World Health Organization

Strategizing national health in the 21st century: a handbook

Chapter 13

Strategizing in distressed health contexts

Enrico Pavignani

Sandro Colombo

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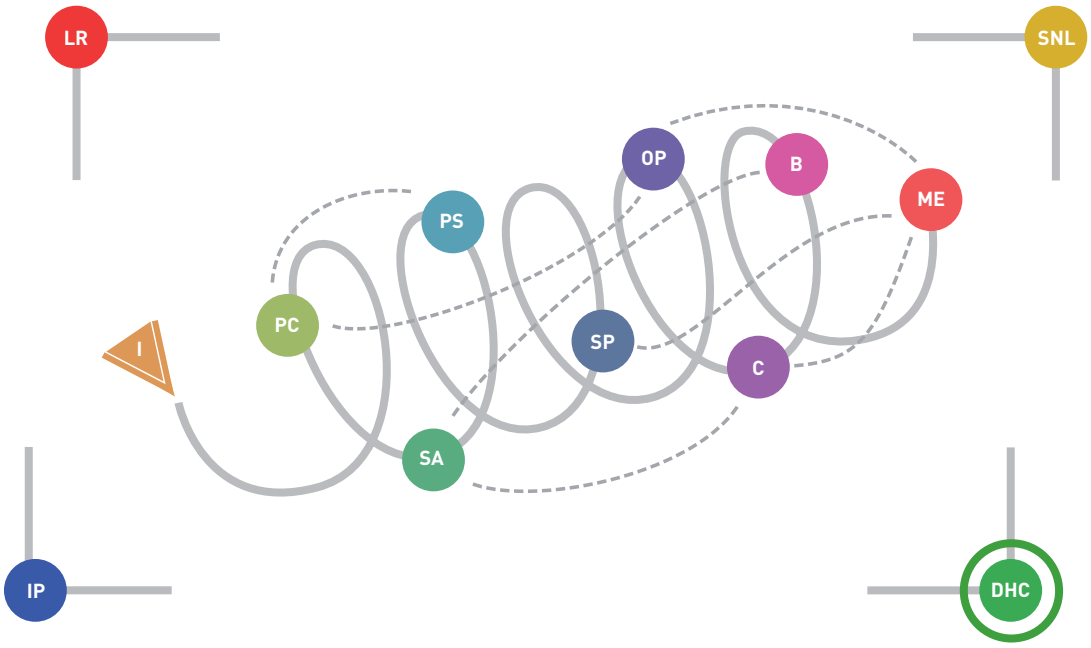

I CHAPTER 1 Introduction: strategizing national health in the 21st century

PC CHAPTER 2 Population consultation on needs and expectations

SA CHAPTER 3 Situation analysis of the health sector

PS CHAPTER 4 Priority-setting for national health policies, strategies and plans

SP CHAPTER 5 Strategic planning: transforming priorities into plans

OP CHAPTER 6 Operational planning: transforming plans into action

C CHAPTER 7 Estimating cost implications of a national health policy, strategy or plan

B CHAPTER 8 Budgeting for health

ME CHAPTER 9 Monitoring and evaluation of national health policies, strategies and plans

Cross-cutting topics relevant to national health planning

LR CHAPTER 10 Law, regulation and strategizing for health

SNL CHAPTER 11 Strategizing for health at sub-national level

IP CHAPTER 12 Intersectoral planning for health and health equity

DHC CHAPTER 13 Strategizing in distressed health contexts

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Contents

13.1 The context of "fragile" states 1

13.2 Aid in fragile states 4

13.3 Health policies, strategies and plans in distressed settings 7

13.3.1 Context and actors 7

13.3.2 Information, the foundation of the policy and planning process 8

13.3.3 General principles 12

13.3.4 Learning from international experience 18

13.3.5 Specific situations, calling for tailored approaches 21

13.3.6 Essential aspects to be considered in relation to some subsectors 26

13.4 Conclusion 34

References 36

Further reading 38

Annex 13.1 Assessing the usefulness of a health policy/strategy/plan 42

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Overview

This publication does not propose detailed instructions to be mechanically followed, nor does it attempt to simplify the issues at stake, in the firm belief that no blueprinted approach can produce satisfactory outcomes. The challenges posed by policy and strategy formulation and planning in health systems under stress are discussed, highlighting the main differences with these processes in more stable environments. Lessons learnt in "fragile" contexts are used to suggest adapted policy and planning approaches and to provide suggestions for avoiding the most common mistakes.

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Summary

Section 1

Sets the scene, looking at how different situations of weakness, poverty and violence fit uneasily into the "fragile state" concept and category. The section introduces the main determinants of fragility and stresses their self-reinforcing nature. It emphasizes the need for understanding the context and its possible evolution before formulating strategies.

Section 2

Discusses aid in fragile states, an issue receiving renewed interest. The section looks at requirements and principles of aid management in fragile states, as well as at some of the most important donor agendas and instruments, arguing that current approaches are ill-suited to unstable contexts and new modalities are needed to improve aid effectiveness.

Section 3

Looks at those characteristics of fragile states that impact on health policy and planning and that require adapted approaches. It considers the dynamic and unpredictable context and the mix of actors within and outside of the health field. Performing a situation analysis in these settings, including assessing the capacity of key public and private health actors is critical, but challenging. Like in stable countries, strategy formulation and planning in fragile contexts are political, iterative and continuing processes, which require negotiation with the many stakeholders.

A strong monitoring and evaluation component is the link between strategy formulation and implementation. It provides indications about necessary adjustments to strategies and plans. To facilitate the tailoring of approaches to specific situations, a new empirical typology of situations is proposed, with suggestions about the possible courses of action. Critical aspects related to key subsectors (financing, human resources, medicines and infrastructure) are then discussed.

The chapter concludes with a selected annotated bibliography. Annex 13.1 presents criteria for appraising a policy or a strategy.

13.1 The context of "fragile" states

In this chapter, the term 'fragile states' is retained because of its widespread currency, despite its obvious inadequacy, which is discussed.

There is no agreement on a common list of fragile states.

Terms to identify and classify weak states have evolved since the late 1980s, when policy-makers and scholars turned their interest to state failure.[1,I] More recently, the terms "fragility" and "situations of fragility" are being increasingly used, to highlight the need to look to non-state actors.[2] Yet, state fragility "remains an elusive concept".[3] Together with the evolution of the terms, typologies and indices of state fragility have multiplied: as a result, no agreement exists on a common list of actual fragile states. The various definitions converge towards a combination of dysfunctions in key governance dimensions: inability to protect populations from violence, failure to provide basic services, lack of legitimacy, often combined with human rights violations.

The label of fragile states is broad: not only are there differences in degrees, types and drivers of state weakness, but fragility varies substantially within the same country, as, for example, in the Democratic Republic of the Congo and Sudan. Further, fragile states tend to cluster geographically, as in the Great Lakes; the Horn of Africa; Afghanistan and Pakistan. Such regions are characterized by trans-border trade of legal and illegal goods, human trafficking and other criminal activities, and often provide havens to terrorist and rebel groups. Globalization enables, through communication technologies and market deregulation, the integration between informal and formal economies, and between state and non-state networks.

Measuring state fragility is problematic: it requires not only defining some state model as a benchmark, but also choosing among ranking systems developed for different purposes and

I quasi or pseudo states to least-developed countries, low-income countries under stress, collapsed, rogue, failed, failing, in crisis, poorly performing, in arrested development.

NATIONAL IMMUNIZATION DAYS (NIDS)
SAY NO TO POLIO, VACCINATE ALL CHILDREN
UNDER FIVE YEARS OF AGE ON NOVEMBER 11 - 15
AND AGAIN ON DECEMBER 9 TO 13
UNICEF
PolioPlus
Rotary International
EUROPEAN UNION
UNMIL
USAID
WORLD HEALTH ORGANIZATION
GOL
MINISTRY OF HEALTH AND SOCIAL WELFARE

based on different indicators, data sources and aggregation methods.

Determinants of fragility include conflicts, weak institutions, external shocks, poverty, disease and regional instability. [2, 4] It is the interplay of these determinants that establishes the outcome; dynamics can vary from one situation to another, even when key characteristics of fragility look similar. Drivers of dysfunctional governance are often self- and mutually-reinforcing: as a result, the rapidly changing environments pose additional challenges to policy-makers, donors and practitioners.

Before formulating recovery strategies, stakeholders should consider what the main characteristics of the given crisis are, and what the future country context might look like.

- First, whether the present turmoil is structural or transient should be assessed. Indeed, the recent turbulent history of the Darfur region of Sudan or that of the Democratic Republic of Congo, once appraised in a perspective of the past 100 years, suggests the presence of structural stressors that are not likely to recede anytime soon.
- Second, the odds that a legitimate, benevolent, performing state administration will eventually emerge from the protracted crisis need to be realistically evaluated.
- Third, the chances of a country already fragmented by violence remaining intact must be assessed. Eritrea and South Sudan succeeded in their quest for internationally-recognized statehood, and there are regularly other political formations in the world that aspire for their own independent statehood.
- Fourth, the economic prospects, the recovery (or not) of livelihoods, and the resettlement of displaced people and refugees have to be appraised.
- Finally, the supranational landscape needs to be understood: for how long will external actors remain involved in domestic affairs? Will donors support transition and health system development? Will neighbouring countries recover, or contribute to perpetuating the crisis? Whereas the Guinea-Liberia-Sierra Leone crisis complex seemed to be on its way to recovery before the 2014 Ebola outbreak, the one constituted by the Central African Republic, Chad, and the Darfur region of Sudan offers no such hopes.

The first step in health strategy development and planning is to analyse the broad context, identify the main characteristics of the crisis, and understand likely political and economic evolutions.

In situations where facts are scarce but rumours abundant, simplified narratives may displace more insightful interpretations and strongly influence the identification of policy and strategy priorities, regardless of the reality on the ground. Autesserre illustrates how in the case of the Democratic Republic of Congo dominant "frames" about the country have had a profound influence on strategies and practices, with unintended consequences.[5]

The limitations of current definitions and typologies suggest that effective health policies and plans need a contextual understanding vastly deeper than the one of the conventional Fragile state approach. We propose, therefore, an empirical typology of situations for adapted approaches to health policy and planning. This characterization, to be discussed in section 3.5, considers the country context, the political and health actors, and their interactions in health policy and planning. Fragile states' health systems are typified according to the capacity and resources made available, the legitimacy and commitment of the government and other power holders, and the other key health actors: donors, charities, international agencies and programmes, private providers, etc.

13.2 Aid in fragile states

In the aftermath of the September 11 events in the United States of America in 2001, the discourse on dysfunctional states has taken centre stage: "The threat of an excluded South fomenting international instability through conflict, criminal activity and terrorism is now part of a new security framework",[6] a sharp turn from the previous doctrine that preached the rolling back of the state. Consensus is now that "resilient" states constitute a prerequisite for international security, stability and market liberalization.[7,8] Given the mounting awareness of the costs and consequences of instability, the risk of delivering aid to weak countries has been accepted. And, in fact, peacekeeping operations absorb larger resources than development assistance: for example, the cost of UN peacekeeping forces in Liberia and Sierra Leone was five times higher than aid flows.[9]

Discordant voices on the fragile states concept, however, claim that: "current donor interpretations of fragile statehood are flawed, serving ... [the] demand for simplistic forms of information and generalization that lead to technocratic 'solutions' to complex political problems".[10] By conflating different situations, the fragile states agenda confounds rather than clarifies the issues at stake. Moreover, by putting the onus of fragility on the troubled country, such an approach absolves donor states of their responsibilities. Indeed, the permanent turbulence of Afghanistan cannot be understood without considering the chronic intervention of external powers in its internal affairs, a factor sidelined by the fragile states discourse.[11]

By conflating different situations, the fragile states agenda confounds rather than clarifies the issues at stake.

Concomitantly with the new interest of donors in fragile states, more aid has been directed to these environments.[12] However, aid selectivity has been applied also to fragile states: Afghanistan and Iraq absorbed 34% of the total increase in aid to fragile countries between 2000 and 2008.[13]

The need for changes in the volume of aid and the ways to deliver it in fragile contexts has reached the top of the agenda of the international community. Recognizing the special challenges presented by fragile states, the Organisation for Economic Co-operation and Development formulated, in 2007, a set of general principles for "good international engagement in fragile states".[14] Four years later, the "G7+" group was instrumental in the development of a "New Deal for Fragile States"[15] that was endorsed in Busan in 2011. As with other global commitments, however, this proclaimed awareness needs to be translated into actual changes in donor practice, an occurrence not to be taken for granted given the inherent conservatism of the aid industry.

Appropriate approaches wanted: Under- or misgoverned countries test to the extreme the way the aid industry is structured and performs. The role of aid in fixing structural problems, such as those plaguing fragile states, is limited, as Rogerson highlights: "Development processes are led by complex, uncertain, context-specific social and political dynamics and responses to national challenges. ... Aid is marginal to these dynamics in most country contexts unless, by fortunate positioning or even accident as much as good design, it happens to align with them. In the best of circumstances, it provides some positive reinforcement".[16]

Thus, the applicability of the main aid agendas and instruments must be seriously reconsidered. For instance, the basic enabling conditions for achieving the Millennium Development Goals (MDGs) – such as trust, predictability, adequate information, a controlled environment and sustained investment – are not present. A critic of the MDGs agenda claims that the MDGs may be, if the situation does not change, "another major failure of the prescriptive approach to strategy".[17]

The Aid Effectiveness Agenda, as defined by the Paris Declaration and Accra Agenda for Action,[18] needs to be adapted to distressed contexts, where political leaders often give primacy to short-term political needs, rather than to development goals.[19] In contexts where ownership is found mostly in its informal and fluid variety, at local level and with private institutions delivering public goods, aid effectiveness cannot be pursued through feeble governments. In fact, the blind application of the aid effectiveness principles to the complex settings of Afghanistan, where strong local constituencies oppose the strengthening of the central government, has had unwanted but predictable effects, such as undermining peace-building and state-building efforts and even obstructing the emergence of an inclusive national ownership.[20]

In addition, pursued policies can bear little resemblance to official documents: donors risk aligning their programmes to unused country strategies that have been conceived only to satisfy politicians and foreign agencies. The politicization of these environments clearly influences the degree of attainable consensus, inclusiveness and partnership. Alignment cannot be pursued in light of the precarious conditions of indigenous institutions, the increased role of non-state actors to fill the gap left by weak health authorities and the shaky developmental role played by recipient governments. Meanwhile, harmonization, stated commitments notwithstanding, remains elusive. Finally, in fluid contexts, rational programming and management by results must be questioned as realistic decision-making options.

Despite their appeal, the merits of multi-donor trust funds (MDTFs) in such contexts must be questioned. In several cases, the high cost of establishing these instruments, their slowness in disbursing funds, and poor response to unforeseen events have hampered their potential returns. Time and again "standards and procedures difficult for highly developed regimes to follow have been imposed upon young public administrations to the sole benefit of international financial firms".[21] The recent experience of the MDTF in South Sudan has confirmed the inappropriateness of such instruments.[22] Interestingly, Liberia (one of the most successful post-conflict recovery processes before the country was hit by the Ebola outbreak in 2014) has preferred to reject the MDTF model, opting for more modest sector arrangements.[23]

Aid management in fragile contexts must adopt modest, politically-informed, context-specific, and tailor-made approaches.

Another barrier to aid effectiveness is represented by the customary split between development and humanitarian aid, which is inappropriate in chronically-troubled settings, where acute crises are recurrent. Afghanistan, the Democratic Republic of Congo, Haiti, Somalia and South Sudan call for constant, open-ended aid flows, which sustain both developmental and humanitarian actions, according to the needs and opportunities.

"In countries in which donor funds contribute a significant proportion of public health expenditure, public sector failure must be regarded as 'donor and international agency failure' as well".[24] Donors must accept their expanded responsibility in contexts where health authorities are unable or unwilling to play their official role. Accepting their expanded role, and taking full responsibility for failures, implies a thorough redesign of the way donors intervene in under-governed environments, and evaluate their performance. In many distressed contexts, donors are already dominating the health policy process through the financing lever they control, without being willing to acknowledge it. In other situations,

In order to support dysfunctional states, donors must dramatically overhaul their understanding of the operating context and discard blueprinted solutions.

external assistance shapes the health field, without encouraging a productive policy process, with facts on the ground preceding intentions. For instance, in Haiti, performance-based financing (PBF) was initiated in 1999 by one nongovernmental organization (NGO); later on, all the NGOs funded by the same donor were using this scheme.[25] It was only recently, however, that PBF was piloted in public health facilities and was officially acknowledged as a guiding principle for health financing.

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13.3 Health policies, strategies and plans in distressed settings

13.3.1 Context and actors

The analysis of the broad context of the crisis and its determinants – politics, economic and social aspects, and geography – is key to understanding which policies and strategies are feasible and have a chance of success. Fragile contexts are fluid, unpredictable, pluralistic, with huge variations within countries, and important trans-border links. In fact, the broader context shapes health care developments to an extent often unrealized by stakeholders. Thus, the neglect of social factors jeopardizes many health policy and planning efforts, as recognized with hind-sight in Cambodia, where "it has most probably been the underestimation of the social impacts of transition that has been the 'missing piece' in recent national and regional policy analysis (which relies almost solely on epidemiological or technical health reference points)".[26] South Sudan's unravelling in 2013 provides a cautionary tale about investing in conventional health system development, without paying due attention to the precarious foundations on which the newborn state rested.

Among key contextual determinants, geography and the environment are frequently overlooked by health actors, despite their influence on events, and on the responses to them. Internal communications are as important as the links with neighbouring countries or regions. The Democratic Republic of Congo, with its poorly-connected populated peripheries and an empty core, is structurally fissiparous and opposed to centralized rule. Ecological factors, such as drought and desertification, alter established ways of living, and may extend or even perpetuate the crisis, as displayed in the Darfur conflict, which can be primarily read in environmental terms. Countries with a "difficult geography"[27] pose special challenges to state-builders, military commanders, revenue authorities and health planners.

Studying crisis complexes (e.g. the African Great Lakes and the Middle East), instead of single countries, provides a definite analytical advantage, in light of political, security, economic, ethnic, criminal and migratory links, which bind together countries officially separated by porous, arbitrary and often contested borders. Health services provision, too, is affected by supra-national factors, as people, germs, ideas, medicines, funds and health workers incessantly cross borders. The Ebola epidemic that ravaged West Africa in 2014 is a sober reminder of the inadequacy of a narrow focus on official state territories, rather than on populations. Unfortunately, most health management structures and health data are state-centric. Without additional analytical efforts "the geographical reorganization of health care within and across borders under conditions of war"[28] will be missed or misread.

Actors are an unruly mix of official and informal individuals and groups, enjoying different degrees of autonomy, entering and leaving the health arena, often playing multiple roles. Health authorities, state agencies, donors, international organizations, disease-control programmes, charities, NGOs, private entrepreneurs, health workers, professional associations, political parties, activist and opposition groups, all affect health care developments, sometimes explicitly but often quietly. Understanding their roles, links, networks, power and influences in the health system is critical; new approaches have been used to map out relationships between players.

The analysis of the context must be comprehensive, including all factors that can influence the development and then implementation of health strategies. This analysis requires analytical skills, a substantial investment in time and resources and a consultation process, whose modalities depend on the specific political context.

13.3.2 Information, the foundation of the policy and planning process

Since the picture is blurred and quickly changing, making sense of it and identifying trends is paramount. Assembling a reliable situation analysis entails adapted efforts, given the poor information base, the fluid context and the inadequate capacity of health actors to collect useful data, monitor trends and understand macro events and developments, both general and health-related. Penetrating messy realities requires deciding which data should and could be collected and analysed, their level of disaggregation, and their quality and limitations. The trends, patterns and relationships have to be understood, and the findings of the analysis shared in a meaningful and accessible way. Pre-crisis baseline indicators are often absent or too weak for a valid trend analysis; comparison with available data from relevant contexts becomes, therefore, crucial.

In many troubled health systems, the available information is quite rich, contrary to what is usually admitted.

In many troubled health systems, the available information is quite rich (contrary to what is usually admitted), but is dispersed among agencies, programmes and institutions and compiled in assorted formats according to narrow interests, such as disease control or population groups. Many participants hold a detailed knowledge of specific aspects, but lack an understanding of sectorwide characteristics and trends. Assembling the discrete pieces of information may go a long way towards producing a comprehensive picture, whose contours and internal relationships may have been missed even by the most informed actors. Keeping the picture updated is essential. Robust situation analyses have been produced in Afghanistan, Somalia, Sri Lanka, and in the Darfur region of Sudan, but the evolving context requires frequent revisions and adjustments.

A valid situation analysis helps to identify key issues of the health system to be addressed, and to choose between alternative courses of action. Health systems under stress exhibit recurring features, such as privatization and commoditization, urban and hospital biases, poor-quality care, a bloated but unproductive workforce, dysfunctional referral flows, and/or derelict infrastructure. These key issues must be clearly singled out by the situation analysis, and consistently tackled by any valid policy or strategy.

The process of building the situation analysis by putting together pieces of intelligence from different sources has to be iterative. Each round will produce a stronger analysis, single out new aspects to be investigated, and point to measures to be introduced. Once the main health policy and planning issues characterizing the health systems are recognized, the need must be determined for policy-oriented studies to help decision-makers appraise existing problems and options, and to bring attention to aspects that have been neglected. For instance, counterfeit medicines are reckoned to circulate freely in most under-regulated pharmaceutical subsectors. However, the evidence for this claim is frequently inconclusive. The severity of the problem should be assessed through a dedicated study, before corrective measures are discussed and introduced. In this way, a baseline would be set, and the relative weight of this issue would be appraised in comparison to other competing problems.

Common challenges in stable contexts – such as the changing environment, fragmentation, insufficient implementation capacity, extreme politicization, the actions of non-state actors, and the frequent turnover of players – are amplified in distressed environments, resulting in a disconnect between official policies and reality. For example, many countries give stated priority

to primary health care, whereas in practice the bulk of the resources are absorbed by large hospitals. Analogously, even donor agencies that recognize the primacy of context in policy-making and planning, and the need to strengthen whole health systems, may direct their funding to vertical disease-control programmes despite their relative lack of importance at country level.

Furthermore, path dependency, i.e. how past health policy/strategy choices influence future options, has to be taken into account. Documenting past experiences may teach valuable lessons about approaches adopted and discarded, and later adopted again. For instance, many health systems have made repeated attempts with community health workers, each round looking strikingly similar to previous ones. Due to lost memory, continuous reshuffling of decision-makers and new international fashions, the same mistakes recur time and again. Analysing past health policies and strategies gives important clues,[29] including power relationships among key health actors and resistance (or receptiveness) of national authorities to change. In most health systems, the medical lobby enjoys a strong influence, which helps explain certain patterns, such as adopted service delivery models and financing mechanisms.

Conventional opposition terms, such as private/public, formal/informal, foreign/domestic, qualified/unqualified, traditional/modern, legal/illegal, look inapplicable and devoid of meaning in most circumstances. This calls for a redesign of the way data are collected and analysed. Many internationally-accepted data collection procedures are ill-suited to these environments and need to be adjusted. Adapted definitions are needed, so that data shed light on problems, rather than obscuring them. For example, the recognition that most health workers fall between the two poles of qualified and unqualified should help conceive definitions applicable in the majority of situations. Removing (or qualifying) value-laden concepts, such as corruption, from the analysis should in principle focus attention on actual patterns of health care provision, and their effects.

In distressed contexts, information must be assembled from different sources in an iterative process. Methods and approaches for data collection must be adapted to the often insecure and partly inaccessible context.

Routine information systems, even if they generate usable outputs, tend to neglect private, informal, illegal and folk health care provision, capturing only the small portion of the whole health system that is amenable to orthodox definition. Dedicated surveys applying specially tailored methods are needed to explore the large constituents of health services customarily missed. Otherwise, standard surveys carried out in troubled contexts will generate implausible findings, as happens frequently with National Health Accounts, or Demographic and Health Surveys. These surveys also have problems of representativeness, since some areas can be inaccessible for security or other reasons. Unless unconventional health care is brought to the fore, and its role(s) in the whole field understood, no meaningful sectorwide policy can be conceived, nor can a plan be successfully implemented.

Caution is in order about the soundness of situation analyses that may be based on incomplete and weak data, and fail to reflect true patterns and trends. Collected to satisfy the needs of agencies remote from the field, it is tempting for such analyses to portray the situation in convenient (when not misleading) terms, simplifying disorder and suggesting comfortable ways to deal with it. Fund-raising and reputation pressures encourage the production of reports claiming progress in the health field, amidst a deteriorating political and security situation (as in Afghanistan). To be truly helpful, a solid

situation analysis should try to debunk any circulating "social facts", i.e. "things that are deemed to be 'true' because they are widely believed to be true".[30] Its factual foundations must be rigorously ensured, and their limitations acknowledged.

Recognizing diversity. Health systems development is impacted by long distances, poor communications, violence, market forces, demography, actors, climate and inadequate resources and capacity. The customary portrait of a "*national health system*" with a national health policy and strategy should be viewed with caution. Different patterns of health care provision are usually recognizable, if sufficient analytical efforts are made. Assorted local health care arrangements emerge and coexist, sometimes unnoticed (or reluctantly acknowledged) by official sources. In light of such spontaneous diversification, sectorwide analyses must be assembled bottom-upwards, by studying as many distinct local situations as possible, and refraining from countrywide generalizations, such as those based on average indicators, which can hide rather than reveal the variations existing on the ground. The health system under scrutiny has therefore to be seen as a constellation of differentiated regions, each evolving at its own pace and often in diverging directions. Strategies, interventions and service delivery models should be diversified to take advantage and respond to local needs, demands and opportunities. Likewise, "national" programmes should adapt to multiple under-governed environments. For example, different service packages need to be provided to high- and low-density communities, and to nomadic groups.

Strategies, interventions and service delivery models should be diversified to take advantage and respond to local needs, demands and opportunities.

Monitoring and evaluation must be continuous, and feed decision-making in order to adjust strategies or plans in real time. Indeed, "a large part of the information needed for implementation is generated along the way, making it essential that plans are more adaptive to unfolding realities".[31] The resource implications of a strong and continuous monitoring system should be considered in the early phases of planning: "Less time and resources should be spent on upfront planning and more on processes to monitor and feed back learning from implementation".[32] Monitoring trends is essential to capture the progress registered in enforcing policies and implementing plans. Population figures are, in many settings, absent, volatile or vulnerable to manipulation. Trends would be more reliably monitored by using absolute output figures than through coverage rates or measures of impact.

A sectorwide perspective, which identifies and tracks unexpected events and processes as much as planned ones, must be adopted. In fact, certain important developments – such as private provision, dual practice, sub-standard goods and services and trans-border activities – may escape official recognition, despite their impact on service delivery.

Indicators are not only monitoring tools: they may affect management decisions. Some services, or aspects of services, that are closely monitored by health authorities or international bodies (usually because they are easier to measure), are given more attention than others, regardless of their relative importance on the ground. Note also that the awareness of being monitored encourages cheating, particularly if reported figures are linked to incentives.[33] Indicators given special importance by central authorities may affect peripheral decisions. For example, the Sudanese Federal Ministry of

Health (MoH) relies on ratios of health facilities to population to gauge the offer of basic services across the country. In the violence-plagued region of Darfur, this indicator cannot be relied upon, due to the lack of reliable census data, the displacement of large populations and the services provided by NGOs in IDP (internally displaced persons) camps. Furthermore, many facilities are substandard and frequently contiguous. In 2012, only one third of hospitals performed caesarean sections, while only one third of health centres had a laboratory; only a minority of health facilities had electricity and safe water.[34] The rational response to such shortcomings would be to close down redundant and underused facilities, in order to raise the capacity of the rest to acceptable levels. This move would improve actual access to services, but would also worsen population ratios. As such, it would not appeal to local managers keen to feed central health authorities with improving, rather than worsening, ratios.

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13.3.3 General principles

Successful strategies and plans cannot be imposed: they have to be negotiated with key health actors to have a chance of being successfully implemented. Flexible plans and learning from experience during their implementation allow for adaptation and adjustments.

Negotiating health policies and plans. Policy-making and planning in health systems under stress are "an inherently political process"[35] which involves negotiating realistic problem-oriented measures with autonomous stakeholders: "making and implementing strategy among a set of heterogeneous actors subject to a multitude of pressures and priorities is ultimately an act of continuous interpretation".[36] In these situations, it is not always easy to forge common goals; doing so can take up precious time and delay action, especially if tensions are high between stakeholders.

While policy papers and plans are written, facts on the ground are consumed, affecting the directions taken by health services. For example, many MoHs are keen to formulate idealized basic packages of care, while private and public facilities provide very different mixes of services. Or diaspora benefactors finance new health care outlets according to considerations other than rationalist planning criteria. Policies and strategies are often formulated without understanding the issues at stake, neglecting the feebleness of top-down controls and implementation capacity, and ignoring the action of other players, in settings where uncertainty and instability prevail.

Furthermore, overly optimistic forecasts of the outcomes of strategies and plans are common, driven by political factors or the desire to mobilize additional resources. "The world of strategy is full of disappointment and frustration, of means not working and ends not reached".[37] Policy-makers and planners deprived of resources and power in difficult environments for many years are invariably frustrated and cannot be the most innovative professionals. They must be supported and provided with financial and career incentives to regain confidence that policies and plans stand a chance of being successfully implemented.

In distressed settings, health system developments can be influenced, but not controlled: "by and large, strategy comes into play where there is actual or potential conflict, when interests collide and forms of resolution are required".[38] Some actors enjoy too much power and autonomy to be coerced into prescribed behaviours. Their collaboration must be obtained through compelling ideas based on sound information, coherent behaviour, and open negotiations about mutual benefits, using "the art of seduction. If you want to get others to accept your strategy, seduce them (so to speak)".[39] Policies, strategies, goals, procedures, approaches and indicators must evolve in accordance with the changing environment, while incorporating the experience acquired hands-on, and the fresh information generated by implementing the chosen measures.

Where central control is weak and formal strategy processes are marginally influential, strategies "emerge"[40] almost spontaneously, as a result of decisions taken at different levels of the health system, until a new pattern is recognizable and identified as a new strategy. For instance, the enhanced role of community health workers (CHWs) in service provision can be the result of training activities carried out by different actors at the periphery, until health authorities formalize the reality of these new "cadres". In the same vein, the famed Zone de Santé approach emerged in the former Zaïre, now the Democratic Republic of the Congo, as an effective ground-level response to a management vacuum, formulated by local actors endowed with capacity and resources.

Looking into the future. Crisis settings characterized by turbulence, unexpected discontinuities and uncertainty, amplify another inherent difficulty of policy and planning: to produce accurate forecasting of how the context will evolve and strategies and plans will unfold. Unforeseen changes in security, in donor priorities, in the price of commodities and thus in domestic revenues etc. can disrupt the implementation of strategies in ways impossible to predict when they were formulated. For example, the crisis in Mali at the beginning of 2012 was largely unexpected, as was its precipitous unfolding: the operating environment in the conflict-affected north changed overnight, and health care provision had to adjust to it.

As a result of the uncertainty, the temporal horizon of strategies in turbulent settings should contract, with proximate objectives and mechanisms for revising policies and strategies in place: "The more dynamic the situation, the poorer your foresight will be".[41] In particularly unstable situations, the absence of a prescriptive strategy can represent an advantage, allowing for more flexibility and easier learning and adaptation: "setting oneself on a predetermined course in unknown waters is the perfect way to sail straight into an iceberg. Sometimes it is better to move slowly, a little bit at a time, looking not too far away but very carefully, so that behaviour can be shifted on a moment's notice … strategies are to organizations what blinders are to horses".[42]

Giving purpose to a fragmented field. Decision-makers must be opportunistic, focusing on the feasible, which is usually distant from the desirable: "plans should be light and imaginative, as they are primarily communication tools between involved actors".[34] Drawn-out, cumbersome formulation processes tend to exhaust participants through endless negotiations and the fruitless search for perfect configurations. Once approved, such policies and plans risk remaining on paper.

The challenge is to give a sectorwide purpose to assorted measures taken because they are considered feasible. Clarity of long-term goals must govern decisions that are in large part reactive rather than planned. 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. For example, the establishment of a non-profit pharmaceutical supply agency, able to import and distribute low-cost quality medicines would benefit the whole health care system, as was the case with ASRAMES (Regional Association for the Supply of Essential Medicines) in eastern Democratic Republic of Congo in its first years of life.

Crisis settings are characterized by turbulence, unexpected discontinuities and uncertainty.

Realistic policy-making and planning are premised on the appraisal of resource and capacity constraints. Maximizing the returns of finite resources and scarce capacity is the essence of sound practice. Conversely, trying to address all health needs, by definition infinite, without prioritization, is futile. Needs are usually invoked as the overarching criterion of many policy and planning efforts, but their satisfaction is negated by real-life constraints. Because of resource and capacity determinants, as well as donor interests, the costs of reconstruction of health systems produced by Post-Conflict Needs Assessments are vastly different, despite their intention.[43] In each assessment, the proposed interventions were envisioned according to the varying resource package expected to become available, not according to the health needs of

the affected population, which would arguably differ less from one country to the other.

"The formulation of delivery strategies for a health service never starts with a blank sheet of paper. The present service exists, in whatever form that may be, and the MoH will want to maintain continuity wherever possible".[44] Recurrent funding tends to follow implanted capacity (i.e. investment decisions). Redistributive policies have to be pursued by applying different growth rates to competing health care components, within forecasted total resource constraints. A severe, protracted crisis, by crippling the old architecture of an affected health system, may offer opportunities to design a new one. At the start of the Liberia recovery process, the wrecked condition of the most sophisticated tertiary facility in the country gave health authorities room to invest resolutely on primary health care (PHC), unencumbered by the pressing capacity and resource demands the tertiary facility would have made if it were functioning.

The formulation of delivery strategies for a health service never starts with a blank sheet of paper.

Bottom-up planning focused on strengthening structures already in place, integrating them into a functional system, and establishing new ones as the case permits, is usually more valuable than labouring over a grand national plan with a distant time horizon (which may miss the internal diversity of the health system, and risks remaining on the drawing board). In many contexts under stress, the most promising level for pursuing the rationalization of health service delivery seems the provincial or local one. Here, at a pragmatically-decentralized level, information shortages can be addressed, political dynamics can be understood and taken into account, results can be monitored and informal management practices harnessed to positive effect.

Health systems in these contexts are fragile: they are not suitable to radical and rapid reforms.

Keeping a systemwide perspective. Even simple measures targeting one aspect of service delivery may have system-level effects, which have to be considered when they are conceived and later evaluated.[45] Changing one component of a complex system triggers a readjustment of its functioning. The new level attained may deliver the desired result, but with unexpected side effects or no recognizable effect. Thus, the effects of introducing a change in a subsector must be appraised across the whole health system. For example, physical investment impacts on the number and skill mix of human resources, the supply of medicines, the support systems and, last but not least, the future recurrent costs. Historically, there have been many examples of donor support to narrowly-conceived investments, without any consideration of their effects on the whole health systems, mainly in post-conflict reconstruction.

Questioning the conventional planning approach. Most strategy-formulation processes start by defining a vision, identifying objectives and then describing the ways and means to reach the end goals, but "a strategy that starts with objectives and works backwards is one that is likely to fail".[46] In fact, particularly if the strategy is for the long term, unexpected events will disrupt the envisaged path in its implementation. Freedman argues that "strategy is often expected to start with a description of a desired end state, but in practice there is rarely an orderly movement to goals set in advance. Instead, the process evolves through a series of states, each one not quite what was anticipated or hoped for, requiring a reappraisal and modification of the original strategy, including ultimate objectives".[47] Adaptation 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".[48]

Enforcement and implementation are the most formidable phases for policies and plans. But they are also the stages of the whole cycle when more learning can be achieved. Resources, capacity and political attention are needed at this stage to a larger extent than during the formulation phase. A serious shortcoming recurring during the implementation of policies and plans is the inability of decision-makers to assess the actual results. Budget formats may impede the identification of allocative choices, administratively-aggregated data may hide inequitable outputs, and the prevailing fragmentation may blur sectorwide patterns, such as the deployment of the health workforce. Policies and plans must devote serious attention to the indicators to be collected in order to monitor their implementation, to the mechanisms needed to ensure such monitoring, and to making the necessary adjustments.

Building implementation capacity on the move. Policies and plans should deal not only with the features to be acquired by the health system, but also with the role of health authorities in the new political, administrative and financial settings, as well as the structures needed to play such role. A capacity assessment encompassing the whole health system must complement the situation analysis. In most cases, capacity will be regarded as inadequate if only official structures are considered. Expanding the scope of the assessment to cover private and informal operators will frequently modify the verdict. Realistic measures to boost capacity must be introduced across the constitutive elements of the health services provision system, to ensure that enacted policies are enforced and plans are implemented. Compelling plans may constitute powerful capacity-building enhancers.

Capacity-building traps should be avoided. State agencies are encouraged by international partners to acquire institutional capacity, by emulating the structure of their developed congeners.[49] This model usually translates into larger, structured institutions composed of many departments interacting through hierarchical rules. MoHs recovering from decades of disarray may see their premises, working tools and employees expand considerably. Their outputs, however, may not improve proportionally to the registered growth of their physical assets and to the related operating cost. In the Democratic Republic of Congo, such "institutional inflation"[50] was fuelled more by the lure of external assistance than by performance-enhancing considerations.

Enforcement and implementation are the stages of the policy and planning cycle when more learning can be achieved.

Everywhere, procedure-bound civil servants absorbed by internal activities or international events demonstrate a progressive loss of touch with reality. Ideally, a nascent or recovering MoH should be lean, responsive and competent. Given the degree of informalization and privatization attained in most settings, a problem-solving, task-oriented culture would be preferable to a rule-bound one. Some brains rather than many hands are needed to govern a health system under stress. High salaries delinked from civil-service rates must be paid to ensure a small group of highly-qualified and motivated cadres.

Prioritizing and sequencing the activities foreseen by a strategy or a plan is critical. Too many "strategic" documents are un-strategic in nature, presenting exhaustive lists of activities, without clearly prioritizing the order of interventions. No action ensues, as implementers are paralysed by the sheer quantity and difficulty of the actions included in such strategies and plans. Selecting the first steps to be taken, with added details about implementing prac-

ticalities and respective responsibilities, and setting realistic deadlines within a timeframe of 6–12 months, may trigger action, while offering indications about existing capacity and commitment. Clarifying priority actions may also help decision-makers react to unexpected shocks, such as funding cuts. For instance, if revitalizing referral capacity calls for the building and upgrading of 40 rural hospitals, choosing a subset of 5–10 vital facilities to benefit first will be useful in case of funding or implementation delays. The same rationale holds for human resources (HR) development: among the many categories of health workers to be trained, those most demanded by the services should be singled out by strategies and plans.

Prioritizing and sequencing first entails the scrutiny of the various actions included in the strategy or plan.

Prioritizing and sequencing entails first the scrutiny of the various actions included in the strategy or plan. Within their remit, some will logically precede others in the implementation. The sequence obtained in this way will have to be revisited in light of interventions already under way, some of which will mesh with the adopted strategy or plan, while others will not. Additionally, the funding in the pipeline must be explored, as some actions will materialize sooner than others. A round of negotiations with the actors involved will provide valuable indications for reformulating the original prioritization and sequencing. The resource and capacity implications of ongoing investments will have to be estimated, and budgets adjusted accordingly. For example, when the investments of agencies specialized in infrastructure and equipment have been decided apart from the sectorwide strategy, but are not at odds with it, modifying the latter to operationalize the former would make good sense. More demanding will be the handling of interventions impacting negatively on the adopted strategy or plan. In resource-poor settings, the typical occurrence is the building of a sophisticated facility, which would absorb or redirect most inputs and capacity, in this way enfeebling further the rest of the services. When negotiating a trade-off or a revision of the original decision is impossible, the only option may be to take a wait-and-see approach.

Planning for contraction (should this be the case). A special, largely neglected challenge is posed by a misalignment between health care supply capacity and the ability of a society to sustain it. A large supply capacity may have been planned in light of rosy economic forecasts, such as was the case in United Republic of Tanzania in the 1970s and 1980s. In other cases, the situation may have arisen spontaneously during years of laissez-faire, due to private initiatives. Or it may be due to oil-backed political expediency, as happened in Angola. Whatever the origins of an excess supply capacity, its correction is poorly served by orthodox policy and planning techniques (by nature, expansive), and clashes with inherently-conservative management habits.[51] Backing sensitive measures with credible information helps reduce the impact of the predictable backlashes. To contain political controversies, planning for contraction must be discreet; resource and capacity constraints can be artfully invoked to support downsizing measures. In this way, an oversized hospital may be "temporarily" rebuilt to half its original size, without attracting too strong objections.

Annex 13.1 proposes a simplified set of criteria for appraising a policy or a strategy.

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13.3.4 Learning from international experience

Radical reform approaches have a poor record in distressed contexts.

- Fast-changing environments offer opportunities for the testing of innovative approaches to health financing, delivery and regulation. But caution is in order: radical reform approaches have a poor record in distressed contexts. Newcomers are inclined to perceive the health space as open and advocate for hurried reforms, usually sold as unproblematic, easy fixes. This danger increases if the context improves and hopes of recovery start to be entertained by outsiders. Blueprinted, imported reforms are unlikely to take root in distressed health environments.
- Policy and planning standards borrowed from international models, usually premised on the assumption of stable and homogeneous contexts ruled by competent health authorities, appear inapplicable in light of the huge transformations caused by protracted conflict, state withdrawal and mass displacement. For instance, the accelerated and frequently forced urbanization of large rural populations is usually ignored by health policy and planning guidelines. The time-honoured operational district model is ill-suited to spontaneously-growing large cities, inhabited by mobile health customers with different purchasing power.
- Health authorities called to govern recovering health systems have often preferred to neglect their regulatory mandate, usually seen as thorny and unrewarding. Most have focused on direct health services provision, with lacklustre results. Health authorities willing to lead the sector might invest on regulation early, rather than contemplating its inadequacy later, when the stage has stabilized and introducing regulatory provisions would face even higher hurdles. Liberia deserves to be studied in its efforts to monitor and raise the service standards practised in its facilities, through a quite sophisticated accreditation system.[52]
- Donor preferences, by stressing some components at the expense of others, are prone to distorting health service development. Proliferating "priorities" may overburden the health sector and undermine rational resource allocation. A review of "priority" areas must identify where efforts must be concentrated. Priority-setting is meaningful only when parsimoniously practised. The purposeful collection of relevant information becomes a critical preventive strategy to ward off irrelevant "priorities".

- Donors do not generally transfer national ownership and leadership, unless they are proactively obtained by national health authorities. Successful takeovers, such as those witnessed in Liberia and Mozambique, have involved committed, realistic, coherent, open and frank national health authorities. On the other hand, genuine ownership may be manifested by indigenous choices, which may look unorthodox to international eyes, like the rejection of free-market pressures in Mozambique after the peace agreement, or the partial and temporary adoption of the performance-based financing model in Liberia during the transition to peace. If well justified, they may attract the support of true development partners. Ownership, as expressed by government bodies, should not be interpreted as popular ownership: global health policies adopted by national health authorities may be flatly rejected by a mistrustful population.
- In many post-conflict health systems, policy documents have been produced, with negligible impact on actual dynamics on the ground. Inadequate information, poor enforcement capacity and pressures from various interests can yield "decorative planning" or "planning as public relations".[53] Additionally, the merit of drawing up formal policies and plans in extremely informalized environments, such as Somalia, must be seriously questioned. Even no-nonsense, solid, context-grounded policy and strategy proposals may be ignored, if considered risky, unpalatable, or just unfashionable by the decision-makers concerned. All in all, investing scarce resources and capacity in writing elaborate policies and strategies, usually covering extended periods exceeding the decision-making and planning time horizon of most stakeholders, may be unwise. Conversely, an open-ended policy process may be more conducive to progress than a sequence of one-off policy papers: "strategy could never really be considered a settled product, a fixed reference point for all decision-making, but rather a continuing activity, with important moments of decision".[54]

In many post-conflict health systems, policy documents have been produced, with negligible impact on actual dynamics on the ground.

- After decades of profound disorder, the temptation of rebuilding a large public health care system is usually very strong. Several health recovery processes were guided by the assumption that a well-designed, adequately-funded and competently-run public health system would reclaim its traditionally-dominant role vis-à-vis private competitors who had expanded their share of the market during the crisis. The assumption applies to an even larger degree if the publicly provided services are geographically and financially accessible. Yet such a sensible rationalist assumption has been found wanting in a number of health systems already advanced in their recovery trajectory, such as Afghanistan and Cambodia. Private provision, far from shrinking as expected due to the resurgence of its public competitor, has thrived.[55]

Table 13.1 Proposed typology of health systems under stress

TYPE
Politically-legitimate but technically-weak government, with a ministry of health willing to lead health care developments
Absent, disinterested or resourceless government leaving both policy formulation and health care provision to other actors
Stable / peaceful but poor and vulnerable country, with health authorities unable to play a leading role in the health care field (despite their legitimate mandate)
Recognized central government, formally in charge of the health care field, but with contested regions and opposed by powerful donors on political or human-rights grounds
Permanent turmoil, with contested government, competing power holders, unresolved conflicts

Countries in crisis require health strategy and plan approaches tailored to their dynamic context.

13.3.5 Specific situations, calling for tailored approaches

Whereas most of the general principles covered in the previous sections apply to these situations, each of them demands dedicated approaches. The goals set and the methods adopted must be fine-tuned to match the respective contexts, the demands expressed, the risks incurred and the opportunities offered. This characterization (summarized in Table 13.1) is necessarily fluid, with countries moving from one group to another, and frequently back. In 2005–2007, Liberia changed, quite suddenly and to the surprise of many observers, in a favourable direction. Devastated by the Ebola outbreak, its health system has been pushed back. On the other hand, Syrian Arab Republic, for long considered a paragon of stability, has been engulfed in a vicious civil war whose end is not in sight, with a severe impact on its health system.

Politically-legitimate but technically-weak government, with a MoH willing to lead health care developments
(e.g. Mozambique 1990–2000)

This privileged situation occurs only rarely. In many other countries, the hopes nurtured at the beginning of a perceived transition from turmoil to stability have been rudely frustrated. In Afghanistan, the unravelling of the political and military situation has jeopardized the advancement attained in the health systems. Elsewhere, a misreading of the picture by over-optimistic international partners has induced premature investments in MoHs not ready or interested in assuming a leadership role (beyond ritual but shallow gestures).

Working on the formulation of policies and plans can reveal the extent of the commitment of new or recovering institutions to play a constructive role in health care provision.[56] Signs of commitment would be the active participation of apprentice policy-makers and planners in discussions, arguments over competing priorities, curiosity in relation to alternative options, awareness of the field conditions in which plans would have to be implemented, concerns with the political implications and the technical challenges of the proposed measures. When these signs are recognizable in some key actors, a renewed effort in policy formulation and planning is warranted. Otherwise, a reappraisal of the whole health system is needed: perhaps the MoH is not (yet) the place where health care developments can be promoted and take shape.

Working on the formulation of policies and plans can reveal the extent of the commitment of new or recovering institutions to play a constructive role in health care provision.

A committed MoH is a necessary but insufficient determinant of progress in the health field. Other players influencing health systems development must be engaged, starting with powerful government agencies, such as the ministry of finance and the civil-service authority. Influential international bodies, like the International Monetary Fund and the World Bank, determine events to an extent frequently unrecognized by health stakeholders. For instance, if the number of public employees is part of an agreement conditioning debt relief, it is likely to be honoured regardless of health service needs. Global health initiatives tend to rely on their financial clout and proceed on their own, paying little attention to overarching policies and plans. To these official players, private ones must be added.

If progress is registered, thanks to sensible policies and plans, effective leadership and generous donor support, there is a real risk of the health field being overwhelmed with proposals, projects and pilots pushed by international agencies. The aid industry loves success stories, which are rare and usually oversold. Both Liberia and Mozambique

The locally-embedded health systems that may have emerged in response to protracted stress should be supported with incentives and technical inputs.

quickly became "donor darlings", partly due to the convincing policies and plans they formulated. Large aid flows followed, spurring an impressive growth, which vastly exceeded the modest original expectations. In both cases, developments diverged markedly from the planned goals.

Absent, uninterested or resourceless government, leaving both policy formulation and health care provision to other actors

(e.g. Somalia since 1991)

Such situations create room for experimenting with alternative approaches. Intelligence from the field should inform discussions among decision-makers, in order to identify encouraging approaches and/or to avoid the replication of less successful models in the absence of serious evaluations. Ideally, policies and plans should aim to harness spontaneous events by apportioning tailored incentives. These in turn should be continuously adjusted, in light of the effects detected in the health system.

However, such a sensible, down-to-earth approach is rarely adopted. Without government oversight, different approaches are applied by external agencies at the periphery, without learning from their implementation and open discussion of the results at country level, and only positive findings are published in scientific journals. In these situations, policy transfers pushed by strong agencies — such as PBF in the Democratic Republic of Congo — can give unsatisfactory results because, contrary to other countries where they have been relatively successful, key enabling factors are simply not in place.[57] But, as observed in Haiti, lack of positive evidence is not enough for a powerless MoH to reject a strongly-advocated and generously-funded approach.

In most cases, the overall situation will remain precarious: fragmented health management arrangements with inefficient operations will result in unequal access to poor-quality health care. Given the likelihood of protracted turmoil, health services should maintain a degree of redundancy (to withstand recurrent shocks). For example, several mid-sized hospitals might be better adapted to an open-ended crisis than a large and sophisticated referral one, which would be more vulnerable and less accessible. Moreover, health services need to maintain some autonomy from the state, itself a source of troubles. Private management with a public-good orientation may constitute a sensible alternative: in northern Uganda in the 1970s and 1980s, faith-based facilities provided most of the health services. The locally-embedded health systems that may have emerged in response to protracted stress should be supported with incentives and technical inputs.

Stable/peaceful but poor and vulnerable country, with health authorities unable to play a leading role in the health care field

(despite their legitimate mandate)

In the absence of financial means to develop health services provision, nor to shoulder the future recurrent expenditure generated by such development, health policy and planning may play a crucial role, provided they are sensibly practised. Credible policies and plans that are actually used to make decisions may influence partners' behaviour and provide

negotiating levers with other influential government bodies. They may give credibility and leverage to otherwise powerless health authorities, and reassure donors about their good faith and commitment. External funds may in this way be tapped, sometimes surpassing both expectations and absorption capacity. By attracting competent international professionals, acted-upon policies and plans may help the health sector acquire badly-needed skills.

A feeble MoH might improve its reputation and clout by investing its scarce capacity in policy and planning, rather than in administration. Such an institution might lead by superior knowledge and a compelling vision, even without harnessing sufficient funds, nor enforcing capacity. These enlightened health authorities should remain aware of their future limitations, and avoid burdening themselves with excessive duties. Donors, too, would be wise to refrain from shouldering unsustainable investments. In a country vulnerable to shocks, financing and management responsibilities should be distributed among public and private actors, mostly assumed at local level, in order to inject flexibility and resilience in the health care provision system. Financial squeezes, epidemics, natural disasters, refugee inflows, and/or social upheavals will certainly strike: the stronger, more responsive and distributed the future system becomes, the more it will be able to react successfully.

Whatever the wisdom of adopted policies and plans, it may prove difficult for them to withstand pressure from various concerned parties. The modest goals praised on technical grounds may be criticized, and the unmet needs of the population may be invoked to launch ambitious programmes. That such forward leaps failed in the past to attain their goals and were not sustained is usually ignored by domestic, as well as foreign, actors. Producing reliable information in formats understandable to different stakeholder groups may help defuse some negative reactions. In the end, vested interests, ideology, convenience or fashion will regularly overrule decisions suggested by available evidence.

To withstand frequent shocks, financing and management responsibilities should be distributed among public and private actors, mostly assumed at local level.

Recognized government, formally in charge of the health care field, but opposed by powerful donors on political or human-rights grounds

(e.g. Myanmar until 2012)

Policy and strategy formulation in these contexts tend to be a domestic affair. For political reasons, donors usually refrain from being involved in these processes, when they are not barred from them. With aid channelled to NGOs mainly for relief and/or using separate management instruments, limited resources reach government health services. The formulation of humanitarian and recovery strategies is usually managed by the UN, with a formal, but token participation of the government. Coordinating aid-supported health care provision is even more difficult than in other settings.

Policy-making and planning are essentially window-dressing processes, with vision, goals and principles often detached from reality, or referred to privileged parts of the country. Strategies aim at conveying the sense of central control, even in a federal system like Sudan, where decentralization has been more the result of "laissez-faire" unwritten policies and practices than design.

On the other hand, the low status assigned by the government to health care provision gives some room for manoeuvering (to be discreetly and ambiguously enjoyed) to the players engaged.

In sensitive contexts, such as Darfur, state authorities and aid agencies are forced to cohabitate in tense, awkward terms marked by mutual distrust. Heavy restrictions, imposed by government, donors, rebels, militias and criminals curtail the actions of health care providers. Activities on the ground depend more on their feasibility (once all the restrictions are taken into account) than on official policies and plans.

Activities on the ground depend more on their feasibility (once all the restrictions are taken into account) than on official policies and plans.

Independent research is hampered by danger and restrictions. Such weak grasp of actual features, events and trends in the health care field undermines policy discussions, which tend to become theoretical rather than factual. The fear of eliciting negative responses inhibits frank debates, while valuable data are not circulated as they should be. Thus, monitoring and evaluating health care developments is all the more arduous. Without an appraisal of the effects of the introduced measures, new mistakes will follow old ones, and go unrecognized.

Myanmar has long presented a peculiar pattern of segregated health services, induced by its political geography. On the one hand, the central valley was served by flourishing private health services, with limited public contributions and a constrained role for aid agencies. Meanwhile, humanitarian agencies based across the borders were offering health care to refugees, and supporting mobile health workers inside the country. Facts on the ground prevailed over policies and plans. Furthermore, while health services provision inside Myanmar was poorly documented, humanitarian cross-border health services were studied in detail. A similar split of health services provision across political and military frontlines was recognizable in Afghanistan during the Soviet intervention, in southern Sudan before the peace agreement and the ensuing secession, and in the West Bank and Gaza Strip (with the unique characteristics of this permanent crisis).

Protracted turmoil, with contested government, competing power holders, unresolved conflicts

Classical policy formulation and planning sit uneasily in such contexts. On the one hand, even the best-intentioned policy proposals (a rare occurrence in such circumstances), once issued by a contested government will be rejected by the opposition, or viewed with suspicion by mistrustful constituencies. UN agencies collaborating with such governments (as they must in light of their charter) may find themselves in an awkward position, as occurred in Darfur in 2006, when the UN were blamed for conducting a recovery-oriented needs assessment in the midst of increasing violence and political crisis, or in Syrian Arab Republic in 2014, where the World Health Organization (WHO) was criticized for its conduct in responding to the polio outbreak.[58] In these situations national and international agencies would need strong communication

III and the twin Post-Disaster Needs Assessment, applied in natural disasters.

skills to manage perceptions and rumours fuelled by the prevalent mistrust in official bodies. Many authoritarian states fare poorly in this respect.

On the other hand, the capacity of an embattled government to access territories and populations, to enforce any policy or plan, to allocate funds to the sector, to coordinate external agencies and to deliver services, is necessarily limited. With the emergence of regional or local governance arrangements de facto autonomous from the state administration, separated health policy and planning domains may take root (when the respective power holders are interested in health care provision). In some settings, such as in Iraq and the West Bank and Gaza Strip, costly trans-border referrals of large contingents of patients (in part financed by the public purse) have become established practice, by necessity if not by design.[59] Such a development is instructive of the gap that may open between conventional policy and planning habits and on-the-ground responses to shifting contextual determinants.

Even in the face of such constraints, abandoning any pretence of formulating policies and plans and falling back exclusively on pure humanitarian assistance, is unsatisfactory. The humanitarian response is needed to address immediate needs, but its drawbacks are well-known. If relief operations are left to provide health services without direction, fragmentation of services, inequality, egregious waste, high costs, inefficiencies and unstable delivery will follow. The aid system has formulated approaches intended to give coherence to its interventions, such as the post-conflict needs assessments.[III] Such exercises are nominally conducted jointly by the government and international agencies, but in practice are usually run by the latter. They have generated recovery strategies that have been at best only partially implemented, and in some cases not at all. Their main unstated purpose has been largely limited to raising political attention and funds for reconstruction. Indeed, many hoped-for peace processes have stalled, political interest has soon faded away and donor support has not materialized as expected; as a result, plan documents have been promptly shelved and forgotten. In some cases, the proposed recovery strategies were probaby too impractical to implement anyway.

A solid, continuously-updated situation analysis, understood in its implications, can encourage informed decision-making, and in turn foster some planning coherence.

In such trying circumstances, the stakeholders concerned cannot hope to unify an inherently fragmented field, but can attempt to encourage informed decision-making, so that some policy and planning coherence is fostered by converging interventions. For instance, autonomous players made aware of the comparative service deprivation of a certain region may opt for addressing such an objective gap. A solid, continuously-updated situation analysis, widely disseminated and discussed in its contents and strategic and operational implications, is perhaps the best result to be aimed for. To induce actors to design adapted, long-term responses, such analysis must factor in the enduring turmoil, rather than assuming unlikely turnarounds towards peace.

13.3.6 Essential aspects to be considered in relation to some subsectors

Health care financing

The chosen or – in many health systems under stress – the spontaneously established financing mechanisms affect all aspects of health care provision. The common occurrence of health professionals setting plans related to service delivery, while economists debate financing strategies, should be avoided.

In many settings, health expenditure reaches surprisingly high levels (for the assumed severity of poverty).

In many settings, health expenditure reaches surprisingly-high levels (for the assumed severity of poverty). Larger-than-expected private expenditure, remittances from abroad and aid inflows add together to attain quite respectable totals. In response to dwindling or absent public financing, private health spending is large in every situation where estimates were produced, be it Afghanistan, Liberia or the Darfur region of Sudan. The ability to pay for health care becomes the main determinant in a deregulated market. Inequities of access and inefficiencies of service production ensue.

Health expenditure figures are of dubious accuracy, and never complete. Gathering information on finances requires particular skills when national health accounts and expenditure reviews are not available, incomplete or unreliable. The study of aid flows to the health sector in Somalia is illustrative of the significant challenges encountered when analysing a complex health aspect in a complex environment.[60]

Expenditure levels appear to be rising everywhere. The mix of factors pushing expenditure upwards differ from one country to another, and even within the same country. Disease-control programmes, multiplying practitioners, easy access to medicines, the prominence of curative care, high-tech choices, referrals abroad (like in Iraq or the West Bank and Gaza Strip), and expensive humanitarian operations contribute to health spending inflation. Lebanon offers precious lessons about out-of-control health expenditure: "[The hospital] sector has been characterized by unplanned expansion and high-cost coverage, arising not out of health need but in order to maximize revenue. [...] the public sector, through its contracting arrangements, foots the largest share of the health bill".[61]

Public health financing is paltry in most under-governed health systems. Crippled public financial management systems thwart the spending of budgeted funds, particularly in insecure, remote regions lacking roads, banks, safes and telecommunications. When they are known, actual health expenses regularly diverge from budgeted amounts.

In many health systems under stress, official external assistance accounts for a sizeable proportion of total health expenditure – although not as dominant as perceived in aid circles, if private spending is taken into account. Aid flows support health services provision, through the formal financing of health activities, as well as informal resource transfers to indigenous entrepreneurs. The latter phenomenon (inadequately studied) helps explaining the buoyancy of the commercial segment of certain health care markets, such as those of Afghanistan and Somalia.

Private benefactors make in the aggregate a large contribution to health financing, using a variety of intermediaries: charities, foundations, international agencies, solidarity groups and political parties. The extreme dispersion and informality of many charitable transactions makes exploring their aggregate patterns labour-intensive and technically demanding. In contexts with a large diaspora, this sustains health services through direct initial investment, the recurrent support provided to facilities, donated equipment and goods, as well as voluntary short-term work. Remittances are also critical to enable destitute patients to buy health services that would otherwise be unaffordable. In most cases indistinguishable from profit-oriented operations, diaspora investments are prone to generate redundancies as well as gaps in health care provision.

Key considerations in relation to health care financing are summarized below.

- Discussions in this area tend to assume ideological tones, and to end inconclusively with pitting alternative options rarely appraised for their merits and drawbacks. Such options are often invoked in abstract terms, without considering their applicability to a given context. Thus, user fees may be banned without introducing alternative funding means; or a social health insurance may be recommended in the absence of the basic enabling conditions. Furthermore, market forces shaping the health systems are often overlooked when financing options are debated.
- Estimating the total future resource envelope likely to be allocated to health is the first step to be taken to ensure meaningful policy and planning discussions. Once a credible figure has been obtained, it has to be conveyed to the policy-makers concerned in such a fashion that they grasp the way it has been computed, its meaning and implications. In light of the enormous uncertainty of every forecast, boundaries can be set for future financing levels. Planning scenarios consistent with low- and high-level financing can then be sketched. These can be used as fund-raising levers, as well as to assuage excessive expectations. If additional resources are attracted in this way, the best-case planning scenario can be adopted; otherwise much more modest goals are preferable.
- In light of the large private expenditure characterizing many health care markets, a devoted study ranks among the most useful initiatives at the beginning of a policy and planning cycle.
- Service delivery costs need to be estimated, with a view at projecting the outputs to be produced for certain financing levels. Different delivery models should be considered in their different resource implications, together with the financial impact of high-tech approaches.

The dispersion and opacity of financing flows in these contexts makes studying their aggregate patterns and trends technically difficult.

Pharmaceuticals

The benefits of successful policies and interventions in the pharmaceutical area justify the risks incurred in addressing its main distortions and inefficiencies.

Where estimates of expenses on pharmaceuticals are available, they are consistently large, mostly shouldered by households, and account for a fat share of total health expenditure. Medicines are commoditized, with profit or affordability taking precedence over therapeutic indications. Self-medication is widespread. Substandard and counterfeit medicines circulate freely in most health systems, due to poor regulatory and management capacity.[62] Medicines play a central role in sustaining underfunded health services, frequently constituting the largest source of income for health workers officially earning meagre salaries.

Many countries under stress present thriving, if under-regulated, pharmaceutical markets. These are, however, poorly studied despite the visibility of import-export dealers, selling outlets and street vendors in most derelict settings. The informality of such pharmaceutical markets combines with their illicitness to cause challenges to researchers. The precarious conditions of many long-suffering states make the resuscitation of their border, law enforcement and regulatory functions unlikely. Depending on geography, under-governed pharmaceutical markets may acquire regional dimensions, with unchecked and unrecorded medicines supplying neighbouring (and sometimes distant) countries. This aspect is missed by most studies, which restrict their remit to national borders, despite the permeability of such borders to agents, money, goods, and diseases. Pharmaceutical policies and plans tend to suffer from the same flaw.

Public and private not-for-profit schemes have been set up to improve the situation, with questionable success. Revolving drug funds, central supply stores, and essential drug programmes have sooner or later run into trouble, sometimes inflicted by health authorities. Fragmented procurement and supply channels tend to prevail, with predictable effects on prices, availability and quality of medicines. The competitive edge of private for-profit dealers and vendors may be so strong that even public operators prefer to place their pharmaceutical orders with them. In some instances health authorities have interests in the commercial deals they are supposed to regulate. Furthermore, the highly informal operating environment, with its prevailing incentives, puts formal public schemes at a disadvantage.[63] In reality, the pressure to sustain health services through the sales of medicines encourages adoption by public providers of business-oriented practices akin to those of their private colleagues.

Understanding the characteristics, business models and the rules governing these pharmaceutical markets would greatly help public policy-makers in their quest for ways to regulate them. The intersections between multilateral, bilateral and private procurement and distribution have to be explored before realistic policies and plans are conceived and negotiated with the stakeholders affected by them. Realistic ways to manage the danger to public health caused by the unregulated supply and consumption of medicines, as well as to tap the potentials represented by this market, must be conceived, tested and adopted.

Formulating enforceable policies and implementable plans in these pharmaceutical areas is forbiddingly difficult. Some considerations should be kept in mind when engaging in this field.

- Given the interests involved, some political clout is needed to intervene with any chance of success. On the other hand, the benefits that successful interventions can induce in the pharmaceutical area are huge, thus justifying the risk incurred. Indeed, a hands-off stance should not be adopted, due to its ominous consequences for the whole health system: rising and inequitable health expenses, severe market distortions and potentially-dangerous health outcomes.
- Borrowing the models developed in more affluent countries is futile, as they presume substantial capacity, resources, and enforcement procedures. Most poor countries have imported pharmaceutical policies without the ability to enforce regulations; this often promotes corruption.
- The advanced privatization registered in many settings is probably irreversible. This market can be harnessed through positive incentives, rather than coerced. Effective incentives have to be negotiated with the operators concerned, so that mutually-acceptable trade-offs are struck. Informing the public, accreditation and franchising rank among the strategies to be considered.
- Every alteration in the economy of health services provision (salary levels, user fees, incentives, subsidies, financial management) affects the way medicines are traded and used. Measures targeting pharmaceuticals must be considered in a sectorwide perspective. Conversely, many interventions not directly related to medicines have an impact on their access, quality, and use.

Health facilities

The health care network is deeply affected by violence, under-resourcing, mismanagement and the reshaping of societal patterns, including altered livelihoods and population movements. Thanks to investments shouldered by charities, aid agencies, local entrepreneurs, politicians and the diaspora, it may expand in an unplanned and often undocumented way. Small, lightly-equipped facilities may come to dominate the landscape, as seen in Lubumbashi, Democratic Republic of Congo.[64, 65] Booming cities, such as Nyala in Darfur, present quite large health care networks, with sizeable hospitals. Clusters of redundant facilities can be found in comparatively-privileged areas, in contrast to investment-deprived ones. Underutilization is a recurrent pattern, due to a variety of factors deterring customers: user fees, poor quality of care, absent staff, unavailable medicines, lack of diagnostic capacity, competition among facilities, limited opening times, lack of transportation and insecurity.

Small, lightly-equipped health facilities may come to dominate the landscape in distressed contexts.

Inventories compiled by assorted agencies usually present grossly-diverging counts. Particularly at primary level, many ghost or derelict facilities may be included. Misclassification is a regular occurrence, for several reasons. Atypical health facilities diverging from the standards set by health authorities usually escape inclusion. Privately-owned facilities not subjected to regulatory criteria tend to evolve organically, adding revenue-fetching equipment and services whenever the opportunity arises. Their nomenclature varies, regardless of the services actually provided. Similarly, publicly-owned facilities fail to adhere to the standards implied by their official classification. Vertical programmes contribute to the diversification of health facilities, by strengthening selected services while ignoring others.

The health care network may look more akin to an archipelago than to the referral pyramid postulated by health authorities. In fact, proper referral paths may be negated by political and military barriers, by geographical, financial, and transportation obstacles, by misconceived guidelines, by perverse incentives, by violence, sectarian/ethnic mistrust and by partisan partition. In the end, referral flows depend more on customer opportunities and preferences than on provider decisions. In most distressed settings, health care is consumed locally, or conversely far away thanks to the mobility of its users.

Oddly, violence-affected locations may be better served than peaceful ones, owing to aid-backed investments: eastern Democratic Republic of Congo, Mogadishu and the Gaza Strip are instructive examples. Frequently, trans-border health-seeking movements account for a large if inadequately-quantified share of the health care market. Health statistics confined to officially-administered territories regularly miss, or misinterpret, actual service uptake on both sides of the border. Additionally, mutually-segregated health networks have emerged in some conflicts (Angola, Myanmar and South Sudan). This poses distinctive challenges to policy-makers and planners on each side of the frontline, who tend to ignore the events taking place beyond it.

Health care networks in fragile states should not be considered homogeneously; they present different mixes of services, staffing, ownership, utilization, and financing modalities across different regions.

Studying and planning the health care network as a homogeneous set is a common fallacy. In reality, it presents different mixes of services, staffing, ownership, utilization and financing modalities across different regions. When considering the public-private mix, different aspects must be considered before classifying a health facility: its ownership (official and de facto), its management, its financing and its modus operandi (health- or profit-oriented). Given the different combinations that are recognizable in the field, few facilities belong exclusively to one or the other category. In any case, as public and private health facilities tend to respond to similar commercial imperatives, the distinction becomes blurred.

Main considerations to be taken into account in relation to managing and planning health care facilities are listed below.

- The health care network can be meaningfully studied only through the formulation of empirical classification criteria that manage to capture non-standard facilities. Adopting functional criteria may dramatically modify the outlook of the whole health system. Interventions should be conceived starting with the actual situation on the ground, rather than with idealized patterns, such as basic packages of services.
- Rationalizing a fragmented health care network requires sustained efforts backed by flexible investments. Usually, it is preferable to start by supporting the functional recovery of favourably-located health facilities. Building of new facilities should be postponed until peripheral security improves, displaced populations resettle, and reliable demographic data become available.
- Maximum efforts should be made to ensure the accreditation and contracting of existing private health facilities, so that they are induced to provide public goods. Adequate funding modalities have to be introduced by governments and donors alike.
- Raising capital for investment is usually easier than covering the subsequent financing of recurrent costs.[66] Ensuring that adequate resources and capacity are deployed to

operate upgraded or new health facilities should rank among the top concerns of decision-makers.

- Big hospitals tend to remain the largest component (in terms of absorbed resources) of most health systems, stated policies notwithstanding. They are usually able to attract resources and capacity, therefore fuelling their own growth. Containing this spontaneous tendency is crucial to the development of a balanced health system, but is made difficult by several factors: political (prestige of local administrators), economic (due to the large investments implied), financial (opportunities for health workers to raise additional income) and expectations of local communities.

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Human resources for health (HRH)

Human resources respond to stressors, individually as well as by professional groups. Coping strategies take precedence over other concerns. Looking for security, health workers move to safer areas. Public employees complement their shrinking earnings with private practice. Average productivity usually decreases due to reduced demand, overstaffing of secure health facilities, absenteeism, inadequate working tools and environment, poor or absent supervision, and low salaries. Professional skills across the workforce deteriorate, whereas they may improve in aid-supported secure spots. The number of unemployed professionals is usually unknown, but it is 'believed to be high in most cases.

Normative planning based on absolute needs should be abandoned in favour of contextualized criteria taking resource and capacity constraints into due account.

The workforce may contract due to death and outward migration, particularly where health workers have become political targets, as witnessed in Iraq and Syrian Arab Republic. Conversely, the over-production of under-skilled health professionals is recognizable in many under-governed health systems. In the Democratic Republic of Congo, this phenomenon has reached an extreme degree, with myriads of training institutions churning out crowds of job-seekers holding a health degree backed by precarious skills. In most under-regulated settings, training institutions largely financed by student fees offer courses demanded by applicants, rather than those needed by health services. A surplus of medical doctors and a shortage of nurses and midwives is the predictable outcome.

Public sectors hire large numbers of health workers, trying to absorb new entrants into the labour market, regardless of health service needs. Creating new positions and raising the funds needed to pay the related salaries appears to be one of the most pressing concerns of health authorities keen to gain political leverage and ensure loyal supporters. This trend is visible in many settings, with varying intensity depending on the financial position of public employers. In this way, an expanding workforce may absorb most of the scarce public funding for health.

Professional job titles tend to multiply, leading to overlapping, inconsistent categories. Civil-service payrolls give a very misleading picture of actual staffing patterns in public health facilities. On the one hand, ghost and absentee employees may constitute a large portion of the official ranks. On the other hand, many health workers without formal jobs may join their officially-employed colleagues, a frequent observation in the Democratic Republic of Congo. Personnel inventories are plagued with flaws, in most cases underestimating the actual number of active staff. In fact, not all practising health workers hold recognized qualifications. Some went through informal training initiatives, or formal programmes unrecognized by health authorities. Workers posing as qualified professionals, holding fake diplomas, or no papers at all, are common.

In some countries, health training programmes have been developed to satisfy the requirements of foreign labour markets. A health care career abroad is increasingly seen as an appealing prospect, given the scarcity of job alternatives in the home market. In countries with large diasporas, many health professionals have been trained abroad, and may return home to stay, or commute from and back to the country of settlement.

A gender bias may skew the production of health workers in favour of males. Once trained, the scarce female health workers are less likely to be deployed to hardship posts; in conflict-affected areas, the incurred danger curtails further the availability of female health workers, with severe effects on service provision. Such a staffing flaw is difficult to correct, due to a shortage of female candidates to health care training programmes, and cultural restrictions on the employment of women, common in many traditional societies.

Aid agencies have encouraged the training of community health workers (CHWs) in many contexts, despite the doubts about their effectiveness and cost, generated by past experiences. Reliance on these cadres appears questionable, given the limited support that weak formal health systems can ensure to these grassroots providers and the attrition caused by the lack of career and financial perspectives.

When formulating HRH-related policies and plans, some considerations are worth noting.

- Most health professionals surviving a protracted crisis need intensive and sustained retraining and skill upgrading. But before launching training initiatives, the actual job practice of assorted health workers, who cannot in most cases be barred from the health care market, needs to be empirically assessed.
- The management and regulation of HRH need as much attention as training.[67] Deployment, fulfilled tasks, workloads, terms of employment, incentives and career prospects rank among the key aspects to be assessed by HRH managers as well as by planners.
- A certification programme open to assorted health workers is one of the first steps to be taken in the resuscitation of a distressed workforce, as done in Cambodia and later in Afghanistan.[68] In the process, categories can be merged and upgrading training programmes introduced, in this way reducing the existing fragmentation. This exercise will generate a wealth of information useful for later HRH planning.
- The accreditation of health training institutions deserves adequate attention. In an open health care market, a reputable accreditation system may induce operators to abide by norms otherwise ignored. Where it cannot be enforced by feeble health authorities, a voluntary process can be offered. If the state is mistrusted or contested, an international body could be assigned this role.
- Normative planning, whereby the health workforce is projected to expand according to absolute needs, should be abandoned in favour of contextualized criteria taking resource and capacity constraints into due account. Indeed, different service models and health care networks have different HR requirements, whatever the served population is. Forecasted financing levels offer a much better guidance to HRH development than international norms (themselves the result of averaging vastly diverse situations).

Normative planning guided by absolute needs and international ratios should be abandoned in favour of contextualized criteria taking resource and capacity constraints into due account.

13.4 Conclusion

As repeatedly stressed in this chapter, fragile contexts present policy-makers and planners with complex and diverse challenges requiring innovative, flexible and incremental approaches.

- Many of the issues discussed are not exclusively relevant to fragile environments, but apply equally well to more stable health systems weakened by underfunding and poor management. However, the need for formulating and implementing realistic, feasible policies and strategies is higher where the duration and intensity of the crisis have damaged the health system and eroded the legitimacy and capacity of the government to a much larger extent. Addressing such gaps is arduous, and cannot be achieved through conventional approaches.
- A sound analysis of the context, focused on the determinants of the crisis, its historical evolution, the constraints posed and the opportunities offered, should be at the basis of any engagement in dysfunctional contexts. An investment in intelligence, related to both context and health care, must be associated with profound changes in the way decisions are taken. Moving closer to the service delivery point is a necessary step towards informed choices.
- Conceptual distinctions, such as the role of state vs non-state actors in health systems and service delivery, humanitarian vs development aid, formal vs informal policy processes, public vs private sector are not useful in distressed contexts. Traditional conceptual distinctions should be disregarded where the multiplicity of actors, the weakness of the government, the presence of different settings in the same country, the coexistence of humanitarian and development needs, the interplay of factors, and the emerging local strategies blur traditional dichotomies.
- Where uncertainty is pervasive, risks of mistakes and wasted resources can be reduced, but not eliminated. Shorter planning horizons, more modest goals, and stronger monitoring permit readjusting and adapting strategies and plans to unanticipated events, constraints and errors.
- The formulation of top-down, countrywide strategies is ineffective in situations of central government weakness, fragmentation of health system and diversity of situations. The alternative line of conduct is shifting the focus to the local level; supporting and documenting promising approaches that can be transferred to other areas of the country; and addressing concrete problems.
- Strategy development and planning are inherently political processes, even more in turbulent, politicized contexts; negotiation with the different key players is crucial. Trade-offs need to be made, to reduce the risk of resistance when policies and strategies will be implemented.
- Blueprint approaches and policy transfers from other contexts have proved ineffective time and again. No prescriptive guidelines can be issued for fragile contexts, as Zoellick claims: "...the worst thing the development community could do is develop a step-by-step handbook for dealing with fragile states".[69]

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Further reading: a selected annotated bibliography

Buse K, Mays N, Walt G. Making health policy, 2nd edition. Maidenhead: Open University Press; 2012.

An updated development of the classic: Walt G. Health policy: an introduction to process and power. London: Zed Books; 1994. This book, drawing on different disciplines and theories, helps the reader to understand the role of actors, as well as of political, economic and contextual factors in shaping policies and strategies that directly affect how a particular health system performs. The importance of understanding the processes through which policies are developed and implemented is discussed. Real-life examples illustrate the difficulties and intricacies of analysing the health policy process, at the same time pointing to issues that are relevant in an emergency context, such as the role and influence of international agencies and institutions in the policy arena. Activities, intended to stimulate the participation of the reader and to encourage the exploration of well-chosen topics, punctuate the text.

Freedman L. Strategy: a history. New York: Oxford University Press; 2013.

This important book reviews the concept of strategy and its applications over recorded human history, covering the most diverse domains, from zoology to politics, war, the corporate world and social science. To a curious reader Freedman distils many propositions and examples that are useful also for health policy-makers and planners. Rational choice in policy and strategy making is wishful thinking; strategy is rather bound up with intuition, deliberation, persuasion and the "rationality of irrationality", a concept that fits well with most health systems under stress.

The book suggests that "as a practical matter, strategy is best understood modestly, as moving to the 'next stage' rather than to a definitive and permanent conclusion. The next stage is a place that can be realistically reached from the current stage". The authors of this chapter could not agree more with Freedman when he claims that "the picture of strategy that should emerge from this book is one that is fluid and flexible, governed by the starting point and not the end point". Thus, "the realm of strategy is one of bargaining and persuasion as well as threats and pressure, psychological and physical effects, and words as well as deeds ... strategy is the central political art".

Green A. An introduction to health planning for developing health systems. Oxford: Oxford University Press; 2007.

Now in its third edition, this is a classic textbook, clear, comprehensive and readable, which offers the best available comprehensive review of the field, thoroughly balancing techniques with real-world concerns and constraints. Green provides a fair appraisal of the most influential ideas that have shaped health systems world-wide, examining their strengths and weaknesses, as well as the assumptions and values they are built upon. In spite of portraying the difficulties of planning health care in developing countries and admitting its unsatisfactory record to date, the book nonetheless succeeds in conveying the necessity of supporting decision-makers with rational, evidence-based approaches, stripped of ideological elements and wishful thinking. Worthwhile reading for every practitioner

interested or already involved in health planning. Even if the book does not address the specific features of fragile contexts and the additional constraints posed by them, it provides a wealth of general insights and instruments, against which crisis-adapted approaches can be developed.

Mintzberg H. The rise and fall of strategic planning: reconceiving roles for planning, plans, planners. New York: The Free Press; 1994.

A classic that does not show its age. Despite being directed to business organizations, from which it draws its examples, this book is an important resource for everybody engaged in policy-making and planning. Full of provocative statements, it debunks a lot of myths in strategy development and planning, pointing out the numerous fallacies and flaws of the rationalist approach to strategic planning. Mintzberg claims that "most organizations enter into planning with little understanding of the definitions and various purposes of planning", a statement that has not lost its validity twenty years after it was made.

Due to this lack of understanding and the adoption of bureaucratic approaches, only a few strategies are successfully implemented. The failure of strategies and plans that look too far ahead to identify discontinuous changes impacting on the organization explains in part their poor performance. Instead, Mintzberg proposes a more flexible approach, one that is more "simultaneous, holistic, and relational than linear, sequential and orderly.... No amount of elaboration will ever enable formal procedures to forecast discontinuities, to inform managers who are detached from their operations, to create novel strategies". Discontinuous changes are defining aspects of fragile contexts, hence the need to heed Mintzberg's cautionary words, and to follow his advice in the pursuit of alternative approaches.

Noormahomed AR, Segall M. The public health sector in Mozambique: a post-war strategy for rehabilitation and sustained development. Geneva: World Health Organization; 1994 (Macroeconomics, health and development series no. 14; http://whqlibdoc.who.int/hq/1994/WHO_ICO_MESD.14.pdf; accessed 15 January 2016).

One of the very few examples of successful post-conflict health recovery strategy, it was developed before the end of the war in 1992 by the MoH of Mozambique, with limited external assistance. Resulting from three years of studies and discussions and largely conceived by insiders, this document provided a roadmap for sector reconstruction, planning what was at the time considered affordable in the long term; it managed to rally considerable donor support. Despite its age, it is a recommended reading to every practitioner involved in a recovery process.

Pavignani E, Colombo S. Analysing disrupted health sectors. Geneva: World Health Organization; 2009 (http://apps.who.int/iris/bitstream/10665/44299/1/9789241599269_eng.pdf, accessed 15 January 2016)

A modular handbook covering the main areas relevant to the study of health systems in crisis and offering practical advice, experiences from the field, references and suggestions

for further study. The handbook is essentially practical and action-oriented, based on the long experience of the two authors in countries affected by crises, mainly conflicts. Common flaws in the analysis of the context and health care provision are discussed, together with their effects on strategies and plans. Most of the issues covered in this chapter can be found, expanded and complemented with examples, tools and references, in the handbook.

Ramalingam B. Aid on the edge of chaos: rethinking international cooperation in a complex world. Oxford: Oxford University Press; 2013.

Everybody interested in the debate on aid effectiveness should read this original book. Drawing on complexity theory and systems thinking, Ramalingam provides a scathing critique of aid policy and practice, characterized as they are by the fact that "there is far more policy-based evidence than evidence-based policy". Simplifications, mechanical models and assumptions, and standard tools and prescriptions on which aid is built are inadequate, if not damaging in complex and dynamic environments: "Some problems are so complex that you have to be highly intelligent and well informed just to be undecided about them". The root problem is the common belief among many aid experts and agencies that there are technical and often simple solutions to underdevelopment. As a result of this misconception, effort and money are spent finding "ways to do the wrong thing righter". For example, discussing the inadequacy of the logframe for monitoring complex development interventions, Ramalingam quotes a donor arguing that: "We don't pretend that it matches reality, but we still find it useful". No aid tenets or myths are spared by the critique: MDGs, PRSPs (Poverty Reduction Strategy Papers), 'bestpracticitis', or the excessive focus on results.

The introduction to complexity theory is brilliant: the reader can not only appreciate its principles, but also its relevance to development and humanitarian work, including strategy formulation. Aid adaptive strategies are needed in the face of complexity: "different solutions need to find their niche in an evolving landscape ... the development strategic toolkit ... needs to find a dynamic balance between no strategy at all and the rigidness of blueprints. Effective aid strategies are those adaptively positioned between order and chaos". New approaches, based on the 'new science' of complex adaptive systems can make aid more relevant and effective, as experiences of practitioners who have put these principles into practice have shown. Wisely, the book does not provide clear-cut recommendations. Maybe to pre-empt criticism, the author argues that aid practitioners "should move from being people who know the answers to people who know what questions to ask".

Republic of Liberia, Ministry of Health and Social Welfare. Country situational analysis report. Monrovia: 2011 (http://www.indiana.edu/~cehls/2011%20Country%20Situational%20Analysis%20Report_Liberia.pdf, accessed 15 January 2016).

The product of an inclusive national health policy and planning exercise started in 2010, this frank, complete and thorough analysis of the

health system highlighted both its post-conflict impressive achievements and the departures from the planned track. The evolution that occurred during the period 2006–2010 was not only described, but understood in its fundamental characteristics. A wealth of data and insights dispersed across programmes, institutions, publications and subsectors were blended to an unprecedented extent into a clear picture. The impact of the National Health Policy and Plan formulated in 2006–2007 was appraised, and the reasons behind the recorded divergences from the original goals were unpacked. Events taking place in the health system were read within the broader political and economic context.

Particularly valuable is the discussion of the choices made in 2006–2007 against the dearth of relevant information affecting the policy discussion at the time, revisited in light of the stronger understanding of patterns and events gained afterwards. Whereas the preparation of such an analysis in 2011 offered to decision-makers an excellent starting point to steer the health system through another planning cycle, the magnitude of the detected problems offers a reminder of the need to make sense of events continuously, or at least more frequently than at 5-year intervals. Many of such problems, if identified earlier, would have been more easily addressed.

This brilliant work should offer inspiration to participants to future health recovery processes, who will find in it plenty of valuable insights, related to methodological issues as well as policy and planning aspects.

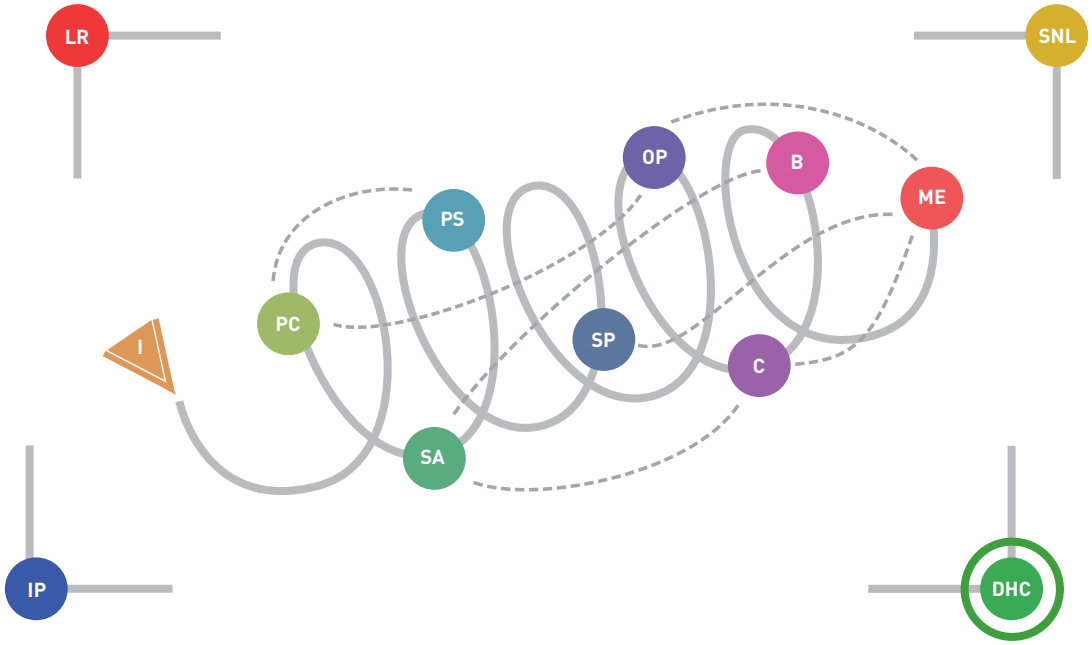
Segall M. Health sector planning led by management of recurrent expenditure: an agenda for action-research. Int J Health Plann Manage. 1991;6(1):37–75.

This almost historical paper offers a clear, insightful overview, firmly grounded in direct experience, of what health planning is all about: the making of informed choices between alternative allocative options, within political, financial and managerial constraints. The logical steps to be taken and the frequent hurdles to be overcome for a progressive, redistributive policy such as primary health care (PHC) to materialize, are discussed. Both the poor reputation health planning has suffered from in recent times and the mediocre results registered in implementing PHC in many health sectors may be ascribed to a certain degree to the prevailing neglect of the rational, realistic approach presented in this classic paper. No reference is made to the additional, specific constraints affecting war-torn health sectors. However, most if not all of the considerations offered by the author hold in these settings as well, at least at the conceptual level.

Annex 13.1

Assessing the usefulness of a health policy/strategy/plan

- **Degree of contextualization.**
  If the policy or plan could easily be applied to other settings, it scores low in this respect. The extent the conflict, or other societal stressors, is/are factored into the proposed actions is revealing.
- **Plausibility of the assumptions adopted (explicitly or otherwise).**
  For instance, is the stabilization of the political landscape likely to occur, as assumed by many recovery plans? Will the economy take off, and tax extraction improve, so that planned health services will become affordable?
- **Value for decision-making.**
  Guidance to managers facing difficult choices in uncertain conditions should be offered by the policy/strategy/plan under scrutiny. To that effect, its content has to be related to concrete decisions with tangible effects.
- **Appropriateness of the adopted time-frame.**
  While the decision-making horizon is necessarily short, large investments are slow to materialize and have long term effects.
- **Appraisal of costs, capacity implications, risks and side effects.**
  A thorough appraisal suggests solid technical work, a broad perspective and readiness to address problems as they emerge.
  A policy/strategy/plan extolling only the benefits of the proposed measures is dangerous, as it may lead to misinformed decisions.
- **Integration of monitoring and evaluation tools into the policy/strategy/plan, with explicit reformulation/updating mechanisms included.**
  The fluid context imposes the frequent revisiting of the original documents. Otherwise, when left untouched during years of rapid change, they cease to offer valuable guidance for decision-makers. In many cases, they were never appropriate, which explains their oblivion.
- **Extent of prioritization and sequencing of the proposed actions.**
  When every proposed action is given the same weight and is expected to take place at the same time, implementation is likely to be incoherent, or will stop.
- **Accessibility (in terms of language, technical contents and cultural meanings) for the different stakeholder groups affected by the policy/strategy/plan.**
  Proposals resonating only with health actors will be neglected or misunderstood by other influential parties.
- **Consistency between stated ends and the means (resources, capacity and political clout) made available.**
  Discrepancies may be due to technical flaws, political expediency or external factors.
- **Receptivity of the main actors to the measures proposed by the policy/strategy/plan.**
  Where the relationships between the parties concerned, say government and foreign agencies, are adversarial, not much implementation can be expected, whatever the merits of the proposal.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