventions (activities and investments) with resource attribution;
- establishing a sector monitoring and evaluation system that allows for measuring implementation (inputs and outputs), effectiveness and result (outcomes and impact), as well as adjustments of the plan in the course of its implementation, as per need.

In any case, NHPSP development is in a sense an ongoing process. While the overarching NHPSP document is developed jointly by health sector stakeholders once every 3–5 years, an adjustment for an area-specific strategy such as, for instance, community health or malaria, may be slightly earlier or later but impacts on the core substance of the NHPSP. In the same vein, specific activities may require a separate strategy, such as performance-based financing, which will affect the NHPSP content. In practice, only very major changes and events elicit a completely new NHPSP. Smaller changes can be taken into account through modifications to the operational plans, which are more flexible and closer to the actual tasks undertaken on the ground.

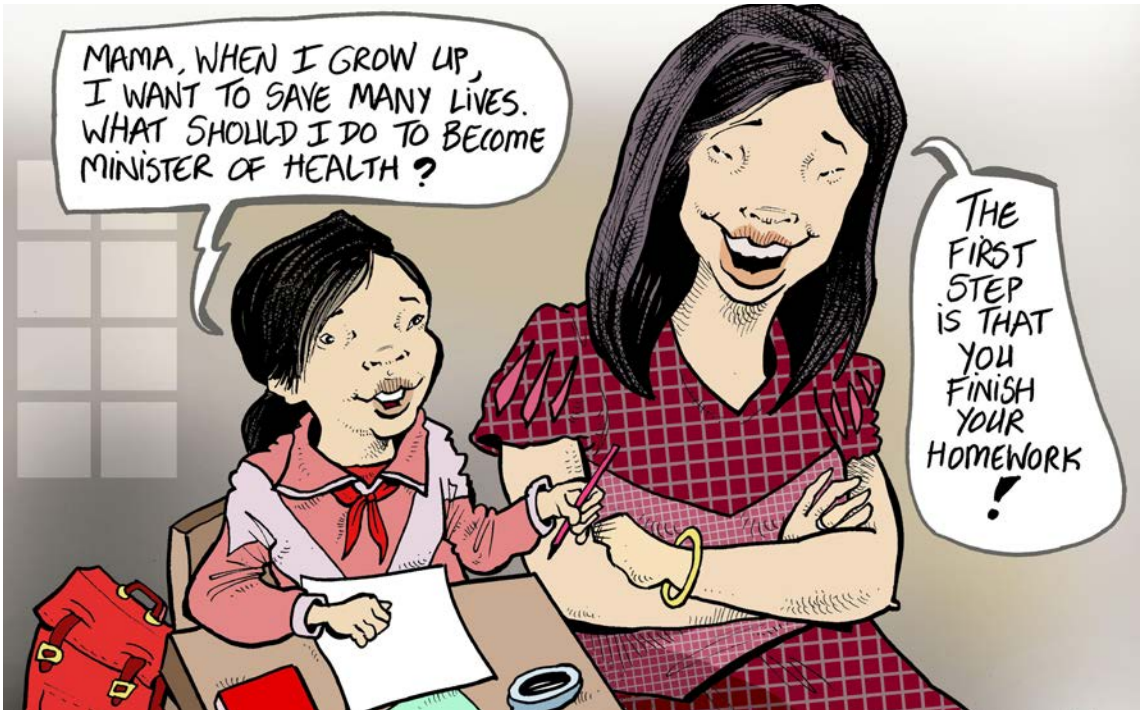
A strategic plan defines above all the direction in which the health sector should go, while an operational plan describes in detail how to get there.

(a) Strategic planning vis-à-vis operational planning

The processes for strategic and operational planning can be viewed as a continuum made up of a series of "whats" and "hows".[2] A strategic plan defines above all the direction in which the health sector should go, while an operational plan describes more in detail how to get there.[I] For example, "strengthen primary health care services" can be an objective of a strategic plan. The strategic plan may then lay out proposed broad activity areas for strengthening primary health care services, such as "ensure implementation of the essential health services package". An operational plan would detail the activities to be undertaken to provide the services mentioned in the essential health services package, such as "training programme on nutrition for district hospital staff" or "support and supervision visits by district health management team".

Operational plans specify the different activities which are suitable to implement the strategies. The strategic plan takes a longer-term view (generally 3–5 years or more), while operational plans focus on shorter time segments (annually, semester, quarterly, monthly) (see Table 5.1).

I See Chapter 6 "Operational planning: transforming plans into action" in this handbook



Damian Glez; scenario by Bruno Meessen.

Fig. 5.1 Strategic planning: sequencing actions to reach a long-term vision

Table 5.1 Key characteristics of strategic and operational planning

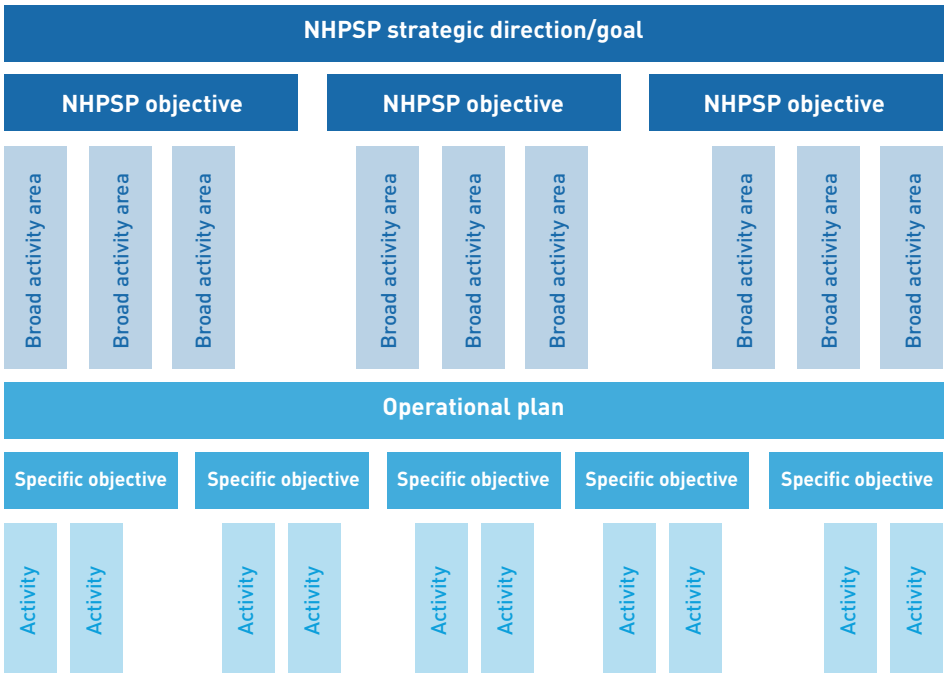
	STRATEGIC PLANNING	OPERATIONAL PLANNING
PERSPECTIVE	Medium- to long-term development	Short(er)-term interventions
FOCUS	Strategic direction for the health sector	Concrete activity implementation
TIME FRAME	3- to 5-year document	1 year, sometimes shorter time frame
FLEXIBILITY	Less likely to change during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

Operational plans are sometimes also called implementation plans. This can lead to confusion because strategic plans are also implemented. Also, operational plans are sometimes considered to be plans specifically for middle- and lower-management levels. This is incorrect, as high-level staff at the central ministry of health (MoH) work on the basis of both the sector strategic plan as well as on their unit's operational plan.

Operational plans must be linked to the strategic plan (see Fig 5.3) by defining the actions that are to be taken to produce outputs in a specified period of time as defined by the strategic plan.

The operational plan should identify the resources required, activities to be carried out and those involved in and responsible for carrying them out. For the strategic plan, there will always be a certain degree of uncertainty about the feasibility to achieve outcomes and impact, as it will depend on the details of implementation during a medium term (approximately five years) period which one cannot always foresee. By contrast, the feasibility to fully implement the operational plan must be assured as much as possible. For a time horizon of one year or less, this is possible because targets, responsibilities and resources are quantified and the operational plan is usually linked to an approved sector budget.

Fig. 5.2 Link between the strategic (NHPSP) and operational plan



Box 5.1

Linking strategic and operational planning in the United Republic of Tanzania[3]

The United Republic of Tanzania's health sector is guided by its national health sector strategic plan, which is implemented through operational plans at different levels of the health system, including in districts. The MoH provides overall strategic directions, guidance, supervision and training for districts in operational planning, with the aim of bridging the strategic plan at a national level with operational plans on the ground. In 2007, the MoH developed training manuals for this purpose, in the recognition that district operational plans in the past had very little linkage to broad NHPSP objectives and activity areas, thus rendering the tracking of long-term objectives difficult.

The training module encourages districts to study the NHPSP objectives and discuss with MoH planners how those objectives can be realistically operationalized at district level, given the donor landscape, local epidemiology and public health needs.

(b) Strategic planning vis-à-vis costing and budgeting

Strategic planning and costing go hand in hand.[II] The initial, more approximate, cost estimation should be considered as a reference point to inform the strategic planning process, while further fine-tuning of cost calculations should reflect a back-and-forth dialogue with health planning stakeholders. Understanding the costs and resource implications is imperative to the policy dialogue on the affordability of the stated aims of the NHPSP, and more importantly, whether they are feasible and realistic, given the existing state of the health system.

In order to ensure realism of the exercise, it is imperative that the link between planning and costing is very strong from the beginning – any NHPSP discussion on planned reforms and targets should take into consideration the resource requirements. The process is highly iterative because planning decisions must take into consideration operational and financial feasibility, while the cost projections need to adjust between planned activities and available fiscal space.

A cost estimation of a NHPSP can thus help anchor the planning process in reality. The costing process often serves to demonstrate that a NHPSP may be too aspirational, in that it does not consider the constraints of limited financial resources available. The costing needs to be combined with realistic projections of available

II See Chapter 7 "Estimating cost implications of a national health policy, strategy, or plan" in this handbook.

financing (all sources included), in order for the analysis to be credible. Countries may use frameworks such as the Medium Term Expenditure Framework (MTEF) or other approaches to organize and present the information.[III]

If a MTEF is being developed simultaneously with the NHPSP, it is possible to go back and forth between the drafts of both documents before finalizing them, in order to ensure that they are compatible.

5.1.3 A brief overview of strategic planning approaches

(a) Health sector planning may be more top-down or more bottom-up

In top-down planning cycle stages, terminology and orientation are predetermined by the central level for the whole planning process, starting with overall design, goal and objective-setting, up to implementation modalities, possibly even targets. The lower levels of the health system are mainly seen as implementation arms of the central level. In bottom-up planning, the central level acts to support managers and directors of different budget centres (where the operational planning will take place) in the identification of issues that are important and relevant to them, which helps feed into the strategic planning process. The input from the various operational units is then used as the principal starting point for central-level planning.

In the context of this chapter, we categorically advocate for the latter approach, with a process as participatory as possible, bringing in a wide range of expert and non-expert stakeholders at various points during the health policy and planning cycle.

In reality, many countries may practice a mix of top-down and bottom-up planning. Bottom-up planning does not mean a disengagement of the central level – instead, the central-level health authority has a pivotal role to play in providing guidance and collaborating with the different health sector institutions and sub-national entities to ensure alignment with the strategic directions given by the NHPSP.

(b) Strategic planning may be done in a more normative or a more flexible way

If the approach is normative, it is a rational, orderly progression of predefined steps in a policy cycle, usually set by the central health authority. In such a situation, the central-level decision-making capability tends to be located at the top, concentrated at the level of a limited number of actors from senior management.

Strategic planning can be approached in different ways: top-down or bottom-up; normative or flexible.

If the approach is more flexible, it allows for a certain degree of autonomy of the various interest groups, population groups and government agencies involved in the planning process. The emphasis here is on discussion and negotiation where a pragmatic path helps to sift through the often divergent values and views.

Again, in reality, many countries practice a mix of both. One can also have a normative bottom-up as well as a flexible top-down approach. A certain level of normative central-level guidance and authority is necessary to ensure coherence across the different topics discussed as well as consistency across geographical regions. The central level should approach its collaboration with other stakeholders in the spirit of a partnership, where all views are taken into consideration in a balanced way and feed into the final decisions made collectively. Flexibility is necessary here in order to accommodate and/or challenge the diverging views.

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5.2 Why is it important to transform priorities into a plan?

Priorities must be translated and articulated into a written strategy and orientation for action. The rationale for this is elaborated upon in this section.

5.2.1 To concretize priorities

A good strategic plan translates long-term sector vision and priorities into concrete implementation phases and incremental steps, thereby providing a medium-term horizon for overall sector development. This ensures continuity and direction of the longer-term priorities, considering that many problems are complex and cannot be solved within a short time frame.

Strategic planning is a function that – if well done – translates leadership vision, objectives and priorities into a robust document that will ensure not only effective and smooth implementation of activities but also efficiency and sustainability. If one views all of the health planning stakeholders as co-managers of the health sector, a strategic plan is necessary to define roles and responsibilities, giving each of them direction, clarifying what they can expect and what is expected from them. This clarity on involved institutions' and individuals' roles and responsibilities is essential for broad adherence and commitment of health stakeholders, and thus, better implementation.

5.2.2 To keep focus on the medium to long term

A plan can help keep the country on the chosen, optimal path towards health sector development underpinned by universal health coverage, given outside influences and events.

As mentioned previously, a written vision is important for orientation of the health sector. The strength of it is the fact that it has been debated and discussed, and carefully pinned down with a solid evidence base. This can help keep the country's health sector on this optimal path as far as possible, despite political or other changes. Robust strategic planning can thus be a means of minimizing the effects of outside influences that may cause unwanted deviation. It helps avoid priorities being set in an ad hoc way by reacting to external pulls and pushes, rather than following a discussed, debated and agreed upon plan. A solid NHPSP can also be seen as a way to minimize the level of uncertainty or risk faced from the outside environment.

A good strategic plan translates long-term sector vision and priorities into concreate implementation phases and steps, providing a medium-term horizon for sector development.

5.2.3 To avoid fragmentation of the health sector

The topics and goals highlighted in the NHPSP serves as a reference against which subsequent health sector activities are assessed, oriented and revised.

Because of its comprehensiveness, a sector strategic plan involves and includes all programmes and services, including support functions. This facilitates coordination and can help avoid fragmentation due to parallel planning and implementation.

A big part of avoiding fragmentation is ensuring that the baseline data as collected for and presented in the NHPSP is agreed upon by the full range of health sector stakeholders, including programmes, services and support functions. These numbers set the tone for all future activities in the health sector as progress will be assessed and measured against them.

5.2.4 To help focus the policy dialogue on health sector priorities

The strategic plan provides a focus towards priority areas and interventions, as it is directly linked to the situation analysis, costing and budgeting. The NHPSP is the reference document against which all subsequent health sector activities will be assessed, oriented and revised. The topics which will be at the centre of policy dialogue during all of the planning cycle steps will be those highlighted in the NHPSP.

Box 5.2

The role of strategic planning in progressing health sector development in five country studies[4]

In a study done by the Overseas Development Institute, an analysis of health sector development in five countries— Cambodia, Mozambique, Nepal, Rwanda and Sierra Leone — highlights various strategic planning pathways that were used to improve governance and result in positive gains for maternal and child health (MCH) and neglected tropical diseases (NTDs). The key disease areas of MCH and NTDs were selected as indicators due to their centrality to the Millennium Development Goals and as such their ability to act as proxy for general health services. Countries were chosen based on quantitative indicators denoting health improvements, both in terms of key disease areas studied and compared with other countries in their respective regions.

Case studies from 2013 to early 2014 and extensive literature reviews served as the basis to analyse concerted efforts made in different country contexts to improve strategic policy-making and their consequences in the health sector. In Mozambique, improvements in strategic health plans, with targeted objectives and broad activity areas linked to MCH and NTDs, resulted in increased sector investment by donors through sector budget support. In Cambodia, national commitment to the strategic health plan which included an emphasis on NTDs, facilitated a key partnership between the MoH and the Ministry of Education, Youth and Sport; this was critical for scaling up the NTD response. In Rwanda, the MoH placed a strong focus in the health sector strategy on decentralized health planning, with reforms allowing for more community and local-level participation in planning. This has led to more community ownership of the strategy, and a greater willingness to take part in implementation.

The study suggests that, despite the various economic and political constraints, multilevel efforts to improve health sector governance and strategic policy-making can lead to more successful policy implementation and thus bring about positive results in health.

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5.3 When should strategic planning be done?

In the context of ongoing comprehensive health sector development, strategic planning is an iterative process that should be conducted every 3–5 years (medium-term). Most health sectors work with long- and/or medium-term strategic plans, as well as with annual and quarterly operational plans. The strategic planning exercise generally comes after the phase of priority-setting and precedes operational planning.

It may be useful to ensure adequate bridging of the strategic plan with the annual operational plans through a rolling implementation plan or programme of work and forward budgets. Such a bridging planning document is necessary when the strategic plan is too broad in orientation for guiding implementation, often because it does not provide enough detail on phases/steps, targets, implementation modalities and/or responsibilities.[5]

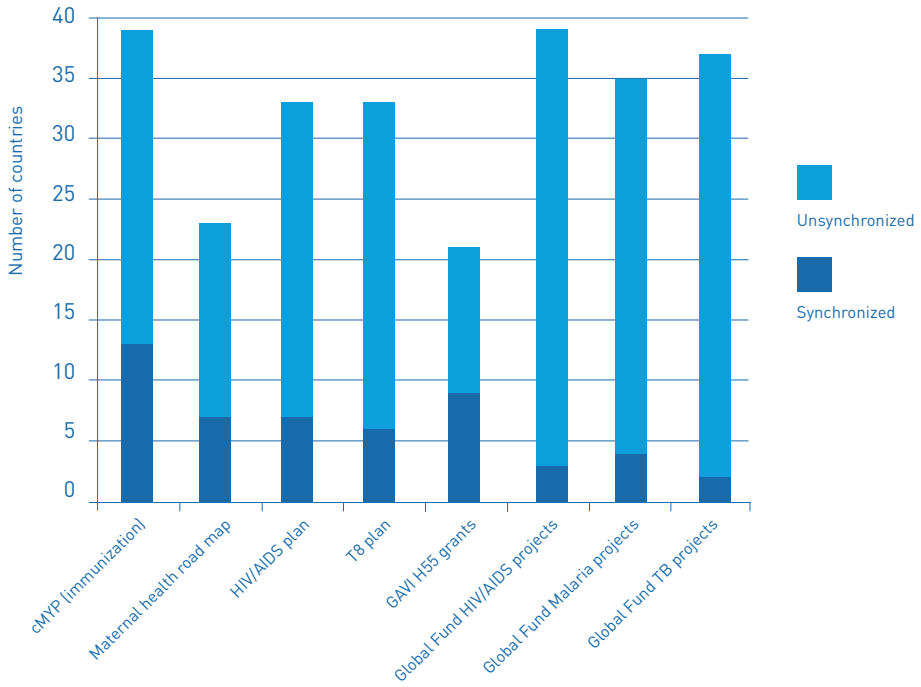
The term prospective planning is used in the case of long-term strategies, i.e. one that covers at least a 10-year period. Increasingly such a long-term view is used in combination with short-term rolling plans which have shorter cycles. Such a combination is seen as a flexible response to the need for short-term detailed plans within the context of a longer-term view.[6]

A strategic planning exercise with a narrower scope can be necessary whenever there is a broad and open question to be answered, for example, in the case of the emergence of a new health problem or when a new vision or strategic direction emerges. In such cases, it is not necessary to review the entire existing sector strategic plan. The area-specific newly developed medium-term strategic orientation can be considered as an addendum to the sector strategic plan.

When (donor funded) programmes and projects are vertical in nature, their management cycle may be different from the national governmental planning cycle. Fig. 5.3 illustrates a recent analysis of vertical programme plans and their synchronicity with the national health plan – it is clear that many vertical programme plans are not synchronized with the national health plan. This lack of synchronicity means that probably different specific programmatic stakeholder groups met in different places at different times and may have developed sub-plans in isolation from each other, and from the overall health sector strategic group of stakeholders. This situation may lead to duplication and overlap. To overcome this, it is important not to settle for a sequenced planning exercise for individual programmes, but rather to integrate their planning elements into the sector-wide NHPSP exercise. Efforts should be made to progressively adapt the planning cycles of programmes that are still vertical in nature to the government/sector NHPSP cycle.

Strategic planning is an iterative process that should be conducted every 3-5 years (medium-term); operational plans are more often annual or quarterly.

Fig. 5.3 Programme-specific plans and national health plans: to what extent are they synchronized?[7]



At some point in the course of 3–5 years, the need may be felt to revise the strategic plan. The temptation may arise, for instance, when a new government defines new development priorities that affect the health sector considerably, or when a particular health problem is labelled as a particular priority by the global (health) community. The risk of a complete revision of the entire strategic plan in such a case is that it will cause confusion in the health sector stakeholder community. It may cause interference with ongoing implementation of operational plans, stall sector coordination and even disrupt continuity in service delivery. Usually, it is better to maintain the existing sector strategic framework and only adjust, as per need, the sector priority agenda and directives for annual operational planning. These unforeseen important developments can then be integrated into the following strategic plan.

The above recommendation does not hold in countries where the NHPSP covers a whole decade; in that case, the NHPSP is not really a medium-term plan but a long-term one. Since important sector-specific and contextual changes can be expected over such a long period, it may be necessary to revise or update such a 10-year plan halfway, i.e. after five years.

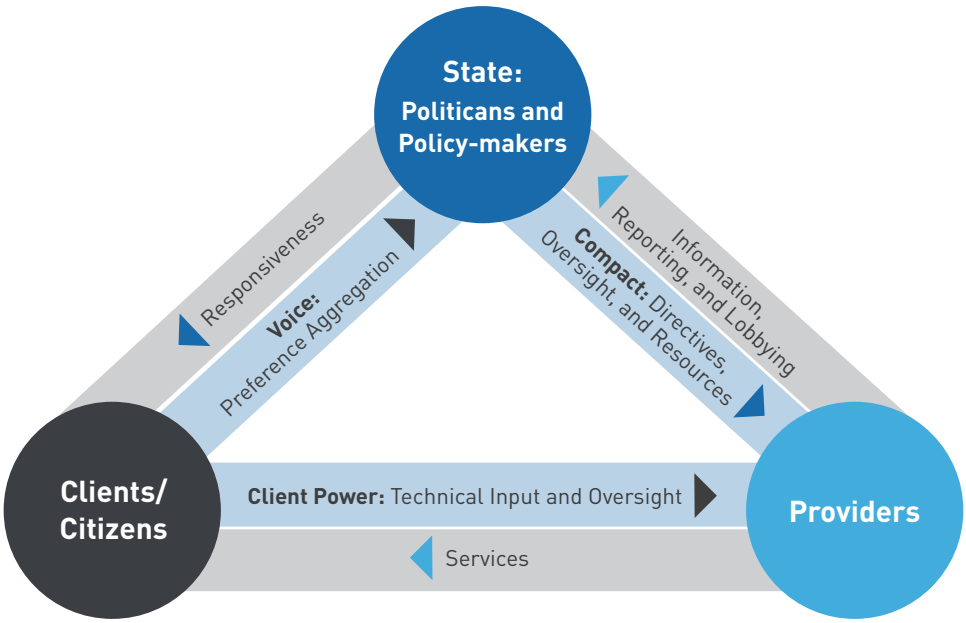
5.4 Who should be part of strategic planning?

All levels of the health system have their own unique role to play in strategic planning. Strategizing for health will be more effective if a wide range of stakeholders is involved in it, and both the process and the product are truly owned by the country. Health sector stakeholders will need to come to a common understanding of the key issues and share institutional goals and expectations. Such an inclusive approach is likely to be more potent, not only in terms of planning the right vision and activities, but also in ensuring that implementation of the strategic plan is jointly undertaken by all actor groups.

Another angle to take when considering whom to involve in the strategic planning process is to examine stakeholders' contribution to planning based on their function. Categories could be for instance: idea generators, entrepreneurs, managers, networkers and champions. The aim would be to include not only those who will write the plan but also those who will implement it and those who will benefit from it.[8]

Brinkerhoff and Bossert's three categories of population groups who have a stake in health governance (see Fig. 5.4) can be used as a lens to better understand the specific roles of the different stakeholders in the NHPSP development process.[9]

Fig. 5.4 Population groups with a stake in health governance



5.4.1 The state: politicians andpolicy-makers

The central-level MoH coordinates and leads NHPSP development and is responsible for informing, instructing and guiding the concerned stakeholders at all levels through the development exercise.

This group includes:

- policy actors within the government (policy-makers, health managers);
- parastatal institutions;
- representatives of other sectors (e.g. finance, gender, education);
- representatives of local government global, multilateral and bilateral development partners.

We include development partners here because those acting at global level, through multilateral or bilateral channels, usually engage directly with policy-makers, most commonly at the national level or at least through the national level to lower levels of the health system.

The central-level MoH initiates, coordinates and leads NHPSP development according to a chosen approach, methodology and process. In some settings, a uniform planning framework and calendar may be provided by national government for all sectors. The MoH is responsible for informing, instructing and guiding the concerned stakeholders at all levels through the NHPSP development exercise.

The perspective of relevant citizen groups and institutions is important for providing feedback and evidence on the most pressing health priorities being discussed in the NHPSP planning process.

All these tasks cannot be simply delegated to MoH departments as part of their routine work. It is a considerable extra workload. In addition, in the spirit of participation, it can be extremely useful to involve a few representatives of main stakeholder groups in the organization itself of the NHPSP development process. Establishing a core team of not more than 10 people is one way to do this. This group could include 2–3 senior MoH staff – usually from the planning and/or monitoring and evaluation department – as well as representatives of key health sector stakeholders groups and other sectors.

The MoH may seek the assistance of international, (sub)regional or national independent experts for developing and preparing methodology and tools, as well as for facilitating the process.

5.4.2 Clients/citizens

This group includes:

- civil society/ NGOs;
- for-profit private sector;
- community representatives;
- academic/research institutions.

The core team established with MoH coordination should ideally include the most relevant citizen groups and institutions that can provide the necessary feedback and evidence for the most pressing health priorities.

Obviously, not all levels of all stakeholder groups can be intensively involved in all the stages of the strategic planning process, so it is important to determine the best role for each of them at each stage, depending on the aspect(s) in which they can contribute: defining the scope, preparation, write-up of the plan, validation, etc. For instance, through their membership

in thematic (or technical) groups, research institutes can play an important role in defining medium-term roadmaps for implementing specific activities, while regional health offices and district health management teams can ensure that the strategic planning takes into account district-specific needs for increasing health service coverage or for strengthening a particular intervention. In some countries, non-profit or faith-based institutions provide the bulk of local health services; their input into defining the scope and preparation of the NHPSP would then be vital, given their insights and stakes in the health sector.

In some settings, bringing on board the for-profit private sector has proven difficult, as interests and viewpoints diverge considerably with the public sector. Nevertheless, a concerted effort must be invested in making the case for an added value for both sides to be involved in the NHPSP development process. This should be an ongoing effort as there may be issues to resolve, concerns to look into and a common ground to be found – all of which can take time.

5.4.3 Providers

Health providers are at the crux of implementing the NHPSP. Their experience of the health sector comes from the inside, is practical, and offers insights on feasibility. Their input into the NHPSP development process is therefore crucial, as it is a complementary perspective to those of patients and the population. In addition, any hesitance or outright opposition will become a major hindrance to NHPSP implementation; health providers' reservations need to be addressed openly and dialogue channels actively sought to find a joint solution. This investment is key to the credibility of the NHPSP as well as to the implementability of the plan.

Health care providers are at the crux of implementing a NHPSP; their input is crucial as a complementary perspective to those of patients and the population.

Box 5.3

The health policy formulation process in Thailand: who are the different stakeholders?

Policy formulation in Thailand underwent a change in 1997 following enactment of the People's Constitution, effectively increasing public participation in policy decision-making.[10, 11] While policy in the past was mostly characterized by a power struggle between military rule and elected bureaucrats, the 1990s political reform has led to improvements in other stakeholders' involvement in the policy process.[12, 13] Today, formulation of national health plans and policies involves an array of policy actors, each with their own perspective and agenda for action and each influencing policy at various stages of the process.[14] The prime minister serves as the agenda setter, influenced by a large support system made up of research institutions and nongovernmental organizations. State bureaucrats and health professionals are closely linked, demonstrating the long tradition and mindset of a centralized hierarchical health system structure which may be changing, but only slowly. Civil society also holds a large stake in the process as representatives of people's voice. NGOs provide a large number of specific health services, often with funds from different donor groups, and hence are interested in better collaboration with public services. Additionally, private hospitals are mainly concerned with access to funding and resources. Understanding the different vantage points of each stakeholder is critical and facilitates the development of strong policy reforms.

For example, the Thai Universal Coverage (UC) policy was borne out of a series of communications between different policy actors, starting among a small number of civil servants and elected officials. The explicit objective of the UC policy was to expand health insurance coverage to all citizens through the means of two main features: a single standard for all in terms of benefits and care, and a decentralized sustainable insurance system. Policy elites and members of government, such as the prime minister, minister of health, minister of finance etc., held mostly pro-market economic viewpoints and had reservations regarding the creation of a welfare system; however, this was overridden by the Party's commitment to ensuring citizens' entitlement to health care. Results from focus group discussions with villagers and commentary from civil society representatives revealed concerns that the rich might have more opportunities to use public resources than the poor. Health providers and hospitals, especially in the private sector, were eager to join the scheme as soon as possible, hoping that the insurance system could be a major source of income. In the end, no single stakeholder had absolute power to dominate every decision in the policy; the space for interplay between multiple policy actors was key for the decision-making process.[15]

5.5 How do we transform priorities into plans?

Medium-term sector strategic planning is a complex undertaking that can be done in different ways. Its complexity comes from the sheer comprehensiveness of the exercise, involving all aspects of the full health sector, as well as other sectors with a stake in health. A wide variety of actors must be an active part of the process for it to be successful – thus adding to the complexity of the task. However, if done well, the NHPSP process will pave the way for operational planning as well as activity implementation for all aspects of the health system (health care, support systems, other determinants), for all actors and for all levels. Depending on how the government and the health sector and the services are organized, the type of planning process may vary (result-based, programme-based, etc.) and the role of the different actors may differ (stronger bottom-up planning in decentralized settings, influence of donors in a setting of strong dependence on external financing, etc.). The national context will determine how the NHPSP process will be organized and phased.

Of course, policy-making does not take place in a vacuum. The process is set within the constitutional and legal framework – as well as the history and culture – of each country. The NHPSP process will take into account demographic, economic and fiscal trends, as well as international and regional commitments. Health sector stakeholders leading the NHPSP process should keep the general policy environment in mind at all times and work within its confines.

The NHPSP process will pave the way for operational planning and activity implementation for all aspects of the health system, for all actors and for all levels.

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Ensuring buy-in from all stakeholders and keeping it realistic and feasible is the key to ensuring the NHPSP is a dynamic document.

Box 5.4

National planning cycle database: a WHO resource[16]

The Country Planning Cycle Database is an open, online resource that provides information on all 195 WHO Member States and their national health policies, strategies and plans. Initiated in 2009, the goal of the database is to provide countries with the necessary information to improve the coordination and synchronization of health sector planning efforts. The database provides a country-by-country overview of different planning, programme and project cycles in the health sector, and generates country profiles with a snapshot of important milestones and graphical representations of donor commitments. It also offers access to an online repository of NHPSPs.

Information in the database is continuously updated through the efforts of WHO and collaborating partners to maintain the accuracy and comprehensiveness of the resource. The database can be accessed through the WHO national planning cycles website (www.nationalplanningcycles.org).

5.5.1 How can we ensure that the NHPSP is actually used as a key orienting text?

In some countries, the NHPSP process has become a periodic, bureaucratic formality, a mere obligation met behind closed doors in government offices. In such cases, there is a considerable risk that, in the implementation phase, the plan will not be considered a fundamental reference document; it will just gather dust on the shelves. Without this important steering function, sector development efforts are likely to become fragmented, inefficient, with poor final outcomes and impact as a consequence.

The key to ensuring that the NHPSP is truly a living, breathing document, which is used dynamically to achive buy-in from all stakeholders and keeping it realistic and feasible, while still expressing ambition for the future. Ensuring buy-in from all stakeholders is only possible when all stakeholders are adequately represented in the national health planning process, and are able to meaningfully participate. This requires a skilled MoH to convene all relevant actors and broker a decision among potentially divergent views. The final result should be a balanced and evidence-informed decision on the strategic directions for the health sector.

5.5.2 Some strategic planning basics

Comprehensive, balanced and coherent NHPSP content

National health policies, strategies and plans must articulate a country's goals, objectives and broad activity areas for the health sector in a comprehensive, balanced and coherent fashion.[17]

Comprehensive

This includes all aspects impacting on the health sector, such as human resources for health, health sector governance, pharmaceuticals, health information systems, health financing arrangements, personal and non-personal health services, all specific programmes (disease-specific and others) and all actors and budget centres, public or private.

Balanced

The content of the NHPSP must be well-balanced in terms of finances and inputs, as well as depth of analysis on the principal health issues of the country. In other words, each strategic direction needs to be developed with the same level of detail as the others, and with a level of resources that corresponds to its extent and scope.

Coherent

(a) Coherence with other sectors and the national development plan

Strategic planning for health should ideally be based on a government-wide policy framework laid out for all sectors. Success in implementation will be influenced by whether health strategies and planned reforms are coherent with overall government policies. It is crucial for health planning stakeholders to examine the national development plan, or any other relevant overarching vision statement for advancing the country as a whole.

(b) Coherence with programme-specific or subsector plans

Ideally, programme-specific or subsector plans have already been established before the comprehensive sector NHPSP process starts. It is then principally a matter of integrating these elements into the NHPSP. Even without finalized subplans, the active and meaningful participation of programmes and subsectors in the overall national health planning process is important for ensuring harmonization and alignment, and for shaping the strategic directions for the health sector.

Coherence with other plans can also imply coherence with a large injection of funding which may arrive during an emergency situation. A case in point is the recent Ebola crisis in West Africa, which was accompanied by a proliferation of plans that were developed separately from the NHPSP: Ebola emergency plans and health system recovery plans. Ideally, these plans would fall under the umbrella of the existing NHPSP, if the course for the health sector as outlined in the plan remains relevant; if not, it might make most sense to prepare a new NHPSP, or write an amendment to the existing one. A plethora of plans overlapping with each other does not give clarity for the health sector in any way. It is thus desirable in most country settings to have one overarching document giving orienting

A NHPSP must be comprehensive, balanced, and coherent to effectively articulate a country's health sector's goals, objectives and activity areas.

guidance overall, with all other plans linking with and aligning with that strategic orientation.

(c) Coherence with the epidemiological and socioeconomic context

A strategic plan will only be valid if it addresses the principal concerns of the health sector in its broadest definition – this includes not only the epidemiological but also the socioeconomic context. This implies working with the health sector across all levels and actors, but also beyond the health sector with other ministries and stakeholder groups. The NHPSP must include input from all of those institutions, interests and actors in order for it to be relevant and valid for implementation on the ground.

(d) Coherence with the available current and estimated future resources

The resources and costs necessary to implement the NHPSP must be reasonable and within the fiscal space for health estimated for the period.

Baseline data

The strategic plan will define the intended sector development and will indicate the expected results in terms of outcomes and impact. In order to measure progress during the course of plan implementation, and evaluate the end result based on NHPSP targets, it is necessary to know exactly where the starting point is. For this reason, baseline indicators on service availability, workforce distribution, vaccination coverage, prevalence and incidence of major health conditions, performance of support functions, and progress on institutional and organizational reforms, among many others, are crucial. This baseline information will be used in the monitoring and evaluation of the NHPSP.

Demographic trends are decisive: information on population trends, with gender and geographical disaggregation, is basic to strategizing for health. For example, the population by age cohorts is often the starting point for the allocation of health services. Outward migration (and internal migration within the national territory) is obviously another key element in health service investment. The same holds true for mortality and morbidity data, which may come from the national government or may be the responsibility of an independent health agency. The point here is: the quality of the NHPSP will be largely influenced by the quality of the (baseline) data available for review.

Working within a given budget ceiling

The MoH is expected to translate government policy goals (as described in the NHPSP) into cost estimates to fit into the suggested budget ceiling for health. The budget ceiling is given by the ministry of finance (MoF) based on its revenue forecast outlining the country's macroeconomic prospects in the medium term.

In many settings, the full quantity of resources available might be known with considerable accuracy, and the NHPSP guides the maximum possible progress toward a goal, using these available resources (see Box 5.5). In some cases, the availability of resources is only approximate (for example, where large donor monies are not on-budget, but fund many health sector activities), and the plan may be produced to justify a request for resources to reach a stated goal. Whether the NHPSP is developed before or

after the allocation of resources, it is intended to ensure the best return on investment, that is, the greatest possible achievement of results given the available resources.[18]

Macroeconomic projections and fiscal space analysis will provide the information on opportunities and constraints within which the health sector will operate.[IV] Equally important are the population's income levels — which are themselves influenced by employment — and their distribution, as they will impact on the nature of their health problems and health-seeking behaviour. Regarding fiscal trends, three aspects will be salient in the NHPSP process, and should thus be kept in mind during NHPSP development:

(a) the budget for the current year;

(b) the forecast for the medium term, for example, three years ahead;

(c) any unforeseen circumstances that force immediate and short-term adjustments to spending plans.

Box 5.5

Developing a NHPSP within a fixed budget ceiling in Uganda[19, 20]

Uganda's Ministry of Finance gives the health sector fixed budget ceilings. For the fiscal year 2014–2015, the health budget ceiling in Uganda was USD 385 million, about 9% of the GDP.[21] With this number in mind, the MoH must guide NHPSP cost estimation to ensure maximum progress towards NHPSP goals.

Budget Framework Papers, or medium-term budgets, are then prepared by sector working groups, based on the given budget ceilings, to reflect the sector's priorities and expenditure plans as outlined in the NHPSP. The cabinet and parliament subsequently decide on sector budget allocations. Once the Budget Framework Papers are finalized, there is room for renegotiating sector budget allocations within the given sector ceiling.[22]

IV See Chapter 8 "Budgeting for health" in this handbook.

5.5.3 Multisectorality

It is necessary to involve, and if necessary guide, other sectors from the outset in the NHPSP process to ensure that, in the end, much-needed cross-sector interventions happen.

Since health is to a very large extent determined by other factors than those which can be influenced by health service delivery, the NHPSP process should consider elements which can and should become part of the agenda for other sectors. Governments usually acknowledge the need for this broader approach; in a general way, intentions for a multisectoral modus operandi are often reflected in overall national development plans. Mechanisms may exist for coordination between sectors. However, when it comes to assuring joint planning for the implementation of multisectoral interventions, there is often hardly any content in NHPSPs, with defined targets that can guide resource allocation and operational planning. The risk is then that the synergy between efforts of and with other sectors is insufficient, or worse, that intended health-related interventions which require multisectoral collaboration do not end up in operational plans and budgets. It is therefore necessary to involve, and if necessary guide, other sectors from the outset in the NHPSP process and to ensure that, in the end, much-needed cross-sector interventions actually happen.[V]

5.5.4 Mitigating risks

To the extent possible, the strategic planning process should include dialogue on possible and probable risks and the means to mitigate them.

Any strategic planning process will have to deal with uncertainties related to developments that are beyond the control of the health sector. Under normal circumstances, there should be no uncertainty about the availability of national and donor resources for the implementation of the NHPSP; however, an important downturn in the country's macroeconomic situation or an unforeseen epidemic outbreak (e.g. Ebola) may hamper complete NHPSP implementation. In a similar way, important political reshuffles can also negatively influence strategic plan implementation. Therefore, to the extent possible, the strategic planning process should include a dialogue on such possible and probable influences in terms of risks and conditions, and think through means to mitigate them.

V For more information, please see Chapter 12 "Intersectoral planning for health and health equity" in this handbook.

5.5.5 Approaches to policy development

The rationalist model developed by Howlett and Ramesh[23] is characterized by an orderly progression of well-defined steps:

1. identification of objectives — agenda-setting;
2. evidence-gathering — formulation of options;
3. decision-making — weighing the options in terms of cost and benefit;
4. implementation — putting the chosen solution into effect;
5. evaluation — monitoring results; and
6. termination/adaptation/confirmation.

The systematic approach of this model clearly has appeal, but in reality policy-making rarely proceeds in a rational and orderly manner. Objectives often cannot be agreed upon. The evidence is often incomplete or ambiguous, and political considerations often intrude at all points, disrupting the orderly sequence. Busy policy advisers will rarely have the opportunity to approach their daily work in terms of such a model. The model implies that the steps identified follow each other in a linear sequential fashion. In practice, the process tends to take place in a more haphazard manner, driven by circumstances. Nevertheless, the labelling of the stages draws attention to the logic of a rational policy process. It underlines the point that policy-making is more than isolated decisions; it is a process in which more than one party is involved and in which the issues may be revisited in an iterative process.

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The **stakeholder model** focuses more on the interaction between principal policy actors, and tries to negotiate a pragmatic path through the often divergent values and views of the various interest groups and government agencies. In reality, stakeholder bargaining can be undemocratic and exclusive, and is often captured by the most powerful players. It requires very skilled and diplomatic leaders to ensure that a balanced viewpoint emerges from the policy-making process.

At different times, and in various ways, any subset of stakeholders can exert power and influence over the health system. Ways must be found to ensure that all legitimate interests are assessed and weighed in the policy-making process. The success of NHPSP development may well depend upon the extent to which the key stakeholders have been involved and are committed to supporting its implementation.

Some important preparatory activities for NHPSP development are defining the schedule, putting together a core team, determining budgetary requirements, assigning tasks, informing the health stakeholder community of the chosen methodology and process, and collecting reference documentation for review.

The **participatory model** can be considered a particular form of the above-mentioned stakeholder model. It takes more of a socially democratic and inclusive approach, and is the model that is explicitly endorsed here. It is the most recent arrival in policy studies literature, but it is by no means new. The participatory process requires that the resulting policy or strategy is "democratically legitimate". In practice, this implies an open, inclusive, interactive and highly politicized approach. The contention is that multiple criteria should guide policy-making processes. Such criteria could include relative dependence on expertise, the availability of an evidence base, the analytical policy support available, resource and time pressures, the political sensitivity of the issues, and the relative power of the principal stakeholders involved.

This model has also been described as incrementalism, or a deliberative process, which recognizes the political nature of planning in a far more overt manner than in the rational approaches.

In practice, an evidence-based, flexible and pragmatic approach to policy-making will most likely move things forward.

5.5.6 Process and steps for developing the NHPSP

Preparation of NHPSP development

NHPSP development requires considerable time and resources. It should therefore be planned and budgeted for, and funds made available. Health planning stakeholders in the core team are expected to set aside adequate time for preparation, which may take two weeks or more. The important preparatory activities to be considered are:

- defining the schedule for NHPSP development;
- putting together the core team for NHPSP development;
- determining the budgetary requirements for NHPSP development and matching them with available funds in the current annual work plan;
- assigning specific tasks and responsibilities to each member of the core team;
- developing a methodology and selecting indicators for evaluating the NHPSP development process;

- securing funds for NHPSP development;
- informing citizens and the broader health stakeholder community of the methodology and process;
- collecting reference documentation for review.

The steering, organization, implementation and monitoring of the NHPSP development process are functions that should be attributed to the appropriate stakeholder groups and structures. Steering can be done by a mixed group of health sector stakeholders under the leadership of MoH, while the responsibility for the actual organization of NHPSP development activities may be given to the core team. The whole process should be coordinated and led by the MoH (usually its department of planning).

Mixed thematic groups of area-specific experts from a broad range of stakeholder groups are needed to provide targeted technical expertise. The thematic groups should include ministries (health and other sectors), service providers, private sector (for-profit and not-for-profit), research institutions, sub-national health authorities, etc.

The core team should prepare a roadmap for NHPSP development, inform all sector stakeholders about the work at hand, develop terms of reference on the exact role to be played by various actors, provide instructions on methodology, coordinate and provide technical and organizational support. This core team should also ensure mobilization of the resources which were budgeted for the NHPSP exercise.

Setting goals (or strategic directions)

NHPSP development requires setting goals, setting objectives, formulating broad activity areas, creating medium-term implementation guidance, and approving and disseminating the NHPSP.

A goal, sometimes called a "strategic direction" in NHPSP documents, is a broad statement of the overall outcome(s) which the health system is expected to achieve. For instance, the United Nations' eight Millennium Development Goals, valid from 2000–2015, included goals such as "improve maternal health" as an expected outcome of the health system. Usually only a few goals, or perhaps only one, are mentioned in strategy documents, as they are general and all-encompassing in nature. Setting a goal will be the result of policy dialogue during the population consultation, situation analysis and priority-setting phases of the policy and planning cycle. Mostly, these goals will not change drastically over time and will not entail huge surprises.

Setting objectives

According to the WHO *Health Systems Strengthening Glossary*,[24] an objective is a statement of a desired future state, condition or purpose, which an institution, a project, a service or a programme seeks to achieve. It is thus a broad approach to be followed to achieve a health system goal. Taking "improve maternal health" as an example, an objective could be "reduce the maternal mortality ratio by two thirds within the next 20 years".

A NHPSP objective can lay out the path to reach a goal or fulfill a strategic direction. Like goals, objectives describe planned outcomes resulting from implemented activities – they are not activities themselves. Setting objectives is essential for three main reasons.

First, they define in a clear and precise way what the plan is designed to achieve.

Second, the objectives largely determine which key activities should take place during NHPSP implementation.

Third, objectives provide the required guidance for health planning stakeholders and implementers to apply appropriate monitoring and evaluation tools.

The SMART approach describes a set of key criteria to ensure in an objective.[25] Adapted to the medium-term NHPSP context, they are:

(a) measurable: quantifies the change to be achieved (in the above example, the quantification is "reduce by two thirds");

(b) appropriate: logically relates to the overall goal/strategic direction ("reduce maternal mortality ratio" is directly linked to "improve maternal health");

(c) realistic: provides a realistic dimension which is achievable with available resources and implementation capability (this evidence-informed discussion begins during the priority-setting debates and is specific to each country);

(d) time-limited: specifies an expected time for the objective to be achieved ("within the next 20 years").

Measurable, appropriate, realistic and time-limited objectives are those that can be achieved with hard work. Objectives that are too ambitious will discourage implementers or will be bypassed. Objectives that are too easy to achieve will foster complacency.[26] It is an art to agree upon objectives that are truly attainable for an entire health sector, but an art which health planning stakeholders must master if achievements and progress are to be made.

Formulating broad activity areas

After setting goals and objectives, health planning stakeholders must address the means of reaching their goals, at least in a general way. The operational plans will address it in a more specific and concrete way; however, even the operational plan will take guidance from the NHPSP, so broad activity areas should be explicitly mentioned. These activities can address expansion, testing, reform or strengthening of sector areas. The activities should be feasible, given the strengths and weaknesses of health sector stakeholders.

In formulating broad activity areas, it is necessary to identify:

- the levels, organizations and sectors to be targeted;
- which population(s) or geographic areas are targeted;
- the personal and environmental factors to be addressed;
- those who can most benefit and contribute.

Broad activity areas, when formulated well and thought through adequately by the health sector stakeholder group, should fulfill the following characteristics:[27]

- they point out the overall path, in line with goals/strategic directions, and sometimes a specific approach;
- they match resources;
- they take advantage of opportunities, current skills and strengths, and public opinion;
- they minimize resistance and barriers;
- they reach those who are most affected;
- they involve communities.

Box 5.6 describes an example of how broad activity areas can evolve, starting from a goal/strategic direction and objectives, and how they provide a starting point for operational planning.

Box 5.6

Example of a goal, objectives and broad activity areas in a NHPSP

Goal

- decrease under-five mortality rate by strengthening and expanding primary health care services.

Objective

- increase the focus on health promotion and prevention services as an integrated part of the maternal and child health programme;
- strengthen staff skills at primary and secondary care level;
- intensify collaboration with other sectors on health prevention issues (education sector, water and sanitation, etc.).

Broad activity areas included in the medium-term NHPSP

- expand the community health worker (CHW) network;
- training in "Integrated Management of Childhood Illnesses" (IMCI) for all health facility staff;
- link district health plans with local water and sanitation development plans.

Activities as they might appear in annual operational plans

- recruit and train additional CHWs; provide refresher training for existing CHWs.
- develop an IMCI training module adapted to the local context and organize training courses locally;
- develop a guide for district councils to better link health and water and sanitation plans.

Ideally, the relevance and feasibility of the proposed broad activity areas will have been verified during the priority-setting exercise, and if necessary tested, with a team of experts and advisers with different capabilities. Since the broad activity areas will require the active involvement of a range of actors, often at several levels, and possibly co-financing by development partners in some countries, it is imperative that various stakeholder groups are part of, understand and agree to the broad activity areas. This cannot be overemphasized. Apart from the useful input they can provide to this process, it will enhance their willingness to contribute and cooperate in later implementation. Stakeholder buy-in can make or break the success of implementation.

NHPSP implementation guidance

A medium-term NHPSP will not go into detail on implementation issues. However, some key aspects related to implementation can be extremely useful, depending on the activity area. Those key aspects include synergy with other sector development strategies, assumptions, preconditions to be fulfilled, resource requirements, attribution of responsibilities, establishment of a monitoring and evaluation (M&E) mechanism, sequencing and timing. Many of these aspects enable the practicability of the broad activity areas. In the NHPSP, these activity areas will be linked to milestones and targets.[VI]

A number of other plans or strategy documents might be developed to expand on specific areas covered in the NHPSP, and to support NHPSP implementation. These could include:

- specific intervention plans (e.g. HIV voluntary testing and counselling, prevention of mother-to-child HIV transmission, antiretroviral therapy, etc.);
- M&E plan;
- health financing strategy;
- donor technical assistance plan;
- procurement and supply management plan;
- health workforce strategy.

In some settings, a NHPSP can provide enough guidance for direct annual operational planning in terms of:

- reforms and programme interventions;
- key activities per level;
- sequencing with milestones and targets;
- levels of responsibility and tasks;
- implementation and management modalities for the M&E system.

If the NHPSP is less specific about these issues, one possibility is to bridge the NHPSP and the operational plans with a rolling programme of work or MTEF for two or three years.[VII]

VI See Chapter 9 "Monitoring and evaluation of national health policies, strategies and plans" in this handbook.

VII See Chapter 6 "Operational planning: transforming plans into action" and Chapter 8 "Budgeting for health" in this handbook.

Approval and dissemination of the NHPSP

Once the core team agrees on the pre-final version of the NHPSP, it can be presented to the wider stakeholder community for final comments. For that purpose a concise, two-page summary of the plan can be written in simple language, with the purpose of:

- informing the population about the proposed plan;
- informing other services and sectors;
- championing the cause of improved services among local authorities, development partners and the government.

This summary should highlight salient points of the NHPSP and should include:

- major health problems and system development needs;
- goals, objectives, broad activity areas, and expected outcomes;
- major reforms to be implemented for the planning period;
- roles and responsibilities;
- total resource needs estimate, potential sources of funding and, if applicable, financial gaps;
- relationship/synergies of the plan with other ongoing programmes.

A broad range of health sector stakeholders must reach consensus on the content and presentation of the NHPSP. One way to arrive at consensus is through an intense and ongoing involvement of major stakeholders in the NHPSP development process. This may not always be possible due to the heavy time and resource commitments involved; however, it is the ideal option as it enables stakeholders to provide their perspectives and assent at each step of the process. The second approach is by circulating a draft of the NHPSP as widely as possible, to all stakeholders and interested parties, allowing sufficient time for review and feedback. This provides an opportunity to assess the big picture, raise any additional concerns, and correct factual errors. A consensus meeting could provide a forum to openly express views and for making compromises.

It may be decided to undertake an assessment of the quality of the NHPSP. The purpose of the assessment or peer review is to verify that the NHPSP demonstrates the attributes of a good plan that allows for feasible implementation and provides a sound basis for domestic and international investment. An assessment is usually undertaken jointly by all parties directly involved in developing the NHPSP; other interested external parties may also be invited when it is a larger exercise. One NHPSP quality assessment tool which is widely used is the Joint Assessment of National Strategies (JANS);[VIII] it was developed to assess NHPSP and their constituent plans, such as programme plans and subsector (human resource, financing, procurement, etc.) plans (see Box 5.7).

VIII http://www.internationalhealthpartnership.net/en/tools/jans-tool-and-guidelines/

Box 5.7

Joint Assessment of National Health Strategies (JANS)

The JANS[28] approach is a tool and set of guidelines that can be used to check the quality of a national health plan. The approach emphasizes the "joint" inclusive process, meaning that the assessment is conducted by a wide stakeholder group, based on dialogue and consensus on the final conclusions.

The three main goals of JANS are: to improve the quality of the national health strategy; to increase confidence and help inform funding decisions; and to reduce costs and eliminate the existence of multiple assessments. The idea is that through a systematic assessment of an existing NHPSP, insights can be realized to improve future NHPSPs.

The assessment itself includes a review of the NHPSP as well as the national development framework. In addition, numerous other documents, including multisectoral and subsectoral strategies and budgets, are studied in detail. The JANS focuses the analysis on five main areas: situation analysis and programming; process; costs and budgetary frameworks; implementation and management; and monitoring, evaluation and review. For each area, a series of desirable attributes and criteria gives the evaluator a lens through which to assess the NHPSP.

A number of countries have applied the JANS as part of their NHPSP development process. Feedback has shown that, besides the actual assessment results, the process of assessing jointly, with external and internal parties, brought unexpected insights and forged a sense of ownership around the NHPSP.

"The JANS process significantly improved the quality of the 5-year health plan. Outcomes: more trust and confidence from development partners; more streamlined support to the sector."
--Dr Long, Ministry of Health, Viet Nam[29]

For example, in Viet Nam, to ensure the "joint" aspect of the assessment, government, development partners and NGOs were all involved in the core team, preparing and conducting the evaluation. In Ethiopia, separate assessments were carried out in the form of workshops at various health system levels to ensure that civil society organizations and other local stakeholder groups could participate in the JANS process.

Regardless of the approach taken, the output from JANS is a structured judgement on the NHPSP's strengths and weaknesses, as well as concrete recommendations for improvement that can feed policy dialogue and debate.

Once broad consensus on the NHPSP has been reached and it has perhaps been assessed for quality, the NHPSP must be formally endorsed by the relevant national authorities. The NHPSP final draft will usually be submitted for approval to the minister of health or an interdepartmental committee. Sometimes an official validation workshop or ceremony might be planned.

A NHPSP without formal endorsement will be perceived as lacking legitimacy. Here, two issues are relevant:

(a) internal legitimacy within the health sector: endorsement must be provided by authorities within the health sector, including the minister of health, to demonstrate that it is a formal element within the overall direction the MoH wishes the health sector to go;

(b) external legitimacy beyond the health sector.

Once the plan has received official endorsement, the document must be promoted and distributed widely to guide the contributions of all stakeholders. Dissemination includes not just distribution of a hard copy document; instead, it implies explaining the document to relevant communities and stakeholders, holding special meetings and presentations, making it available online, etc. In effect, it involves a whole communication strategy around the NHPSP that might require additional resources to be budgeted. This issue is pivotal to ensuring that the document is actually used and becomes the point of reference for all activities, tasks and initiatives within the health sector in the medium term.

NHPSP document structure (see Box 5.8)

Usually, a NHPSP begins with an executive summary, after which the overall context of the health sector is introduced, together with the NHPSP goal(s). Before describing the actual plan contents, a summary can be given of the results of the situation analysis, since this analysis has provided the justification for the priority-setting and beyond. The NHPSP objectives should then be presented clearly, with an explanation provided for each, linking with the broad goals/strategic directions.

Next, the various broad activity areas for sector development can be presented, indicating phases and relevant orientation for implementation modalities. In an annex the NHPSP contents can be presented for quick review by readers in a table format, highlighting vital elements such as goals, objectives, expected outcomes (targets), description of all proposed broad activity areas, estimated required resource inputs (financial, human and other), timeline and responsible structures/institutions.

A NHPSP should mention assumptions as well as risks and how these will be managed. Last but not least, the NHPSP must indicate when and through which system its progress and achievements will be monitored and evaluated. The NHPSP can refer to a MTEF.

The M&E section of a NHPSP should be well prepared, allowing space for periodic assessments of inputs, processes, outputs, outcome and, eventually, impact. It requires a well-defined set of key indicators, quantitative and qualitative, often used in combination with a scorecard. To the extent possible, baseline data should be gathered and mentioned in the M&E plan. More details on monitoring and evaluation of NHPSPs can be found in Chapter 9 of this handbook.

Box 5.8

NHPSP sample outline

Foreword/Preface
Acknowledgements
Acronyms and abbreviations
Executive summary
Introduction
NHPSP development process
Community of stakeholders involved in the process
Roles and responsibilities (mapping)
Section I: Background and situation analysis
- Country profile
- Socioeconomic status
- Health status of population
- Health system/sector profile

Section II: NHPSP strategic directions/goals
- Link to long-term vision for the health sector or for country's development as a whole
- Mission
- Guiding principles
- Priority areas
- Main objectives and broad activity areas

Section III: Implementation of NHPSP
- Policy and regulatory framework
- Implementation framework
- Mitigating risks

Section IV: Financing the NHPSP
- Available funds and costing
- Financing gap
- Strategic investment plan

Section V: Monitoring and evaluation strategy
- Monitoring and evaluation systems – indicators, baselines, targets
- Approaches for data collection
- Results strategy

Section VI: Conclusion
References
Annexes

Estimating cost implications of a NHPSP and ensuring necessary resources

Examining the costing implications of a NHPSP must be part of the NHPSP development process from the beginning.[IX] This leverages the costing process to enable fine-tuning and adjustments to the contents and targets of the NHPSP, and prevents the NHPSP from becoming an unrealistic plan which is quickly shelved and not actively used. Scenarios can be modelled by costing experts, especially if resources appear to not match NHPSP ambitions.

Costing a plan requires planners to project the financial expenditures that will be required to achieve the results set out in the plan. Cost estimations provide invaluable input into the NHPSP development process and can inform priority-setting by highlighting resource constraints. Cost estimations provide guidance to decision-makers on the feasibility of a plan. Perhaps most importantly, cost estimates can be matched to available funds to identify funding gaps and mobilize additional resources from the national budget or international sources.

Scenario-building will be a useful tool within the NHPSP development and costing process, with several rounds of iterations between those who primarily perform cost analyses and those who are more involved with NHPSP development. For example, a scenario can be projected for different possible budget ceilings or different health coverage targets to understand and think through the resource implications in order to make strategic decisions.

IX For a more detailed discourse on this topic, please see Chapter 7 "Estimating cost implications of a national health policy, strategy or plan" in this handbook.

5.6 Common NHPSP development challenges, mistakes and possible solutions

5.6.1 Common challenges to the NHPSP development process and possible solutions

Tight timelines, not allowing for a thorough review of evidence

In a comprehensive planning process in a time-limited context, decisions may have to be made to reduce the planning process by some steps or parts of steps. For example, if strategic directions are required in three months' time, it may not be possible to engage comprehensively with the community or collect new data on targeted health sector issues. An effective way to address the lack of time is to establish parallel activity processes through working groups. The working groups should be in close communication with the core groups; what seems to work best is ensuring that core group members are part of the working groups as well, ensuring information exchange and a relationship of trust.

Some common challenges to the NHPSP development process are tight timelines with not enough time to review evidence thoroughly, a rapidly changing environment, insufficient stakeholder involvement, a weak link to planning, costing and budgeting, and weak coordination between programme plans and the overarching NHPSP.

A rapidly changing environment which can render any medium-term planning uncertain

In a rapidly changing environment, medium-term planning can be done for shorter time frames, for example 2–3 years, rather than five years. In addition, flexibility will be crucial to keeping the plan relevant, which may mean keeping the wording general on issues whose details should rather be worked out in the operational planning phase. In any case, in an environment where the future is not predictable, operational plans can fill in the gaps. It is important to ensure that operational plans, linked to the strategic plans, fill the gap, instead of parallel plans overlapping with the NHPSP.

The operational plan takes on a more significant meaning in the context of a constantly changing environment, as it is here that activities can be flexibility adapted and changed. The flexibility of operational plans is absolutely central to the implementability of the NHPSP. The NHPSP gives the strategic orientation for the sector which serves as a basis for the content of operational plans. The operational plans should "operationalize" the strategic plan, allow modifications where necessary (such as in a volatile context), as and when situations change.

Insufficient stakeholder involvement at all levels (not only top leaders)

Stakeholders will be interested in participating meaningfully in the NHPSP development process when they can see an added value for them and when the criticality of the NHPSP for steering the health sector is made clear. Much of the lethargy around partaking in NHPSP development often centres around the place the NHPSP is given in the health sector and its actual feasibility and role as an orienting document. In many countries, especially non-state (private) actors do not see the point in being a part of the process when they see a one-way contribution with no return for them.

The level of stakeholder involvement points back to the steering capacity of MoH and the core team (i.e. not just MoH, but key planning stakeholders as well) to effectively lead, coordinate and motivate the right people to give their input on the one hand, and assist implementation on the other. Investment in and reflection on NHPSP preparation will be crucial in settings where the NHPSP has traditionally been written for a donor audience or to tick off a planning to-do list, and then subsequently shelved.

A weak link between planning, costing and budgeting

In many countries, a lack of understanding of budget-related issues results in delinked processes such that health policy-making, planning, costing and budgeting take place independently of each other, leading to a misalignment between the health sector priorities outlined in overall strategic plans and policies, and the funds that are ultimately allocated to the health sector through the budgeting process. This misalignment has negative consequences: resources are not used as intended, and accountability is weakened. On the contrary, a good understanding of the budget process and solid engagement by the MoH and other health sector stakeholders at the right time during the budget cycle will increase the chances that the final resource allocation matches planned health sector needs.

Early engagement on the part of the MoH with the Ministry of Finance (MoF) can provide a better understanding of the financial management rules and the system within which expenditures must happen. Closer cooperation and inclusion of MoF representatives in key MoH consultations (such as those related to the estimation of NHPSP costs) can help both sides better understand each other's needs and challenges.

Weak coordination between programme plans and the overarching NHPSP

As shown in Fig. 5.3, many countries evince vertical programme plans that are not synchronized with the national health plan, and vice versa. Fig. 5.3 is based on an analysis that simply examined the timing and the years covered by programme plans vis-à-vis the NHPSP, without looking at the content of those plans and how they were harmonized and aligned – this would probably reveal even more inconsistencies. Especially in settings where large programmes are fully externally funded, they are perceived as "independent" from the rest of the health sector, yet are, in practice, influential when it comes to ad-hoc priority-setting for health. The risks are therefore great if a bridge is not adequately built between the NHPSP and programmes: the vertical programme will continue programme activities in a vertical, unsustainable way, with activities ceasing if funds cease. There may be duplications, overlap and wastage of resources, especially with the health workforce if the vertical programme is better funded and organized than the government.

On the other hand, a well-funded programme may be an opportunity to address goals that are in the NHPSP anyway – instead of overlaps and duplications, it would be more beneficial to join forces and ensure that priorities for a programme as well as priorities for the health sector are adequately reflected in both documents. This might entail a good amount of groundwork during the NHPSP preparation if the two sides are not used to engaging with each other. At the very least, during the NHPSP development process, existing programme plans should be studied, programme representatives brought in to contribute on their expert area, and M&E executed for both programme and NHPSP purposes concomitantly.

5.6.2 Common mistakes observed in NHPSPs

Insufficient connection between available inputs and intended outputs and outcomes

It is not uncommon to find NHPSPs in which inputs (resources used, such as personnel and equipment) are inadequate or inappropriate, and show no obvious connection to the achievement of the NHPSP outputs and outcomes. In order to avoid this trap, it helps to always remind oneself of the final result and the ultimate aim of the exercise. Keeping in mind the overarching health sector vision and NHPSP goals and objectives, steps can be plotted and actions thought through that would be required to arrive at the final end point of the NHPSP.

Proposed broad activity areas and implementation modalities are too vague

There may be contexts where NHPSP activity areas and guidance on implementation are deliberately vague – for example, in fragile or rapidly changing situations, or in very decentralized countries. However, in such cases, the MoH and health planning stakeholders should make explicit provisions for strong technical support when operational plans are being drafted and/or disseminate additional guidance documents at a later point in time in order to ensure that the health sector is moving in the intended direction. The risk of not doing so is a potentially fragmented health sector and a NHPSP that is inconsequential.

In situations where it is not really necessary to keep wording vague, there is no reason to not make the requisite effort to provide more detail and orientation. Reasons for not doing so often lie in an insufficiently participatory process, too short a time frame and simple lack of information on the needed details. Investing in the process and having the right people on board can fill in information gaps, for example, based on implicit knowledge and experience.

The plan is static, therefore discouraging a flexible response to change

Sometimes the NHPSP process can end up becoming much too routine. A lot of zeal and enthusiasm might have characterized the beginning stages, but when and if the process stagnates or drags on, it can be perceived as an added burden, with the principal aim being simply to finish the document and move on. This can happen when the national health planning process has not set aside adequate resources for any extra work involved, which the core team is unable to do. In addition, if the NHPSP in and of itself is seen as a separate "project", apart from the key tasks at hand, it is understandable that once it is finished, normal activities resume and the plan becomes a static document, with little chance of being implemented.

In some countries, an overemphasis on formalities and formal procedures built into the NHPSP development process has made it into a largely bureaucratic function. This can weigh down the process unnecessarily and its principle objective gets lost in paperwork and signatures.

The key to ensuring that the NHPSP is a real point of reference is ensuring that the document is realistic and feasible, provides a sector orientation broadly enough without being vague, and giving some detail without getting too operational. In addition, it is imperative that it is truly driven by meaningful input by a wide array of stakeholders – this quality of process aspect is key and should not be mired in bureaucracy.

It is crucial to ensure close links to operational planning by providing enough operational guidance to enable follow-up operational plans. Milestones can be useful here, as they give in-between targets without laying out the operational details. At the same time, the NHPSP should not go into too much unnecessary detail that can better be taken care of at the operational level, where a flexible response is possible.

If evidence analysis is superficial, there may be no convincing options for doing better in the future

Some NHPSPs are based on an analysis of the evidence that remains superficial. A solid, in-depth analysis of evidence is necessary to project what the health sector environment might look like in the future. It goes without saying that the whole policy and planning cycle must be anchored in reliable data – this means not only ensuring the generation and preservation of this data but also putting effort and resources into adequately understanding and interpreting it for purposes of strategizing for health. Otherwise, even if the NHPSP is implemented, the chances are it will not be as effective as expected.

Goals, objectives and broad activity areas reflect departmentalism, silos culture, the tendency to protect own territory and individual interests

A common criticism of national health plans is that they are unrealistic and simply reflect a wish list of desirable actions in the health sector, with little feasibility. This can happen when the NHPSP development process is not a real collaborative effort where stakeholders come together and engage in evidence-informed debate and dialogue and touch upon the contentious issue of setting priorities. Prioritization means that some groups' or institutions' activities may not be selected, and others will. When stakeholder input is piecemeal and individual – i.e. on a one-on-one basis with the MoH or other central planning authority – and not dialogue-based and joint in nature, NHPSP goals, objectives and broad activity areas become a simple collection of each actor's own separate workplan.

The solution to this problem lies in the convening and brokering role of the MoH and its capacity to bring together stakeholders – those who agree and do not agree with each other – and coordinate policy dialogue such that the result is a balanced, realistic and feasible NHPSP. In settings where MoH capacity acknowledged as weak, improving health sector governance should be prominent in the NHPSP.

5.6.3 Health sector governance

Good health sector governance involves stakeholders, leaders, and managers being aligned around the same vision, with the planning process being comprehensible to all.

Most of the above-mentioned challenges and mistakes can be linked to the absence of sound health sector governance. For example, leadership might not motivate their staff and managers at all levels of the health system, i.e. those who are at the frontline for NHPSP implementation. Leaders may not prioritize dissemination efforts with the NHPSP communicated in an understandable way to service delivery personnel and managers. If the intended results and value added for local levels are not clear to implementers, the necessary will and drive to execute will be lacking.

In essence, good leadership ensures that leaders and managers are aligned around the same vision. The point of the planning process must be comprehensible to everyone. Much of the trust in the intended NHPSP results is linked to the level of openness and transparency of the NHPSP process itself. Astute leaders will ensure that all relevant health sector stakeholders have access to the data, information, process and decision-making logic.

5.6.4 Intersectoral action and NHPSPs

Health equity and social determinants of health (SDH) are acknowledged as critical components of the post-2015 sustainable development agenda, and are essential elements of any country's path towards universal health coverage (UHC). Governments and other stakeholders should proactively address social determinants and health inequities by identifying and promoting intersectoral action as an integral and vital component of the national health planning process. Without intersectoral action as a fully-integrated component – and indeed, mindset – embedded in the national health planning process, health inequities will likely persist, and as a result, the population's health will suffer.

As mentioned in Chapter 12 of this handbook "Intersectoral planning for health and health equity", intersectoral planning, as part of the national health planning process, is not a linear process and thus several entry points exist. In particular, the situation analysis phase is an immense opportunity to ensure that the right questions regarding equity and the determinants of health are raised, and that those key issues are adequately assessed. Actions may be undertaken all along the planning cycle; however, without the principal matters coming to the forefront during the situation analysis phase, these actions will not be slated in.

Intersectoral action should be kept in mind when formulating goals, objectives and broad activity areas.

For purposes of NHPSP development, once the situation analysis and priority-setting have been undertaken, intersectoral action should be kept in mind when formulating goals, objectives and broad activity areas. In settings where intersectoral action has long been neglected, this might entail a separate objective specifically on intersectoral action. Otherwise, if it is to be embedded into other objectives and/or broad activity areas, operational guidance can be given specifically on intersectoral action to ensure that it is not forgotten during the operational planning stage.

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5.7 What if ...?

5.7.1 What if your country is decentralized?

A distinction should be made between strategic planning at sub-national level, which is usually only done in highly devolved settings, and national-level strategic planning in a decentralized context. Here, we address the latter.[X]

National-level strategic planning in any context, but especially in a decentralized one, is dependent on data, information, and active input from districts and regions. Central-level guidance, templates and capacity-building initiatives are key here, as sub-national levels will put together their own medium-term and operational plans anyway. Consistent and clear guidance from central level not only assists the national level to better aggregate and understand the information coming from districts and regions, but also supports the strengthening of local health systems to the benefit of all levels.

A decentralized setting may help to achieve more effective planning and decision-making in the health sector, but it can also create new challenges, especially in finding the right balance between national- and local-level planning, as the systems at each level need to be developed appropriately and consistently with each other. Especially in a decentralized setting with bottom-up planning, the dynamics of back-and-forth between levels are of importance. Districts will communicate their most important medium-term needs to central level, while the central MoH will communicate new or adjusted sector strategies and priorities to the districts. Districts may then react with proposals for strengthening certain system components or for adapting national strategies and programme roadmaps to their particular local circumstances. In turn, the central MoH will then have to verify the financial feasibility of such proposals and, if found acceptable, harmonize and coordinate the local adaptations.

Although the principles and broad processes will be similar at each level, as one moves down to the lower levels, plans will be more specific with national-level guidance providing the broad strategic envelope into which they are placed. Each level therefore needs to take into account the other plans, i.e. those being developed both in other organizations working at the same horizontal level, and also plans of both higher and lower levels in the system (the vertical dimension).

Ultimately, district plans should be validated and integrated into the NHPSP; it should then be clear which contribution the peripheral units will play in its achievement and what key results are to be achieved at their level.

X More information on both aspects can be found in Chapter 11 of this handbook "Strategizing for health at sub-national level".

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

In a fragile setting, decision-makers must be opportunistic in strategic planning and focus on the feasible.

NHPSP development in a rapidly changing environment sometimes renders a comprehensive health plan difficult, especially when the plan is not tailored enough to the specific environment. Complex situations require considerable flexibility in planning and a greater focus on learning and adaptation.

As a result of the uncertainty, the temporal horizon of NHPSPs in fragile settings should make room for potential revisions and changes; it should still stay concrete, with proximate objectives and mechanisms for revising objectives and broad activity areas in place. In particularly unstable situations, the absence of a prescriptive strategy can be an advantage, allowing for more flexibility and easier learning and adaptation.[XI]

Decision-makers must be opportunistic, focusing on the feasible, which is usually distant from the desirable. The challenge is to give a sector-wide purpose to assorted measures taken because they are considered feasible (see Box 5.9). Even modest success may attract other players, and generate the willingness to tackle more difficult issues. Partners should seek concrete responses to real problems, which bring benefits to the whole system and stand a chance of working even in a possible worst-case scenario.

Bottom-up planning focuses on strengthening structures already in place, integrating them into a functional system, and establishing new ones as the case permits. This is usually more valuable than an ambitious NHPSP with a distant time horizon. In many contexts under stress, the most promising level for pursuing the rationalization of health service delivery seems the provincial or local one.

Adapting to the evolving context and learning from experience are key: "The more complex and elusive our problems are, the more effective trial and error becomes... Yet it is an approach that runs counter to our instincts, and to the way in which traditional organisations work".[30]

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

Box 5.9

Strengthening strategic planning in Liberia after the end of the civil war in 2003[31]

Following two civil wars, Liberia is on the road to recovery. Since its 2003 Comprehensive Peace Agreement, the country has experienced relative peace and stability through democratic elections and support from the international community. Due to the fragile nature of the post-conflict state, characterized by years of uneven political, economic and social development, strategic policy-making was vital to ensure the development of a solid policy framework void of gaps. The first Liberian National Health Policy (NHP) created in 2007 came at a crucial time for health system development.

Health planning stakeholders were aware of the importance of being opportunistic and flexible in planning, thus the NHPSP consisted of two broad but feasible goals to start rebuilding the health system. The first goal was to establish a basic package of health services that would be free to the entire population, focusing on the most urgent health priorities (communicable disease control, emergency care, maternal and newborn health, mental health care), following a long period of minimal investment in health. The war had had a devastating effect on health and development indicators; ensuring that basic services could be delivered to Liberia's citizens would hopefully set a policy foundation for broadening the services provided by the Ministry of Health and Social Welfare. The second goal placed an emphasis on building strong, sustainable and capable health institutions, particularly through a process of decentralization and integrating health system plans with other development sectors' plans. This goal was deliberately kept broad in order to enable sub-national levels to more easily adapt in their plans to the overarching NHPSP.

The challenges in rebuilding health system infrastructure are far from over. The Ebola crisis in 2014 exacerbated these challenges, especially issues linked to poor monitoring and evaluation systems, continued reliance on donor support, large out-of-pocket payments, low quality of basic and essential services, and health worker shortages. The 2015 Investment Plan for Building a Resilient Health System in Liberia has attempted to build on feasible objectives, with lessons learned from the past, to make progress in Liberia's health sector.

5.7.3 What if your country is highly dependent on aid?

In an aid-dependent context, a robust and inclusive NHPSP development process is likely to increase the ability of the government to set its own agenda and rally external partners around it.

The capacity of multilateral and bilateral agencies to exert leverage over national policy-making processes can increase in proportion to the dependency of the country's government on donor support for financing recurrent costs of the health system. Especially in such cases, a robust and inclusive NHPSP development process is likely to increase the ability of the government to set its own agenda and rally external partners around it.

In an aid-dependent context, a transparent and open consultation is crucial, in order to both ensure relevance of the NHPSP vis-à-vis donor interests and to come to a consensus on any contentious issues. In addition, health planning stakeholders must recognize the need to put effort into developing cohesive support by a broad range of interest groups. Even groups who may have shown little interest should be actively brought into the NHPSP process where possible.

High aid-dependency often goes hand-in-hand with the vertical nature of national disease programmes. This entails the risk of a disconnect between planning for disease-specific programmes and the NHPSP, leading to fragmentation and increased transaction costs. Well-funded programmes may be reluctant or unwilling to participate in the full-sector strategic planning process. Targeted partnership arrangements with these programmes and external partners under national leadership along the lines of national IHP+ compacts,[XII] memoranda of understanding, and bilateral agreements can help to avoid these problems.

XII For more information please the visit IHP+ website: http://www.internationalhealthpartnership.net/en/key-issues/compacts/

5.8 Conclusion

A strategic plan is the overarching guidance document which should steer the health sector towards its stated goals for a medium-term period (generally 3–5 years). The decision on where the health sector should go, as captured in the NHPSP, should be a joint one involving a variety of health stakeholders, with the MoH coordinating and leading the process. A strategic plan is necessary because it has the potential, if done well, to help concretize priorities; to keep the focus on the medium- to long-run, thereby avoiding deviation in vision and optimal strategies; to avoid fragmentation of the health sector; and to help focus the policy dialogue on health sector priorities.

Much has been said on the limited usefulness of strategic plans – but the problem here is not the strategic plan itself; rather it is a lack of coherence in the way it is developed, disseminated and used. For a NHPSP to take on its rightful role as the health sector reference document, it must have adequate buy-in and relevance, be solidly evidence-based and include and involve all programmes, regions, districts, population groups and viewpoints. In the 21st century, the multi-stakeholder process is key, with the aim being a consensus-based strategic document that reflects the priorities of its intended beneficiaries, its providers and the government.

Nevertheless, there are definitely limitations to a NHPSP. It is just a document in the end. In and of itself, it will not ensure success in implementation. It does not replace the need for sector steering capacity and leadership, energetic and innovative management and constant evidence-based policy dialogue on pertinent issues.

In this chapter, guidance is provided on developing a relevant NHPSP which is referred to, consulted and used. Steps are proposed to manage the NHPSP development process and common challenges and mistakes are pointed out with suggested solutions.

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Annex 5.1

Review of existing policies and strategies to ensure inclusion in and harmonization with NHPSP

When developing a NHPSP, it is necessary to review other existing policies and strategies with regard to their relevance for the health plan in development. In view of this, the questions listed below can be helpful.

1. Where does the policy/strategy idea come from? Government manifesto, the minister, the agency, chief executive, policy branch, delivery staff, an interest group, a community consultation?

2. Is the policy/strategy defined adequately?

   - Do we have a clear authoritative statement of intent of the desired outcome? Is there agreement on the nature of the problem?
   - Are there feasible solutions?
   - Is it a problem for the government or someone else?
   - Is there adequate "evidence" to justify the proposal?
   - What is the optimal timing of: (a) the decision? (b) implementation?

3. Is the underlying analysis adequate?

   - Are the objectives and goals explicit and unambiguous?
   - Has there been a thorough search for options?
   - Have the appropriate methodologies (mix of policy instruments) been employed?
   - Is there a preferred option?
   - Has implementation been considered?
   - Is legislative action required?
   - Has the proposal's relationship to "the health plan" been considered?
   - Has a consultation process been developed: (a) within government? (b) with other stakeholders? (c) with the community?
   - Have the possibilities of external assistance been explored?

With regard to inclusion and harmonization into the NHPSP, the following questions should be asked.

- What is the time line for presentation to the decision-maker, chief executive, minister, cabinet?
- Are there dissenting views of which the decision-maker should be informed?
- Are the "right" options exposed to the decision-maker?
- Is there a clear expression of the relationship of the proposal to: (a) the budget? (b) the "health plan"? (c) the "national plan"?
- Are the workforce implications clear?
- Are the legal implications (authority and enforcement) identified?
- Has the proposed involvement of donors, including international agencies, been discussed with them? Are there concrete proposals or commitments?
- Who has been consulted; who should be informed before the decision is announced?
- What should be done to "sell" the policy?
- Is the implementation time line sufficiently detailed; are those to be held accountable identified?
- What are the risks for the government and the community?

Annex 5.2
Mind-mapping

Mind-mapping is a way of capturing a combination of information and ideas, and of organizing them. It relies on pictorial representations of the flow and synthesis of ideas. It is used for standard flip chart-based discussions, as well as computer-based exercises.

This tool is particularly useful when a group of planners with different backgrounds is considering the option of introducing or adjusting strategies or reforms. It helps the group to find common ground in weighing options.

Source: www.mindmapping.com, accessed 4 October 2016

Annex 5.3
Formulating strategic objectives on the basis of SMART criteria

Goal # _____ *(write goal number or statement here)*	**Objective Number**					
Test Questions	**1**	**2**	**3**	**4**	**5**	**6**
1. Will attainment of the objective help the goal?						
2. Does the goal have at least one objective?						
3. Is the objective evidence-based (supported by data and theory)?						
4. Does the objective specify a starting (baseline) value or condition and a desired accomplishment (target value or condition)?						
5. Can progress toward achieving the objective be measured?						
6. Is the objective attainable and realistic, given the planning period and available recources?						
7. Does the objective specify a ***realistic result***, rather than an ***activity***?						
8. Is a time frame specified for attainment of the objective or implied in the Plan, itself?						
9. Would someone unfamiliar with the planning group understand what the objective means?						
10. Have you indentified who will be accountable for achieving the objective?						

Source: http://hr.tufts.edu/wp-content/uploads/ODT_smart_goal_criteria.pdf, accessed 4 October 2016.

Annex 5.4

Intervention logic as a tool for strategic planning

Intervention logic attempts to tease out the steps between the activity and final outcome. Within the context of NHPSPs, the technique focuses the planner on each intermediate step necessary to go from a broad activity area to the intended outcome or goal. It helps avoid big leaps in logic from the most easily identified output to a more distant outcome, without thinking through the intermediate steps. Assumptions are explicitly stated and risk scenarios are considered. Intervention (or programme) logic can be employed for policy design, programme planning and policy evaluation.

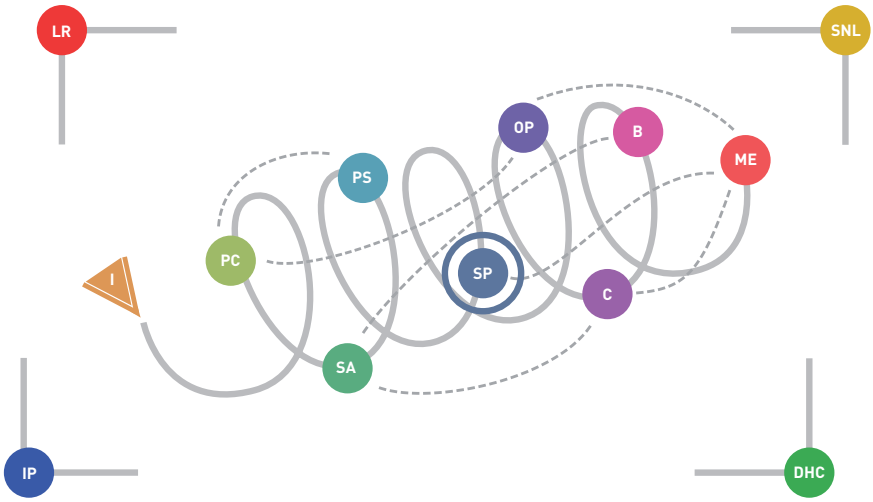
An important advantage of this technique is that it focuses attention on what the government plans to do with what it hopes to achieve. At the heart of the process is the notion of a "hierarchy" or 'cascade' of outcomes (intermediate results).

Annex 5.5

Gantt chart

A Gantt chart is a simple aid used to develop an action plan and monitor that plan, with tasks and timelines visually linked. In the NHPSP context, a Gantt chart can be used for the NHPSP itself, or to prepare and follow up on the NHPSP process. For example, each activity can be listed with start and end dates, depicted on a linear timeline using a horizontal bar. The advantage of a Gantt chart is that activities are presented visually in logical sequence. The chart makes visually clear which tasks need to be carried out and when. For the NHPSP process, a Gantt chart can depict tasks by semester or quarter, with key phases and steps, as well as the person or institution responsible for steering, coordinating, supporting, oversight reporting and implementation.

Source: www.gantt.com, accessed 4 October 2016.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