

# Contexts and Crises

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Evidence on Coordination and Health Systems  
Strengthening (HSS) in Countries under Stress: a  
literature review and some reflections on the findings

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*FINAL REPORT*

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## Abstract

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**Introduction:** The International Health Partnership UHC 2030 Working Group on Support to Countries with a Fragile or Challenging Operational Environments aims to develop guidance for improved aid coordination and health-systems strengthening in fragile settings. This led to the following review question: “What does existing peer-reviewed and selected grey literature evidence tell us about what works (and does not work) in health systems strengthening and actor coordination in countries with fragile or challenging operational environments, and how and why?” This report attempts to find answers to this question.

**Methods:** An initial systematic review of peer-reviewed literature in disciplines such as public health, political science, public administration, development studies, conflict and humanitarian studies was done. Knowledge gaps identified informed a second phase of literature review, which consisted of a scoping review of ‘purposefully selected’ literature aimed at addressing the mechanisms underlying health systems strengthening interventions and actor coordination in countries under stress. In a third phase, outcomes of both reviews were consolidated and analysed – using relevant and available resources from other sectors in the aid industry.

**Results:** The two reviews showed a limited amount of experimental evidence to support a set of general, straight-forward, universally-applicable recommendations for interventions in strengthening health systems, coordinating aid and improving access to health services in fragile settings. Knowledge gaps noted while doing the review were grouped in four major themes: the ‘local perspective’, the contextual factors, issues of accountability and legitimacy, and specific challenges within the international aid and development sector. Widening the scope of the review beyond fragile settings and the health sector provided some insights into reasons for the lack of hard evidence.

**Discussion:** Making sense of the lack of hard evidence amidst a wealth of experience led to a brief side-step to focus on the concepts of evidence, data and research. The vicious cycle of inadequate evidence is caused by the very nature of the contexts of insecurity, instability and fast change in the circumstances in which evidence is sought. Switching between these external barriers and internal constraints in the sector helps to clarify the challenge. A closer look at the historical and political setting of the ‘humanitarian impulse’, as well as a critical look at the security-development and humanitarian-development nexus helped with an understanding of the state of the Humanitarian System. Perspectives for applied research can then be identified which can provide useful evidence better suited to the specific problems that the aid sector must deal with.

**Conclusion:** In order to gather evidence-based building blocks to formulate guidelines for better aid coordination, service delivery, and health systems strengthening in fragile settings, the specifics and fast change in any context do not allow for generic solutions. Best practices are documented and can serve as a basis on which to build. A research-practice linkage is suggested to connect the rather general and unspecified suggestions for improved aid coordination and service delivery to operational research. Combining solid experience in ‘traditional’ research (longitudinal designs, etc.) with locally-contextualised knowledge, applying new ways of evaluation, using elements from the data revolution, and solid experience in action research will deliver interventions that can be tested and improved in real time. Putting these techniques together may prove to be an escape ‘out of the box’.

## Executive Summary

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This report analyses the current state of aid coordination and management among global humanitarian assistance and development aid actors, with a focus on health systems strengthening. Literature pertaining to health systems strengthening and health service delivery as well as coordination between different actors in countries under stress was reviewed, with a synthesis of lessons on coordination of partners and health systems interventions, and an identification of essential knowledge gaps.

The research was commissioned by the International Health Partnership for UHC 2030 (UHC2030) Working Group on Support to Countries with a Fragile or Challenging Operational Environment, and is intended as a first step in the process of the development of guidance for a tailor-made approach to coordination and HSS in these settings. The guiding review question was: “What does the existing peer-reviewed and selected grey literature evidence tell us about what works (and does not work) in health systems strengthening and actor coordination in countries with fragile or challenging operational environments, and how and why?”

We started with a systematic review to assess the size and nature of the existing peer-reviewed literature in disciplines such as public health, political science/public administration, development studies, conflict and humanitarian studies, and compare knowledge gaps across these different disciplines. The knowledge gaps identified during the systematic review process were used to inform a second phase of literature review. This second phase consisted of a scoping review of ‘purposefully selected’ literature, aimed at addressing the knowledge gaps in the peer-reviewed literature and further broadening the scope of knowledge on mechanisms underlying health systems strengthening interventions and actor coordination in countries under stress. In a third phase, the data from the two methodologically rigid reviews was brought together in a report which provides an overall analysis of the findings, including a reflection on the used methodology and its limitations, as well as some important gaps identified during the research.

The results of the two reviews confirmed that there is very limited amount of experimental evidence to support a set of general, straightforward universally applicable recommendations for interventions in strengthening health systems, coordinating aid and improving access to health services in fragile settings. Some interventions such as contracting health services, the introduction of the ‘Basic Package of Health Services’, formation of ‘Health Pooled Funds’ proved successful in one setting, but not in the next, while changes over time would also prevent these interventions to be generally seen as ‘evidence-based’.

In order to move forward we identified and discussed some gaps noted while doing the review. There are several: there is little reference to the role of pharmaceuticals in health systems (availability, procurement, financial aspects, quality and policies on essential drugs); we also noticed a gap in the literature on the substantial role of informal health care providers, whether traditional, private or religious; and there was also little information on recent developments such as urbanisation, migration and mixed populations of excluded people and refugees. We have chosen to organise the discussion of these issues – and others – in four major themes: the ‘local perspective’, contextual factors, issues of accountability and legitimacy, and specific challenges for the international aid and development sector in these changing times.

## **THE LOCAL PERSPECTIVE: ORGANISATIONS, INSTITUTIONS, AND ‘THE PEOPLE’**

The perspective of local institutions and actors was missing from a lot of the reviewed material which seemed to focus primarily on the perspectives of and interactions between actors at the central level, rather than the decentralised and peripheral management and service delivery levels. Working with local or regional governments would be more productive, as not only are these partners closer to the local population, they also tend to outlive political changes. More concerning is the absence of the voices of the people who are meant to benefit directly from humanitarian and development efforts<sup>2</sup>. Although there are many barriers to local populations being heard, the absence of their voices raises the question of the changing perspectives on the legitimacy of the humanitarian enterprise.

## **THE IMPORTANCE OF CONTEXT**

During the review process, it became evident that contextual factors are key. Context is one of the most important barriers to the making of recommendations for interventions which are evidence-based and can be universally applied in all fragile settings. At all levels of governance, the stakeholder composition and actor coordination in each specific situation present different challenges. The dynamic, fast-changing nature of such environments also contributes to the problem.

## **LEGITIMACY AND ACCOUNTABILITY**

The legitimacy of the fabric of international aid has been questioned from different angles over the last decades, and one of the organising principles is the separation between ‘output legitimacy’ and ‘input legitimacy’. The emphasis on output legitimacy (effectiveness and accountability versus use of resources and expected outcomes) represents the view from donor governments and supranational institutions, represented at fora such as ‘Busan’ to the 2016 World Humanitarian Summit, whereas ‘input’ legitimacy (who is represented, by whom, what is the status of values and norms used) is challenged by international academics and non-western actors in the field. These issues of legitimacy are urgent in these times of global political multipolarity and polarisation, where agreements to hand over responsibilities and resources to local actors lag behind, while the humanitarian system is not only ‘outside of its comfort zone’, but even ‘broken’<sup>1</sup>.

## **DEVELOPMENT, HEALTH, AID: THE SECTOR**

The challenges of the humanitarian system are vast, and a closer look at the historical and political setting of the ‘humanitarian impulse’ helps to understand how difficult it is to find the right balance between aid effectiveness principles and humanitarian principles. Humanitarian principles themselves have become political, and sometimes blur the view on how to move forward on the security-development nexus and the humanitarian-development nexus. There is general discomfort with the latter, and in terms of planning, legitimacy and accountability, it can be argued that the separation between relief and development assistance is part of the problem and not part of the solution.

## **HOW TO MOVE FORWARD: TAKING ANOTHER LOOK**

A comparison of settings with fragility caused by different reasons; humanitarian emergencies, low capacity, an absent government, disaster and/or conflict, reveals the importance of making aid strategies and programmes context-driven and context-informed. It shows that local, existing capacities must be the basis for all interventions<sup>2</sup>.

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1 Spiegel, “The Humanitarian System Is Not Just Broke, but Broken: Recommendations for Future Humanitarian Action.”

2 Strand, Suhrke, and Taxell, “NORAD REPORT 7/2016 COUNTRY EVALUATION BRIEF: Afghanistan.”

The uniqueness of each setting makes it difficult to find sound evidence from which the effectiveness of certain interventions can be extrapolated. This led us to widen the scope of the original review and go beyond the confines of just the health sector (as well as the original terms of reference). We reviewed additional material which was either provided by members of the working group, or found through an exploration of material focused on cross-sectoral aspects of aid coordination and management in the humanitarian and development sector.

This confirmed that the lack of evidence in the reviewed material lies more with the chosen criteria for evidence and success, than with the quality of the selected papers (and the many excluded ones). There is also the issue of inadequate exploration of evolution over time of the studied situations. The tendency to relapse into crisis, dramatically demonstrated in Afghanistan, DR Congo and South Sudan, should be highlighted when reforms and recovery are discussed. Fluid, pluralistic, under-governed, trans-national health systems need to be studied with the appropriate lenses – with suitable concepts and methods.

A brief side-step to focus on the concepts of evidence, data and research helped us to understand options for breaking through the vicious cycle of insufficient/inadequate evidence, which is caused by the very nature of the context - insecure, unstable, dynamic - in which evidence is being sought. New developments in research methodology can be combined with digital possibilities for data management, and this opens perspectives to applied research that provides useful evidence which is better suited to the specific problems that the aid sector must deal with.

There are no standard solutions, but there is good practice, and there are strong hints which point towards how to move forward. Some of these hints were found while looking at suggested governance arrangements for health systems in low-income countries which, while not explicitly focused on fragile settings or the humanitarian system, gave recommendations that are relevant both to the humanitarian and development sectors<sup>3</sup>. If the humanitarian-development divide is more problematic than helpful, as is the security-development nexus, it is clear that solutions need to be found in developing and applying a flexible view on rapid changes across the full range of actors in health services and health systems. The challenge seems to be in balancing the idiosyncratic qualities of each setting with an acceptable consensus on the type of interventions that yield results.

## **CONCLUSIONS & RECOMMENDATIONS**

In order to gather evidence-based building blocks to formulate guidelines for better aid coordination, service delivery, and health systems strengthening in fragile settings, the specifics and fast change in any context do not allow for generic solutions. In gathering evidence-based building blocks to formulate guidelines for better aid coordination, service delivery and health systems strengthening in fragile settings, the specifics and fast change in any context do not allow for generic solutions. Best practices are documented and can serve as a basis to build on. A research-practice link is needed that applies available and tested approaches in research methods, data collection and operationality. Solid experience in 'pure' research (longitudinal designs, etc.) combined with locally-contextualised knowledge and new methodologies may offer an escape 'out of the box'. Evidence is needed – and can be made.

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<sup>3</sup> Herrera et al., "Governance Arrangements for Health Systems in Low-Income Countries: An Overview of Systematic Reviews."

# Introduction

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## Background

The unprecedented number of complex and protracted crises, both in terms of the volume of aid they require and their impact on global peace and security, has led to a demand from global health actors on how to better match HSS interventions and actor coordination to implementation factors and context conditions in countries under stress.

One sees a lack of alignment and coordination between the various actors who often have a variety of agendas, service delivery models, funding sources and diversified supporting bodies<sup>4</sup>·<sup>5</sup>·<sup>6</sup>·<sup>7</sup>·<sup>8</sup>·<sup>9</sup>. This is compounded by a lack of information-sharing between actors, and results in humanitarian and development aid streams that are mutually exclusive and fragmented, and therefore ineffective.

This literature review, an initiative of the UHC2030 Working Group on Support to Countries with a Fragile or Challenging Operational Environments<sup>10</sup>, is intended as a first step in the development of a guidance for a tailor-made approach to coordination and HSS in these settings.

## Purpose of the Exercise

To assess what works in HSS and the coordination of support to countries with fragile or challenging operational environments; specifically, how, why, and under which specific context conditions does an intervention work? This includes assessing the current evidence base and identifying the gaps.

## Objectives

To appraise existing peer-reviewed and grey literature from different disciplines including public health, political science/public administration, area studies, development studies, humanitarian and conflict studies, with the goal of developing a better understanding of:

- the drivers of HSS interventions, including harmonised approaches for the rapid improvement of service delivery, particularly primary health care supported by district health stewardship and community engagement;
- mechanisms driving (the lack of) government stewardship at national and sub-national levels, engagement with non-state-actors (horizontal accountability) and accountability towards communities (public accountability);
- the mechanisms driving humanitarian or disaster relief actor coordination, and the modes of operation with specific attention to the role of the WHO as lead agency (compared to the role of UNOCHA) in conflict and natural disaster settings; (b) the complex configuration of, and coordination between actors and their modes of operation in the transition phase from relief to development;
- embeddedness of the mechanisms referred to above in specific governance “patterns”, and the interaction with sub-regional or sub-national context conditions.

To identify knowledge gaps which could be further explored through thematic (e.g. resource extraction contexts) or country studies.

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4 Pavignani and Riccardo, “Mirrors and Mirages: Interpretations of the Multiform, Trans-Border Palestinian Healthcare Arena.”

5 Sørbo, Schomerus, and Aalen, “NORAD Report 6/2016 Country Evaluation Brief: South Sudan.”

6 PATHS 2: Partnerships for Transforming the Health System Phase 2, “Summary Report on Coordination and Alignment in the Nigerian Health Sector (April 2011).”

7 Meessen et al., “Composition of Pluralistic Health Systems: How Much Can We Learn from Household Surveys? An Exploration in Cambodia.”

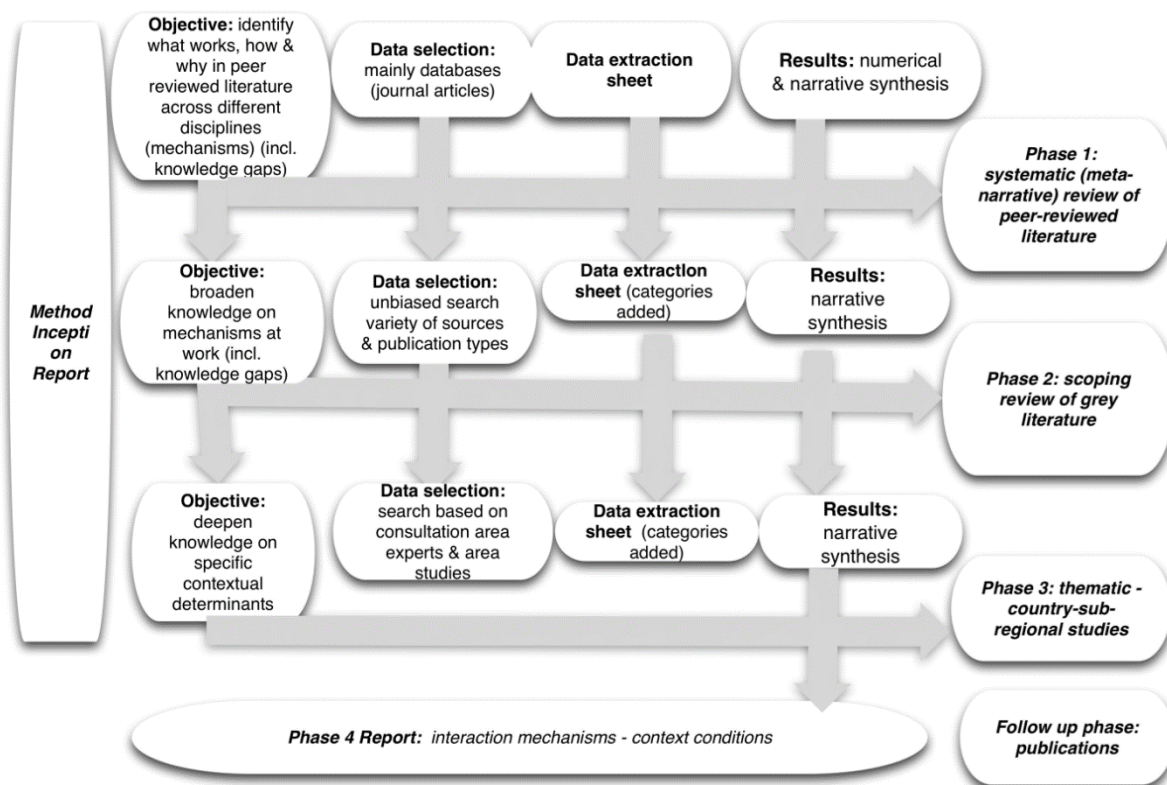
8 Devillé et al., “An Assessment of External Aid in the WHO Eastern Mediterranean Region.”

9 Murru and Pavignani, “Providing Health Care in Severely-Disrupted Environments - Democratic Republic of Congo: The Chronically-III Heart of Africa.”

10 <https://www.uhc2030.org/>

## Methodology

The review follows a three-phased approach, that was reviewed by the UHC 2030 Fragile States Working Group, an international expert committee set up by WHO.



The first phase consisted of a systematic (meta-narrative) review of the peer-reviewed literature, using a meta-interpretation approach, and the Economic and Social Research Council's narrative synthesis guidelines.<sup>11</sup> A detailed explanation, including the study selection, search terms used, and the PRISMA flow diagram of the study selection can be found in Annex 1.

The second phase was a scoping review of published and purposefully selected literature where a snowball strategy was used to find relevant papers. Guided by the review questions, peer-reviewed articles not captured in the systematic review, consultancy reports, NGO papers, working papers by multilateral and academic institutions, policy briefs, meeting reports, dissertations etc. were included. The main criteria were that the data was based on empirical knowledge, not mainly theoretical. The details can be found in Annex 2.

During the review process, it became clear that specific thematic or country studies could not be integrated in the assignment because of time constraints. The WG panel agreed, and provided directions to postpone the carrying out of such studies to a later date. Phase 3, was therefore this report which provides an overall analysis of the findings, including a reflection on the interaction of several elements, limitations of the work and gaps identified during the research.

<sup>11</sup> The meta-interpretation approach aims to maintain an interpretive epistemology in the analysis that is congruent with the epistemologies of primary qualitative research in social science disciplines. Key guiding principles of meta-interpretation are (1) a focus on meaning in context; (2) using interpretation as unit for synthesis; (3) a transparent audit trail. Weed, "A Potential Method for the Interpretive Synthesis of Qualitative Research: Issues in the Development of 'Meta-Interpretation.'" For the narrative synthesis of the review findings, see Popay et al., "Guidance on the Conduct of Narrative Synthesis in Systematic Reviews."



## Findings

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The two reviews showed a limited amount of experimental evidence to support a set of universally-applicable recommendations for interventions in strengthening health systems, coordinating aid and improving access to health services in Fragile and Conflict Affected Settings (FCAS). However, a small number of interventions stood out, as they were repeatedly used in different settings with varying degrees of success. We have selected and chosen to focus on five of these.

### Basic Package of Health Services (BPHS)

BPHS was largely successful in Afghanistan. It helped translate policy and strategy into practical interventions, focus health services on priority health problems, and allowed the Ministry of Health (MoH) to exercise stewardship. As a result, access to and use of primary healthcare services in rural areas increased dramatically; access for women to basic healthcare improved; more deliveries were attended by skilled personnel; supply of essential medicines increased; and the health information system became more functional<sup>12</sup>. However, despite gains in access to services, a survey in 2005 found continued inequalities in terms of use of services, ease of access to facilities and cost of care, with greater barriers faced by poorer households<sup>13</sup>. Other problems included coverage figures which masked low quality, resulting in low patient trust in public provisions, with many Afghans choosing private providers despite the cost and lack of regulation. Data collection and evidence of the effectiveness of initiatives like Community Health Worker programs which were widely implemented with little supervision, was scarce and shaky. Organising BPHS contracts also used up a lot of the limited policy resources<sup>14</sup>.

Like Afghanistan, South Sudan implements a BPHS for its citizens. Often contracted to non-state providers, its success in South Sudan was more mitigated. BPHS implementation problems included access barriers such long walking distances to facilities, poor weather in the rainy season; an insufficient number of health workers as well as candidates who could be trained to join the workforce; severe shortages of mid-level cadres (e.g., nurses, midwives, clinical officers); insufficiently motivated staff<sup>15</sup>. Poorly coordinated aid efforts also created a patchwork of provision, with some areas being saturated, while others remained underserved. In addition to this, the scale of the challenge made it difficult to go beyond the most basic services, and important areas such as neglected diseases, mental health, preventative health and family planning<sup>16</sup> were neglected.

It is clear that BPHS can be used to increase capacity and provide services to cover major health needs. Yet its chances of success are highly dependent on contextual factors. There are many challenges associated with the implementation of the policy, who to cover, what services, and how? In FCAS, the scale of the challenge often makes it difficult to prioritise and provide beyond the most basic services.

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12 Newbrander, W. et al. (2014). Afghanistan's Basic Package of Health Services: Its development and effects on rebuilding the health system. *Global Public Health: An International Journal for Research, Policy and Practice*, 9(Supplement 1), S6-S28.

13 Trani, J.-P., Bakhshi, P., Noor, A., Lopez, D., & Mashkoor, A. 2010, "Poverty, vulnerability, and provision of healthcare in Afghanistan", *Social Science & Medicine*, vol. 70, pp. 1745-1755.

14 Michael, M., Pavignani, E. and Hill, P. (2013). Too good to be true? An assessment of health system progress in Afghanistan, 2002–2012. *Medicine, Conflict and Survival*, 29(4), pp.322-345.

15 Jones A, Howard N, Legido-Quigley H. Feasibility of health systems strengthening in South Sudan: a qualitative study of international practitioner perspectives. *BMJ Open* 2015;5:e009296. doi:10.1136/bmjopen-2015-009296

16 Downie, R. (2012). *The State of Public Health in South Sudan: Critical Condition. A Report of the CSS Global Health Policy Centre*. Washington: Center for Strategic and International Studies (CSIS).

## Performance-Based Financing in Fragile States

Another intervention that is often utilised in FCAS is Performance-based Financing (PBF). In settings with unstable governments and policy environments, where the usual market forces which drive financial incentives are dysfunctional or even non-existent, PBF allows institutional arrangements to be viable<sup>17</sup>. In Cambodia, performance-based incentives for healthcare workers were initiated to promote longer working hours of the staff. This resulted in better staffing of health facilities and increased access to health services<sup>18</sup>.

We must however emphasise that the results from one setting cannot automatically be replicated in a different context. PBF entails the separation of purchasers, regulators, and service providers (health workers) who are paid in relation to agreed deliverables. Monitoring and evaluation is vital, but the process can be cumbersome and expensive, as it is often based on a large number of indicators<sup>19</sup>. In South Sudan, for instance, implementers were penalised for not reaching their targets. This could however be attributed to process issues such as lack of consultation on targets, targets being measured too frequently, and a lack of credibility of the baseline data<sup>20</sup>.

## Multi-Donor Trust Funds (MDTF)

The Health Sector Pool Fund was established in Liberia with a three-fold objective of financing priority unfunded needs within the National Health Policy and Plan; increasing the leadership of the Ministry of Health and Social Welfare (MOHSW) in the allocation of health sector resources; and reducing the transaction costs associated with managing multiple different donor projects<sup>21</sup>. Although the fund was a comparatively small proportion of total donor support, it increased the capacity and stewardship of the MOHSW, particularly in the areas of financial management and service delivery, and improved the coordination of donor funding. It also contributed to the expansion of the network of public facilities and increased the percentage of facilities providing the MOHSW's Basic Package of Health Services. Over one-third of public health facilities in Liberia are now pool fund-financed through a combination of contracting-in to local government and management contracting using NGOs<sup>22</sup>.

In South Sudan, the MDTF was established in 2006 as a basket fund mechanism administered by the World Bank, to which donors pledged USD 252 million to support the development of South Sudan. The Umbrella Program for Health (the MDTF health project) supported the health sector by developing health system capacity and increasing access to basic health services. It also gave the ministry of health some opportunity for stewardship; they were able to issue contracts to partners to address specific health priorities. Unfortunately, in 2007 many health partners reported that the process lacked transparency and sufficient resources to achieve the expected outcomes. Two of the major issues were a dearth of human resources and a high staff turnover rate within the MDTF, contributing to

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17 Witter, S., Fretheim, A., Kessy, F., & Lindahl, A. (2012). Paying for performance to improve the delivery of health interventions in low and middle-income countries. *Cochrane Database of Systematic Reviews*, 2.

18 Egami et al., "Can Health Systems Be Enhanced for Optimal Health Services through Disease-Specific Programs? - Results of Field Studies in Viet Nam and Cambodia."

19 Murru and Pavignani, "Providing Health Care in Severely-Disrupted Environments - Democratic Republic of Congo: The Chronically-III Heart of Africa."

20 Morgan, L. (2010). *A contract too far? Will performance-based contracting (really) work in Southern Sudan?* Washington, D.C.: World Bank.

21 Sondorp and Coolen, "The Evolution of Health Service Delivery in the Liberian Health Sector between 2003 and 2010."

22 Hughes, Glassman, and Gwenigale, "Innovative Financing in Early Recovery: The Liberia Health Sector Pool Fund."

chronic delays and erosion of confidence in the initiative. This situation is an example of how innovative financing mechanisms can fail if they are not transparent and well-managed.

### Contracting Health Service Delivery

In recent years, the contracting, mainly, of NGOs for service delivery has gained popularity in FCAS. The rationale is that one can take advantage of available capacity in NGOs that is lacking within the government, thereby freeing and allowing the MoH to focus on its stewardship, policy-setting and regulatory roles. One of the first contracting experiments in a post-conflict setting was carried out in Cambodia between 1999 and 2003 where studies found that contractors providing health services performed better than the government at reducing inequities<sup>23</sup>. Contracting also improved service delivery, access and vaccination coverage<sup>24</sup>. In post-conflict Liberia contracting-in in Bomi County, played a major role in supporting the MoH's efforts to make progress with decentralisation<sup>25</sup>.

In South Sudan on the other hand, contracting was slow to take off and the process was unduly protracted. Contracts were advertised for all the programme components however it took over a year for just a few to be signed. The service delivery contracts awarded to NGOs and private sector agencies, which were supposed to be the main vehicle for expanding coverage of PHC services, were signed only 2 years later<sup>26</sup>. In Kosovo, contracting was undermined by the absence of accurate data and functional information and management systems<sup>27</sup>, while in Jordan, Lebanon, Syria, and the occupied Palestinian territory (oPt), the lenient contracting practice by the UNRWA has led, in some cases, to contracts that are vaguely redacted and shyly enforced by programme officials<sup>28</sup>.

### Actor Coordination

There is a lack of alignment and coordination between the different actors who often have a variety of service delivery models, decision-making and funding dispersion, informal power structures, and diversified supporting bodies. This is compounded by a lack of information-sharing on who is doing what and where. Yet the alignment of geographical coverage with donor distribution seems to be promising; health clusters and Sector Wide Approaches (SWAP) have been useful in overcoming fragmentation. Engaging with local actors has also shown positive results. In Myanmar, the local-global model of partnership between international NGOs and a local NGO (Back Pack Health Workers Team) allowed healthcare provision to communities in areas that were inaccessible to INGOs. The partnership was successful and led to an increase in patient caseload, vitamin A supplementation, and an improvement in MCH outcomes<sup>29</sup>.

Balcik (2010)<sup>30</sup>, for example, discusses collaborative procurement and warehousing in humanitarian supply chain management. In the literature reviewed, there are no modalities presented to bridge humanitarian and development coordination structures, even after the Busan New Deal. Paul et al. 2014<sup>31</sup> recounts the experience in Mali where there was confusion between development actors and

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23 Witter, Sophie. "Health Financing in Fragile and Post-Conflict States: What Do We Know and What Are the Gaps?" 75 (2012): 2370–77. doi:10.1016/j.socscimed.2012.09.012.

24 Grundy et al., "Health System Strengthening in Cambodia-A Case Study of Health Policy Response to Social Transition."

25 Eldon, Schemionek, and Reynolds, "External Evaluation of Health Sector Pool Fund Liberia."

26 Cometto, Fritsche, and Sondorp, "Health Sector Recovery in Early Post-Conflict Environments: Experience from Southern Sudan."

27 Percival and Sondorp, "A Case Study of Health Sector Reform in Kosovo."

28 Pavignani, "An External Assessment of the UNRWA Health Programme."

29 Mahn et al., "Multi-Level Partnership to Promote Health Services among Internally Displaced in Eastern Burma."

30 Balcik et al., "Coordination in Humanitarian Relief Chains: Practices, Challenges and Opportunities."

31 Paul et al., "Aid for Health in Times of Political Unrest in Mali: Does Donors' Way of Intervening Allow Protecting People's Health?"

the humanitarian aid structures active in the Northern regions. Even though development aid was first commenced on a bilateral basis, the SWAP was only started at a much later date<sup>46</sup>. It is also clear from Derderian 2014<sup>32</sup>, that there was no specific assessment or implementation structure to better align the refugee response (with refugees from Cote d'Ivoire crossing the border) with on-going development work in Liberia.

## Discussion

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The results of the systematic review have so far confirmed that the evidence base for strengthening health systems in FCAS is weak and often hampered by limited research capacity, challenges relating to insecurity and the apparent low prioritisation of this area of research by funders<sup>33,34,35</sup>. Yet the simple conclusion that there is a 'lack of solid evidence' seems to be ill at ease with the richness and quality of the material found. Realising that the aim of this review exercise is to find 'evidence-based' building blocks that can inform guidelines to improve coordination and interventions for HSS, how should this apparent lack of 'solid evidence' be interpreted? In other words, is there truly a lack of evidence, or do we not understand what we are looking at. To quote Edward Rackley:

*"If it looks like anarchy...you don't understand what you're seeing"<sup>36</sup>*

We tried to address this by discussing some of the important gaps we noted while doing the review. In general, we found very little reference to the role of pharmaceuticals in health systems (availability, procurement, financial aspects, quality and policies on essential drugs). We also noticed a lack of inclusion of informal health care providers (traditional, private, religious) who play a substantial role within health systems. In addition to this, there was very little information on recent developments like urbanisation, migration and mixed populations of excluded people and refugees. We have chosen to organise the discussion of these issues – and others – in four major themes: the 'local perspective'; the importance of the many dimensions of 'contexts'; issues of governance, accountability and legitimacy; and some specific challenges for the international aid and development sector in these changing times.

In this part of the report we will:

- Reflect on these themes and look for how to move out of the current stalemate, where evidence is needed but cannot be created because of contextual barriers.
- We will then make a 'turn for the positive,' in an effort to turn those barriers into opportunities. Here we will:
  - Sketch present day scenarios from a slightly different perspective;
  - Take one more look at the methodology and findings to see why we found so little 'evidence';
  - Provide a basis for some practical reflections on the nature of evidence, data and research;

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32 Derderian, "Changing Tracks as Situations Change: Humanitarian and Health Response along the Liberia-Cote d'Ivoire Border."

33 Martineau et al., "Leaving No One behind: Lessons on Rebuilding Health Systems in Conflict- and Crisis-Affected States."

34 Metcalfe-Hough et al., "NORAD Report 2/2017: How to Engage in Long-Term Humanitarian Crises : A Desk Review."

35 Witter, Hunter, and Theobald, "Developing Health System Research Capacity in Crisis-Affected Settings : Why and How?"

36 Rackley, "On the Frontlines of Humanity with Tim Hetherington."

- End with comments on the findings that came up when we opened the wider perspective and looked beyond the health sector to the more general constraints in the Humanitarian System.
- After this section we will conclude with some suggestions that may help the search for what works best further.

## The Local Perspective: People, Organisations and Institutions

The perspective of local institutions or actors was largely missing. Studies were primarily focused on the perspectives of and interactions between actors at the central level, not at the decentralised and peripheral management and service delivery levels (provincial and district health facilities). More concerning might be the absence of the voices of the people for whom humanitarian and development efforts are meant to be, the direct beneficiaries<sup>37</sup>. Twenty years after Robert Chambers wrote ‘Whose Reality counts,’ this is a gap that needs some exploration. Another issue is the overall neglect of a complete overview of the ‘health arena’.

Michael and Hill 2012 point at this:

*“Beyond the known horizon of aid agencies, NGOs and diminished ministries of health, a fluid, fuzzy world populated by informal and traditional health practitioners, quacks, private healthcare providers, non-Western assistance, remittances, diasporas, charities, political groups, and criminal rings must be studied”<sup>38</sup>.*

Gaps identified on information from the ‘local level’ includes information directly from (or otherwise about) people who are identified by the aid industry to be in need of help. In the literature, although local institutions or organisations are discussed, the children, women and men themselves are rarely at the centre<sup>39</sup>.

It is also becoming increasingly difficult to determine *where* those local people actually are, and *who* they are. The UNHCR Policy on Alternatives to Camps (2014) acknowledges the wide variety of scenarios (migration, urban settings, mixed populations) and takes this into consideration in the need for adapted service delivery<sup>40</sup>. Exclusion and inequality of access are risks, and the lack of health services has cross-border consequences, and in situations where emergency aid and development do not interact at all (the most recent example is the condition of refugees stuck in Greece), identifying the ‘local voice’ is a challenge in itself<sup>41</sup>.

In addition to this, local knowledge is severely underutilised. This ranges from practical knowledge that refugees have, with their experience of coping in specific contexts,<sup>42</sup> to indigenous knowledge that has direct relevance for health, for instance, the way in which priorities are set according to views on health and healing, which decides how external assistance will be interpreted and appreciated.

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37 Murru and Pavignani, “Providing Health Care in Severely-Disrupted Environments - Democratic Republic of Congo: The Chronically-Ill Heart of Africa.”

38 Michael and Hill, “‘ Résultats Périssables ’: An Assessment of the Health System in Haïti Providing Health Care in Severely Disrupted Environments : A Multi-Country Study University of Queensland.”

39 Challand, “A Nahḍa of Charitable Organizations? Health Service Provision and the Politics of Aid in Palestine.”

40 UNHCR, “UNHCR Policy on Alternatives to Camps.”

41 Orchard and Miller, “Protection in Europe for Refugees from Syria.”

42 Examples are to be found in many personal experiences that are not recorded formally, but range from Burundese refugees knowing where to go while agencies did not, to Kosovar returnees not interested in irrelevant UNHCR assistance to Pakistani earthquake survivors unwilling to comply to the rules in government refugee camps.

### *Interpretation: Why this gap?*

1. **'Illiteracy'**. At the very basic level it is obvious that in a scoping review of literature, those who do not write will not be heard. But moving towards other connotations of illiteracy, a more relevant observation is that the overall majority of publications or reports seem to be illiterate in taking the 'demand side' explicitly into account. This connotation of illiteracy is all the more relevant here, given the fact that the people whose reality should count have other things on their mind in the midst of crisis. This renders it all the more serious, that in this review we found at best some indirect information, such as in the 'dissonance between findings' about the effectiveness of contracting-out pilot interventions in Cambodia<sup>43</sup>.
2. **Fear**. In a conflict or post-conflict situation there are many barriers to local people assuming their role as civilians, or as part of civil society. Harsh lessons have been learned about airing opinions that have to do with state institutions, ordinary people expect to be in danger, and there is nothing to be gained from volunteering opinions when it is not known how they will be shared or used. There is often little local experience with participative roles in public service delivery, and a limited experience with public service delivery itself. This could be a reason for the misunderstanding between interventionists and potential informants, but these are constraints that one would expect to find in reports about the local perception of interventions, yet we did not find this in the reports.
3. **Opportunistic reasons?** It might be thought that there is too much at stake to leave (parts of) an evaluation to an illiterate local population. An example is the introduction of contracting basic health services in the northeast of Cambodia: "Contracting in round two was the subject of a mid-term review and a final quantitative assessment. Neither of these evaluations, however, afforded an opportunity for local people to express their views about the contracting experiment. This is surprising because a crucial objective of the experiment was to raise the quality of health services, so as to improve local confidence in the system and thus increase local use of government health services. It is difficult to assess whether this objective was achieved without surveying local opinions"<sup>45</sup>.

### *Comments*

The challenge in involving local actors has been high on the agenda since the Busan Partnership for Effective Development Co-operation was drafted in 2011. Since the World Humanitarian Summit in 2016, more attention has been given to the 'localisation' agenda, and donor governments have begun to show a willingness to shift funds to local actors<sup>46,47</sup>. There appears to be a consensus on making aid strategies and programmes context-driven and context-informed, and in taking into account and building on local, existing capacities<sup>48</sup>.

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43 The widely portrayed success of the contracting model is backed up by very high official figures for health service coverage. This contrasts with evidence at household level, which suggests limited utilization of public health services, and perceptions that these offer inferior quality, and a preference for private providers. The dissonance between these findings is striking (Michael, Pavignani and Hill, 2013)

44 Michael, Pavignani, and Hill, "Too Good to Be True? An Assessment of Health System Progress in Afghanistan , 2002 – 2012."

45 Baird and Hammer, "Contracting Illness: Reassessing International Donor-Initiated Health Service Experiments in Cambodia's Indigenous Periphery."

46 World Humanitarian Summit 2016, "The Grand Bargain: A Shared Commitment to Better Serve People in Need."

47 Donors and aid organisations have committed to 'a global, aggregated target of at least 25 per cent of humanitarian funding to local and national responders as directly as possible' by 2020 (WHS 2016)

48 Strand, Suhrke, and Taxell, "NORAD REPORT 7/2016 COUNTRY EVALUATION BRIEF: Afghanistan."

Oxfam recommends that ‘in order to be able to conduct and lead disaster risk reduction, preparedness, and response efforts in their countries, local actors; governmental and non-governmental, need funds and sufficient capacity’<sup>49</sup>. Nonetheless, the same Oxfam research found that remarkably little humanitarian assistance actually goes to national and local actors in crisis-affected countries. Resources provided directly to local actors averaged some 3,2% of total annual humanitarian assistance in 2014, far from the 25% pledged in Busan. The percentage of direct funding to local NGOs appears to have actually decreased.

The problem is worse than just in numbers, international actors treat local partners not as true partners but as sub-contractors who are carrying out plans designed by the international actors with little ownership themselves<sup>50</sup>. Another example of how this attitude plays out is in one of the key findings of a 2014 WHO report on South-South and triangular cooperation in health:

*“Perceptions of the added value of SSC and TrC differ. Key informants in developing countries stressed the value of learning, capacity building, solidarity, reciprocity and empowerment, while the informants from international DP organisations focused on efficiency, resource use and accountability”<sup>51</sup>.*

Related to this push for greater ‘localisation’ of crisis responses is the concept of ‘building resilience’. There is debate about this; some take this to be a people-centred approach to crises, focused on investing in preparedness, managing and mitigating risk and reducing vulnerability, and as such it is high on the international aid agenda<sup>52</sup>. Although far from being new, the resilience approach has generated more creative financing options and ‘commitments for policy change’ by donors<sup>53</sup>. Common to much of the literature is the need for longer-term, predictable, flexible funding that is not ‘earmarked’ to specific donor-decided objectives<sup>54</sup>.

The relationship between local people, government and aid bureaucracies is the subject of a paper by Hilhorst et. al. which reviews recent insights into the complexity of these relations by introducing the notion of social domains of disaster responses<sup>55</sup>. Social domains are seen here as areas of social life where ideas and practices concerning risk and disaster are exchanged. The study of social domains allows one to focus on the everyday practices and movements of actors negotiating the conditions and effects of vulnerability and disaster. This approach seems helpful to come to an organised assessment and inclusion of the local actors. We will come back to this in the conclusions.

## **The Importance of Context: On Different Levels and in Different Dimensions**

### *The ‘political’ context: types of fragility and change*

There is no universally accepted definition of fragility, however fragile states are generally characterised by a lack of government legitimacy – which includes an incapacity or unwillingness to

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49 Gingerich and Cohen, “Turning the Humanitarian System on Its Head.”

50 Douma and Frerks, “Fragility by Choice? A Scoping Mission in Burundi, South Sudan and Uganda.”

51 Bannenberg et al., “South-South and Triangular Cooperation in Health: Current Status and Trends Summary of Findings from an Analysis.”

52 World Humanitarian Summit 2016, “Restoring Humanity Global Voices Calling For Action: Synthesis Report.”

53 Gonzalez, “New Aid Architecture and Resilience Building around the Syria Crisis.”

54 Mowjee and Fleming, “Evaluation of the Strategy for Danish Humanitarian Action 2010–2015: Syria Response Case Study Report.”

55 Hilhorst, “Responding to Disasters: Diversity of Bureaucrats, Technocrats and Local People.”

provide basic public services for the population<sup>56,57</sup>. In recent years the concept of ‘fragility’ has become more diffuse, the new crisis in the Middle East proves yet again that the geopolitical reality moves at its own pace and is not hindered by attempts to capture it in frames<sup>58, 59</sup>.

The Syrian crisis dramatically shows the need for new ideas to improve aid. In a region which already hosts millions of refugees from other conflicts, the conflict in Syria has resulted in a massive influx of refugees to surrounding countries like Lebanon, Jordan, Iraq and Turkey. These countries have all had different responses, with most setting up refugee camps, while others like Lebanon have refused to establish them. Even in countries where they exist, many Syrians have chosen to live outside of official camps, preferring to settle in informal settlements, makeshift camps or private accommodation in urban areas or satellite towns, among local communities. Even though employment opportunities are extremely limited, and the livelihood vulnerability of the urban refugees is no less severe than of those in camps, many prefer these, because they feel that they can look for employment and find opportunities to better their situation<sup>63</sup>. The situation has made it harder and more expensive for humanitarian actors to ensure refugee protection and coordinate aid relief.<sup>64</sup>

### *The context of the government on the national level*

Where central governments are unwilling or unable to cooperate with development and humanitarian partners, it might be better to work at the local/regional level, even if this means concentrating on building the lacking HR, administrative and financial management, research, institutional, and technical capacities first<sup>1</sup>. These partners are often closer to the local population and therefore more focused on helping, they also tend to outlive political change. An example is cited by Pavanello & Darcy (2008) about CFCI, a UNICEF-funded project, which engaged successfully with institutions at the regional level for the delivery of immunisation and basic health care for women and children in Sudan.<sup>65</sup>

The political aspects of governance also have an impact on the demand and supply sides of service delivery, and aid coordination and management efforts. In South Sudan, engagement at the sub-national level was brought about by a change in donor environment dynamics. In order to avoid a duplication of efforts, larger donors like USAID, DFID, and the World Bank agreed to each focus on certain states or geographic areas<sup>66</sup>. This sub-national level of engagement was also seen in

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56 Trefon, “Public Service Provision in a Failed State: Looking beyond Predation in the Democratic Republic of Congo.”

57 Bertone, Lurton, and Mutombo, “Investigating the Remuneration of Health Workers in the DR Congo: Implications for the Health Workforce and the Health System in a Fragile Setting.”

58 Le Borgne et al., “Lebanon: Economic and Social Impact Assessment of the Syrian Conflict.”

59 South Sudan could be seen as an example of a ‘fragile situation’ with a protracted civil war and a government that is only recognised by a proportion of the population<sup>60</sup>. Guatemala, although not currently at war, has a government that lacks political will and capacity to deliver social services, and fails to guarantee security as well as social, economic and cultural human rights to its citizens<sup>61</sup>. Countries as different as Pakistan<sup>62</sup> and CA<sup>63</sup> can either be seen as fragile states or, better, states that include fragile settings.

60 Bornemisza and Zwi, “Neglected Health Systems Research : Health Policy and Systems Research in Conflict-Affected Fragile States Alliance for Health Policy and Systems Research Significance of Conflict-Affected Fragile States.”

61 Federal Ministry for Economic Cooperation and Development, “Observations on Service Delivery in Fragile States and Situations – the German Perspective.”

62 Sondorp, Walford, and Dickinson, “Review of Global Fund’s Support to Fragile States Thematic Review of the Global Fund in Fragile States.”

63 Ferris, Kirisci, and Shaikh, “Syrian Crisis: Massive Displacement, Dire Needs and a Shortage of Solutions.”

64 Refugee Studies Centre, “Forced Migration Review: The Syria Crisis, Displacement and Protection.”

65 Pavanello and Darcy, “Improving the Provision of Basic Services for the Poor in Fragile Environments. Education Sector International Literature Review.”

66 Sondorp, Walford, and Dickinson, “Review of Global Fund’s Support to Fragile States Thematic Review of the Global Fund in Fragile States.”



Afghanistan where the health system support was channelled through various vertical programs, leaving the MoPH with minimal control<sup>67</sup>.

In Liberia, humanitarian actors provided aid at the level of health facilities because the MoH did not have the capacity to develop policies and strategies to address gaps in the health system<sup>68</sup>. In other instances, such as in Burundi, the international community intervened, regardless of the wishes of the government, because of widespread gross violations to human rights<sup>69</sup>.

### *The context of the government on the regional level*

Regional dynamics play a strong role in the generation of fragility and the response to such situations. Crisis complexities in the Great Lakes and the Middle East, show that political, security, economic, ethnic, criminal and migratory links, which connects countries officially separated by porous, arbitrary and often contested borders must be taken into consideration when aid management and coordination is being attempted. Health service provision too is affected by supra-national factors, as people, germs, ideas, funds, health workers, services and goods which 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. Without additional analytical efforts “the geographical reorganisation of health care within and across borders under conditions of war” will be missed or misread<sup>70</sup>.

### *The context of the government on the international level*

A key context condition in fragile settings reported by authors, which impacts on development actor coordination are the dynamic boundaries that exist between development, humanitarian aid and security. Authors included in the first review generally agree that the political economy of aid and the nature of the political settlement (i.e. “peace” agreement between powerful political elites) in a given context will determine the state-building approach and donor support for a particular government in a specific post-conflict context. These contextual constraints could provide opportunities and barriers for implementation, such as in the relationship between state and non-state actors. Authors have primarily reported on implementation failure in state-building, and they have pointed out that donors’ assumptions which underlay state-building efforts are often fraught with problems. State-building work often seeks to support civil society, but professes a conception of local civil society that does not correspond to the actual public sphere. One of the success factors of implementation seems to be a strong government, but risk averse donors do not often allow governments to take the lead. Finally, state-building must seek to avoid the fragmentation of authority as it also might further exacerbate political instability through its actions.

### *Geography*

Geography and the environment, key contextual determinants, are frequently overlooked by health actors, despite their influence on events and on the responses to them. The Democratic Republic of Congo, with its poorly-connected populated peripheries and an empty core<sup>71</sup>, not only makes the country more prone to fragility, it also poses serious accessibility challenges to humanitarian and development activities, because of insecurity and the fact that the population is spread out over such

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67 Michael, Pavignani, and Hill, “Too Good to Be True? An Assessment of Health System Progress in Afghanistan , 2002 – 2012.”

68 Sondorp and Coolen, “The Evolution of Health Service Delivery in the Liberian Health Sector between 2003 and 2010.”

69 Seymour, “Burundi and the Future of Humanitarian Intervention.”

70 Dewachi et al., “Changing Therapeutic Geographies of the Iraqi and Syrian Wars.”

71 Pavignani and Colombo, “Strategizing in Distressed Health Contexts.”

large areas. This may lead to fragmentation in service delivery and poorly coordinated aid efforts which create patchwork provision among actors who in addition to being distant from each other in their agendas and ideology also have the physical distance to contend with.

### *Sociocultural Aspects*

Donors, aid and development organisations often propose policies and interventions because they are part of the agency's routine arsenal or are an agency's favoured approach of the moment rather than because they are context-adapted and/or evidence-based. Limited attention is given to the sociocultural context with the consequent negative impact on service delivery, policy implementation, effectiveness and value-for-money.

#### Example: Context-Specific Training of Midwives

The 2013 study by Mumtaz et al.<sup>72</sup> gives an example from Pakistan about the use of female community health workers (CHW) in a Family Planning and Primary Health Care program where evaluation revealed underperformance. The CHWs selected for the programme were women, yet “a large body of literature describes the highly patriarchal nature of Pakistani society, highlighting clearly demarcated gender roles and the institution of purdah which prizes women's seclusion and limited mobility.” The gender, caste and socioeconomic hierarchies that affect women's ability to access health and other services and which necessitated the development of the service, also acted as a barrier for CHWs in the performance of their duties.

Contrast this with the situation in Afghanistan, where the education of girls and women remains a contentious issue. In spite of this, the country managed to produce a success story with its recruitment and retention of student midwives. Candidates were selected by key members of their community and had to obtain the consent of her husband or father to undertake the training programme. Once accepted, the students were lodged in hostels for the midwives in training, often along with their young children and babies. This safe living environment, with a system of shared accommodation, offered a familiar social network to women who had already extended themselves well beyond the boundaries to which they are accustomed. The supportive learning environment and high motivation of the students in this unique educational setting kept attrition virtually at zero<sup>73</sup>.

This example shows that a failure to take local perspectives and inputs into account can lead to issues linked to the wider social and cultural context being missed, with consequent negative impacts on sustainability, feasibility and equity in service delivery.

### *Spontaneous Developments*

Fragile contexts are by their very nature pluralistic, fluid and unpredictable. Actors must be aware of this and prepared to deal with spontaneous developments which arise, in such a way as to minimise the disruption to aid management and coordination efforts and maximise positive contributions. The cautionary tale of South Sudan, whose government in a row with Sudan about pipeline prices in 2012, stopped oil production and in the process shut down the country's main source of revenue<sup>74</sup>, shows

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72 Mumtaz et al., “The Role of Social Geography on Lady Health Workers' Mobility and Effectiveness in Pakistan.”

73 Currie, Azfar, and Fowler, “A Bold New Beginning for Midwifery in Afghanistan.”

74 Downie, “The State of Public Health in South Sudan.”

the challenges of dealing with dysfunctional, and in some cases obstructive, host governments. The austerity budget that resulted from this episode had a significant impact on the amount spent on service delivery and forced the international community to plug the gap, mostly by moving funds earmarked for development into humanitarian use.

## Legitimacy and Accountability

Reflecting on the position of the local people vis-à-vis the people that come to their aid poses the question of legitimacy. The issue of the ‘legitimacy of actors and interventions,’ defined as output ‘legitimacy’ and ‘input legitimacy’ deserves attention as it came up in nearly 50% of the documents we reviewed. It is not an exaggeration to say that the emphasis on output legitimacy (effectiveness and accountability versus use of resources and expected outcomes) represents the view from donor governments and supranational institutions, represented at fora such as ‘Busan’ and the 2016 World Humanitarian Summit, whereas ‘input’ legitimacy (who is represented, by whom, what is the status of values and norms used) is challenged by international academics and non-western actors in the field<sup>75</sup>. In these times of global political multipolarity and polarisation, where agreements to hand over responsibilities and resources to local actors lag behind, while the humanitarian system is not only ‘outside of its comfort zone’, but even ‘broken’<sup>76</sup>, and trust in perceived “western” global aid governance is lacking, these are issues that should be dealt with urgently. We must acknowledge the fact that there is a new aid landscape, and accept it as the new reality<sup>77</sup>.

The categories of context conditions, barriers, enablers and governance issues were assembled in the second phase of the review and have been summarised into in 4 crosscutting thematic issues: lack of capacity; Issues of legitimacy; political dynamics; and fragmentation.

Across the 97 publications, out of these four themes the ‘legitimacy challenge’ was with 45% is the most cited governance problem, and indeed needs to be addressed.

These issues are captured and summarised in sub-categories in the table below.

Lack of Capacity	Issues of Legitimacy	Political processes	Fragmentation
Gaps in managing resources and finances during and post-conflict	Influence of external stakeholders in program development and implementation	Corruption and predatory strategies	Lack of reach in the local government setting
Low technical capacity to implement programs	Too many stakeholders complicate government's decision-making	Domestic politics lengthens the effect of conflict	Horizontal and vertical fragmentation in health programs
		Citizens are not represented in health policies	
		Political rivalry causes health system decay	

75 On ‘academics’ see for example Ian Buruma and Avishai Margalit, *Occidentalism: The West in the Eyes of Its Enemies*, London, Penguin 2004, on ‘occidental hatred of Western modernity’, or more recently, ‘Age of Anger: A History of the Present’ by Pankaj Mishra (2017), where Mishra writes about how nationalist, isolationist, and chauvinist movements, ranging from terror groups such as ISIS to political movements such as Brexit, have emerged in response to the globalization and normalization of Western ideals such as individualism, capitalism, and secularism. Non-western actors include agencies within the humanitarian system ranging from ‘Buddhism without Boundaries to ‘Islamic Relief Worldwide’ to Hezbollah, and the debate on how humanitarian values affect relief agencies is well known.

76 Crisp, “Displacement in Urban Areas : New Challenges, New Partnerships.”

77 At the core of the challenges facing MSF institutionally in Syria is the reality that the aid landscape has drastically shifted, and MSF is no longer an insider to the aid system, able to criticize the failings of the system from within, while relying on certain operational alliances with NGOs that essentially have the same ‘principles’. In the case of Syria, MSF was a complete outsider of the ‘new aid system’ which was based on political or military solidarity. This requires adaptation in terms of diversity of networks, profiles of human resources and flexibility of ‘standards’ (Whithall, 2014)

Lack of Capacity	Issues of Legitimacy	Political processes	Fragmentation
Lack of structures and processes to manage health activities	Lack in leadership and ownership of the government	Fraud by HRH in health facilities (i.e. added user-fees)	Cultural, geographic, and gender barriers
Poor internal coordination	Coercive influence of international donors	Impact of military regime in influencing health programs and outcomes	Lack of representation from marginal groups
Inadequate monitoring and control mechanisms	Lack of accountability to constituents	Poorly contextualized policies	Poor reach in border regions
Health facilities destroyed during conflict	Using healthcare as a tool to initiate legitimacy	State structure used systematically to pilfer country's resources	Radically decentralized government structures
Non-existent financing plan or strategy (i.e. gaps in absorptive capacity)	Limited capacity to regulate "informal" actors	Conflict of interest in program monitoring (e.g. GF internal validation)	Pluralistic health systems
Roles of government actors are unclear	Strengthening other (non-health) social determinants	Conflicts at border areas	
	Donor must also be accountable to citizen's and government actors in partner countries	Citizens accustomed government providing only limited reconstruction help, due to neo-liberal orientation, incapacity, ineptitude, corruption, ingrained clientelistic politics	
	For pooled fund financing, important to have authority, accountability and transparency		
	Larger impact of "informal" actors as compared to government (e.g. FBOs)		

### *The governmental context of legitimacy*

When poverty reduction and the alleviation of suffering were believed to be the true international aid and development agenda, the legitimacy question could be seen as an academic issue for armchair philosophers. Now that state legitimacy is an accepted goal for humanitarian intervention, the health sector is involved in quite a different way, incorporated as it is now in the 'security-development nexus'. Military advocates for 'Civil-Military Co-operation' believe that the provision of health services is a useful element in state-building and strengthens the legitimacy of the government in place<sup>78,79</sup>. Sondorp and Scheewe<sup>80</sup> state that health interventions can indeed contribute to trust and recovery at a community level, as well as to good governance, state legitimacy, accountability and participation. In that sense, 'health' should not be looked at merely as a technical delivery of services, but as a social intervention with the potential to effect social change. Gordon agrees, but only with the intention: 'Health is advanced as a means of legitimating the evolving state to the people over whom it seeks dominion. Health then becomes a tool with which to foster respect for the state by making it relevant to ordinary people's lives and establishing a process which constructs a social contract from which stability might derive'<sup>81</sup>. Both Gordon and Brinkerhoff when analysing the association between

78 Bennett et al., "Country Programme Evaluation: Afghanistan."

79 Beeres et al., *Mission Urugzan: Collaborating in Multiple Coalitions for Afghanistan*.

80 Sondorp and Scheewe, "Health Systems Strengthening and Conflict Transformation in Fragile States."

81 Gordon, "Health, Conflict, Stability and Statebuilding: A House Built on Sand?"

essential service delivery and state legitimacy, show that the evidence is weak. More worrying is the fact that they suggest that ineffective service delivery can in itself be a source of conflict<sup>82</sup>.

### *Legitimacy across the stakeholders*

An important aspect of this political use of health care delivery and health systems strengthening is that funding mechanisms play an important role in the background, and are not often transparent for the ‘players on the ground’ such as NGOs. NGOs which are independent of government funding can afford to take a stance, such as the recent decision of MSF to no longer take funds from EU Member States and institutions, in opposition to the effects of the EU-Turkey deal. Many others, including local NGOs, miss the overview of the political arena and risk being manipulated by parties in the conflict.

This does not detract from the fact that different stakeholders view legitimacy differently, not only when it comes to decisions at the highest coordinating level but also ‘on the ground’. Those responding are often focused on measuring what happened, the assistance people received, as well as its appropriateness, timeliness and legitimacy, while those in communities are more concerned with how the assistance was provided<sup>83</sup>.

The cross-border character of healthcare poses another challenge for state legitimacy. As healthcare provision is reshaped by displacement, migration, destruction and altered financing flows, into new ‘therapeutic geographies’<sup>84</sup>, the legitimacy of the nation states on which territory the ‘therapeutic geographies’ are found is an obvious a matter of concern. The R2P project is about protecting populations from genocide, war crimes, ethnic cleansing and crimes against humanity, and looks for ways to break the barriers of sovereignty to actually make this happen. One may wonder why this mandate is not extended to health, given the borderless aspects of it, but when the impact of that project which was started in 2005 is evaluated<sup>85</sup>, one realises that this might not be helpful in every context. Syria comes to mind here (see below).

### *Legitimacy in Coordination mechanisms*

The coordination of actors in the ‘health arena’ during emergencies is vital, particularly for the interface between, and ultimately transition from, relief to development assistance and HSS. The literature frequently cites the ‘governance model’, or lack thereof, of the aid system as a serious barrier to improved services and HSS. The global aid architecture is ‘fragmented, overly complex, duplicative, exclusive, unwieldy and resistant to change (see, for example, UNDG, 2016; GCER, 2016a). The enthusiasm generated by recent global processes has to a degree been tempered by concerns that the international aid architecture may be approaching the limits of what is possible via voluntary coordination<sup>86</sup>.

## **The Cluster Approach**

In four out of five countries in a study funded by DFID, strong and experienced humanitarian leadership was found lacking<sup>87</sup>. A striking feature of the mapping studies is that they found no hard

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82 Brinkerhoff, Wetterberg, and Dunn, “Service Delivery and Legitimacy in Fragile and Conflict-Affected States: Evidence from Water Services in Iraq.”

83 Buchanan-Smith, M., Ong, J. C. and Routley, “Who’s Listening? Accountability to Affected People in the Haiyan Response.”

84 Dewachi et al., “Changing Therapeutic Geographies of the Iraqi and Syrian Wars.”

85 <http://www.globalr2p.org/>

86 Stoddard et al., “The State of the Humanitarian System: ALNAP Study.”

87 The ‘NGOs and Humanitarian Reform Project that aims to strengthen the effective engagement of local, national and international humanitarian NGOs in reformed humanitarian financing and coordination mechanisms at global and country levels’ is the name of a

evidence that UN-centred humanitarian reforms have improved the provision of humanitarian response thus far. The failure to establish benchmarks for overall system performance, as recommended in the original Humanitarian Response Review, as well as the failure to integrate accountability into the reform process, makes it hard to gauge the true impact of the reforms on the affected populations. Nevertheless, the fact that the reform is designed to address acknowledged failings in humanitarian response suggests that it has the potential to make a marked difference. It is to be hoped that the second phase of the cluster evaluation will provide specific evidence of this impact.

The synthesis report of this study highlighted a range of lessons, as well as immediate challenges in applying them. However, the overarching influence of politics on aid – particularly in relation to donor states – is perhaps the greatest challenge to enhancing aid interventions in protracted crises. Domestic priorities, including security, commercial and political objectives, are playing an increasing role in narratives around aid in many donor states. The €15.3 billion spent by European Union (EU) members between 2014 and 2016 in a bid to foster economic opportunities and discourage migration from the Middle East, South Asia and Sub-Saharan Africa is a testament to how central concerns around inward migration are to the decision-making of key donors<sup>88,89</sup>.

As an example, we looked at the role of WHO, as designated global lead agency in the coordination of the health sector in humanitarian contexts, within OCHA (Office for the Coordination of Humanitarian Affairs) and Humanitarian Coordinators and Country Teams. The WHO, like many UN agencies, has close relationships with its member states. It provides independent guidance to, and works alongside national governments in the tackling of global health problems and the improvement of people's well-being, with a mandate to respect the sovereignty of its member states and the mission of facilitating 'the attainment by all peoples of the highest possible level of health'.<sup>90</sup>

However, the WHO's proximity to national governments can have negative impacts on humanitarian response. Playing its role, in conflict settings where respecting the idea that the state has exclusivity of jurisdiction and working with such governments will, de facto, lead to the exclusion of populations in non-government-controlled areas from aid and assistance.

#### Example: Polio in Syria

The 2013 outbreak of polio in Syria, documented by Kennedy and Michailidou<sup>91</sup> illustrates how the situation of contested sovereignty can affect the ability of the WHO to play its role of global lead agency for coordination in health sector. Prior to the war, the WHO was a leading partner in the GPEI public-private partnership to eradicate polio. This partnership turned out to be problematic when war broke out. The Syrian government limited humanitarian access and refused to allow the WHO and other UN agencies to operate in rebel-controlled areas. "The WHO complied because as Elizabeth Hoff, head of WHO Syria, points out, 'WHO within a sovereign country has to accept the government's position'." Cut off from aid, polio

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project funded by DFID, that aims to fortify the voices of NGOs in influencing policy debates and field processes related to humanitarian reform and to propose solutions so that humanitarian response can better meet the needs of affected populations. A consortium of six NGOs are part of the project – ActionAid, CAFOD, CARE, International Rescue Committee, Oxfam and Save the Children, together with the International Council of Voluntary Agencies (ICVA). The project ran for three years until October 2011 (Street et al 2009).

88 Cosgrave et al., "Europe's Refugees and Migrants: Hidden Flows, Tightened Borders and Spiralling Costs."

89 Metcalfe-Hough et al., "NORAD Report 2/2017: How to Engage in Long-Term Humanitarian Crises : A Desk Review."

90 WHO, "Working for Health: An Introduction to the World Health Organization."

91 Kennedy and Michailidou, "Civil War, Contested Sovereignty and the Limits of Global Health Partnerships : A Case Study of the Syrian Polio Outbreak in 2013."

vaccination among communities living under rebel-control fell significantly, and there was a subsequent outbreak of the disease.

Attempting to improve the effectiveness of the global system of infectious disease control and address concerns that the old regulations were not suitable for dealing with the resurgence of infectious diseases, especially in countries that did not have the capacity or political will to act, the WHO revised the IHRs in 2005, allowing for the subversion of the sovereignty of member states in a number of ways. For example, the new IHRs allow the WHO to declare a public health emergency of international concern however; it can only issue states with non-binding recommendations regarding their response. This shows how global health partnerships that rely on national governments and international organisations such as the WHO to implement their programmes are at risk in conflict-affected areas where armed militants challenge the state's sovereignty. In such situations, there is a tension between the mission of global health to facilitate the attainment of the highest possible level of health by all people regardless of where they live, and the mandate of its lead-organisation to respect the de jure sovereignty of its member states.

### *Legitimacy in the aid sector*

Coordination mechanisms and implementers have many accountability issues of course and, other than at the state level, they are accountable not only downwards but also upwards. It is often the downward accountability that is debated, mostly by the 'non-local' implementers on the ground, the INGOs<sup>92</sup>. The issue is a recognised one, and relevant recommendations for INGOs can be found in the background paper on Engagement of crisis-affected people in humanitarian action<sup>93</sup>.

*"In order to move forward, agencies might do well to consider more closely what they expect to achieve through engagement, a question which is closely related to how they see their role in future humanitarian responses. They also need to consider and address the conceptual challenges to engagement that have been outlined above, as well as the more practical, operational constraints."*<sup>94</sup>

These conceptual challenges are important for the overall challenge facing the aid system, and that is why we have outlined them briefly here:

- Technical: In emergencies, there is no room for participation and engagement. Lives must be saved, and that is done most effectively through a top-down approach.
- Political: Participatory approaches which come from development work are not necessarily appropriate for humanitarian action.
- Philosophical: The engagement approach has lost its innovative edge and now serves to mask rather than resolve power imbalances.

Parts of the response formulated in the background document are important to quote here:

- The idea that development is intrinsically political, whereas humanitarianism is apolitical (aid is given on the basis of need alone) translates into very practical issues: agencies that operate without

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92 Chambers, "Who Engages with Whom? Who Is Accountable to Whom? Can the Development Sector Learn from the Humanitarian Sector?"

93 Clarke and Darcy, "INSUFFICIENT EVIDENCE? The Quality and Use of Evidence in Humanitarian Action: ALNAP Study."

94 Brown, Donini, and Knox Clarke, "Engagement of Crisis-Affected People in Humanitarian Action."

sufficient understanding of the context to prevent negative effects of their actions such as further marginalising of subgroups or disempowering local institutions cause harm<sup>95</sup>.

- The conceptual difference between development efforts and humanitarian action often seems less important to people affected by crisis than it does to (some) humanitarian workers. People in many crises-affected societies do not distinguish between different types of assistance and often experience disasters and conflicts as a normal part of their long-term development process<sup>96,97</sup>.
- Practical challenges that are inherent in working with local political institutions may be outweighed by the damage that can be done by not working with them and leaving an institutional vacuum<sup>98</sup>.
- Critics see participatory development as flawed, idealistic and naïve. A key articulation of this view is 'Participation: The New Tyranny?'<sup>100</sup> which challenges assumptions about the ability of top-down oriented organisations to transform themselves into bottom-up facilitators of locally grounded processes.

One could add here that the original role of INGOs in the development sector was to strengthen civil society, but driven by donor demands this agenda is now seen as a goal for all INGOs, even though this does not in most cases lead to results. 'As a result of internal and external pressures, most NGO efforts remain palliative rather than transformative.' This is linked to understandable constraints<sup>101</sup>, but raises questions on the legitimacy of INGOs. There is the suggestion that current participatory approaches to engagement may be at odds with the architecture of the system. 'From this perspective, it is meaningless to talk about engagement unless we are prepared to completely overhaul the system, and the power imbalances that currently underpin 'a relationship without reciprocity'<sup>102,103</sup>. This is an important message, given that it may not be enough to repair the broken system. "Accountability is not going to be improved through more 'tweaking' with technical or procedural fixes. It requires a change in mind-set to acknowledge that each and every person affected by and engaged in humanitarian crises has different roles and responsibilities to play, and that they need to be accountable to one another as well as to the collective goals"<sup>104</sup>.

## The Humanitarian System

Now that the challenges of legitimation have been discussed it may help to have a closer look at the humanitarian system itself, in order to understand the barriers to finding clear evidence about what

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95 For example, in the Haiti earthquake response, the participatory approaches of external actors resulted in the marginalisation of state structures, some of which (for example, the health services) had at least some capacity to respond (Schuller, 2012).

96 Anderson, Brown, and Jean, "TIME TO LISTEN: Hearing People on the Receiving End of International Aid."

97 Scriven, "A NETWORKED RESPONSE ? Exploring National Humanitarian Networks in Asia."

98 The report mentions Darfur and Eastern DRC, where aid organisations continued the same short-term responses over many years. This happens in many more countries. 'Given the inevitable tendency of protracted aid programmes to become part of the local political economy, with potentially damaging effects, organisations whose programmes fail to evolve or to include plans for effective transitions should surely be held accountable' (HAP, 2013:8)

99 Darcy, Alexander, and Kiani, "2013 Humanitarian Accountability Report."

100 Cooke and Kothari, *Participation: The New Tyranny?*

101 Banks et al name three: weak roots of the majority of NGOs in civil society in the countries they work in, which affects their impact and influence over the drivers of social change; the rising tide of technocracy that has swept through the world of foreign aid over the last 10 years, which has driven NGOs as "clients" to work on a limited set of agendas biased toward service-delivery and "democracy-promotion" instead of the deep-rooted transformation of politics, social relations, markets, and technology; and the third is the national and international political environments which continue to constrain NGO activities. Nicola Banks David Hulme Michael Edwards (2015) NGOs, States, and Donors Revisited: Still Too Close for Comfort? World Development Volume 66, February 2015, Pages 707-718

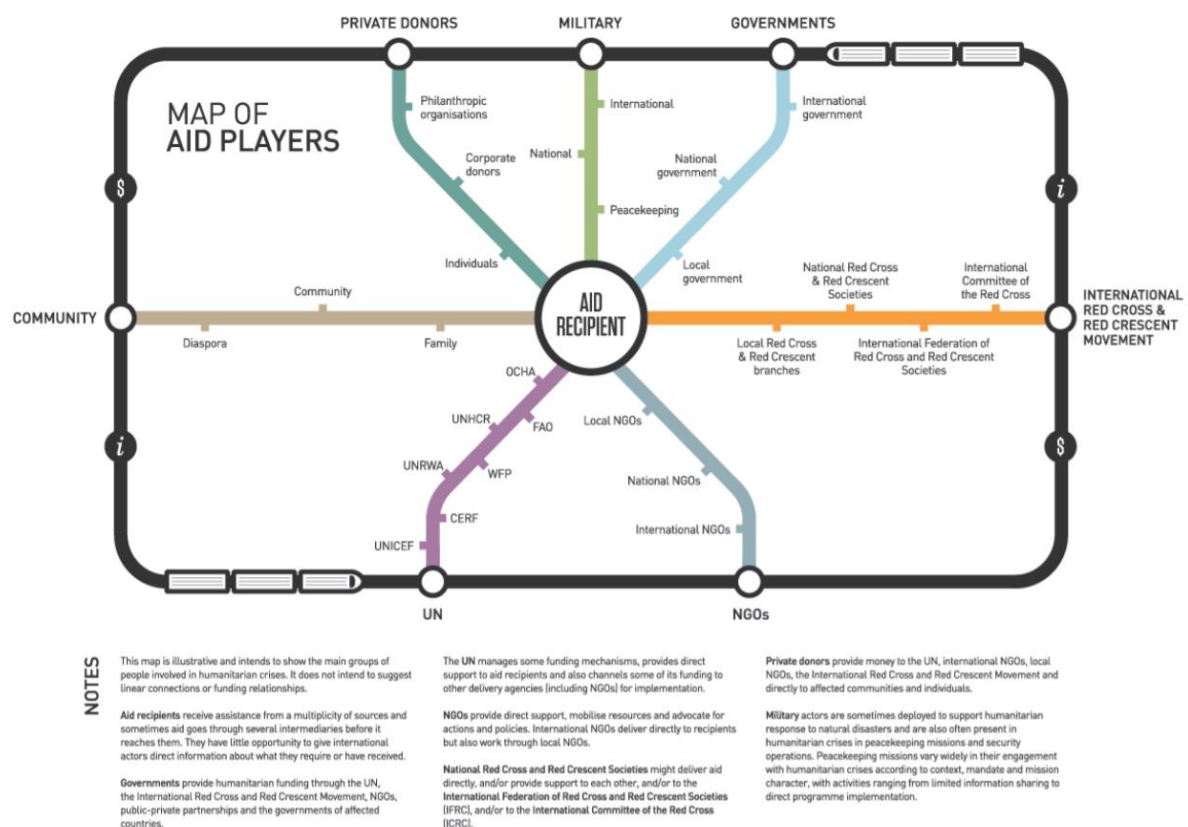
102 Fassin and Pandolfi, *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions*.

103 Donini, "The Golden Fleece : Manipulation and Independence in Humanitarian Action."

104 CHS Alliance, "On the Road to Istanbul: How Can the World Humanitarian Summit Make Humanitarian Response More Effective?"



works and what does not work in health systems strengthening and actor coordination. Since the end of the Cold War in 1991, the Humanitarian System has changed considerably. Responding to new challenges on both the demand side (the sheer volume of needs, new problems such as climate change, urban needs, migration of a different type) and the supply side (new IT solutions, remittances, commercial coverage of mixed populations in mixed settings, military input), new actors have arrived on the scene. These actors are changing the scene, but they are not part of the system in the sense of being included in coordination attempts as mentioned above. They vary from the private sector to commercial agents to the international industry and new donor governments as well as ‘other’ aid agencies (e.g. Physicians Across Continents, Buddhist Global Relief, Hamas)<sup>105,106</sup>. It is interesting to see how these new players fit into a ‘map of aids players’ published in 2014 which creates a sense of control that has since been lost<sup>107</sup>.



The involvement of these ‘new’ aid actors is problematic for some aid agencies because they feel they are gradually being side-lined. ‘In the privatised, commoditised and deregulated Congolese environment, health training has become a business outside the control of health authorities. The proliferation of unregulated private health training institutions, for doctors and for paramedical personnel, fuels the expansion of business-oriented service delivery points’<sup>108</sup>.

In terms of legitimacy and accountability there is a much bigger variety among the new actors. For the populations that need to be served it is complicated to distinguish the different actors, in military

105 <http://physiciansac.org/> and [www.buddhistglobalrelief.org/](http://www.buddhistglobalrelief.org/)

106 Hovdenak, “The Public Services under Hamas in Gaza: Islamic Revolution or Crisis Management?”

107 <http://www.globalhumanitarianassistance.org/infographics/whos-who-in-humanitarian-response>

108 Murru and Pavignani, “Providing Health Care in Severely-Disrupted Environments - Democratic Republic of Congo: The Chronically-III Heart of Africa.”

interventions the identity is often obvious, but things become more complicated when religious, political and commercial parties are taken into account. A brief reminder of the history of the 'humanitarian impulse' may help to illustrate the scope of this change.

### *The humanitarian impulse in perspective*

Humanitarian aid distinguishes itself from other forms of aid by being informed by a set of humanitarian principles. Aid should be motivated by the sole aim of helping other humans affected by disasters (humanity), exclusively based on people's needs and without any discrimination (impartiality), without favouring any side in a conflict or other dispute where aid is deployed (neutrality), and free from any economic, political, or military interests at stake (independence)<sup>109</sup>. The 'humanitarian enterprise' reached its height in the 1990s, and bringing relief to those in need was based on the idea, as a French humanitarian said, "that people are not made to suffer"<sup>110</sup>.

Humanitarian action was seen as apolitical, and flourished in an 'ideological void' according to critics (see Alex de Waal<sup>111</sup>, David Rieff<sup>112</sup>, Michael Maren<sup>113</sup>, David Kennedy<sup>114</sup>, Fiona Terry<sup>115</sup>, Didier Fassin and Mariella Pandolfi<sup>116</sup>, Linda Polman<sup>117</sup>). Yet, however much one can sympathise with the impulse to help, it is not unproblematic. Sondorp and Bornemisza point at the unease that occurred when the enormous global response to the tsunami disaster in south Asia in December 2004 turned out not to match the real needs, and instead wrecked the fragile systems on the ground<sup>118</sup>.

Impartiality, independence and neutrality have become contested concepts, and not just in a theoretical sense. The crisis in the Middle East is the latest and most brutal example of the loss of what was called the 'humanitarian space'.

*'MSF is no longer an insider to the aid system, able to criticize the failings of the system from within, while relying on certain operational alliances with NGOs that essentially have the same 'principles'. MSF found itself to be an outsider in a situation where humanitarian assistance is based on political or military solidarity. This requires adaptation in terms of diversity of networks, profiles of human resources and flexibility of standards.'*<sup>119</sup>

Competition over funds may also undermine the old principles. "The presence of aid intermediaries, such as NGOs and charities, may play an important role in channelling aid to certain countries, sectors, and areas"<sup>120</sup>. As formulated provocatively by Labbé in 2012, once the Band-Aid is applied to an open wound, and minimal follow-up is undertaken to ensure it does not get infected, the work of humanitarians is done<sup>121</sup>. One detects a 'mission-creep', now that the mandates of humanitarian agencies have stretched to 'anticipate disasters, strengthen local capacities, develop new

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109 Labbé, "Rethinking Humanitarianism: Adapting to 21st Century Challenges."

110 Kreisler, "Humanitarianism, Human Rights Movement, and US Foreign Policy: Conversation with David Rieff."

111 Waal, *Famine Crimes: Politics & the Disaster Relief Industry in Africa*.

112 Rieff, *A Bed for the Night: Humanitarianism in Crisis*.

113 Maren, *The Road to Hell: The Ravaging Effects of Foreign Aid and International Charity*.

114 Kennedy, *The Dark Sides of Virtue: Reassessing International Humanitarianism*.

115 Terry, *Condemned to Repeat? The Paradox of Humanitarian Action*.

116 Fassin and Pandolfi, *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions*.

117 Polman, *The Crisis Caravan: What's Wrong with Humanitarian Aid?*

118 Sondorp and Bornemisza, "Public Health, Emergencies and the Humanitarian Impulse."

119 Whittall, "The 'New Humanitarian Aid Landscape' Case Study: MSF Interaction with Non-Traditional and Emerging Aid Actors in Syria 2013-14."

120 Pavignani, "Health Service Delivery in Post-Conflict States."

121 Labbé, "Rethinking Humanitarianism: Adapting to 21st Century Challenges."

partnerships, enhance the funding base, enhance coordination and leadership and innovate'<sup>122</sup>. This tension in how to keep making sense of the 'humanitarian impulse' in a fast-changing, multipolar world illustrates how the new complex contexts need new solutions. From this perspective, it seems almost logical that the slowly worked-through, peer reviewed and published literature is not the place to look for evidence to build guidelines for this new situation.

### *The security-development nexus.*

Changes to the response to crisis situations occurred while Jean-Henri Dunant was in Solferino, but they have picked up pace since the end of the cold war<sup>123</sup>. In 1994 the need for a shift in the organisation of international response to crises was deemed urgent. In its Human Development Report for 1994, the United Nations Development Programme noted the dramatic change from wars between states to intra-state conflicts with many more civilian casualties, and the term 'human security' was coined (UNDP Human Development Report 1994).

A more dramatic change took place seven years later, in the aftermath of '9/11', when the 'security agenda' became more dominate than 'human security' for the donor governments, against a background of problematic globalisation and ecological insecurity<sup>124</sup>. It shifted the attention from poverty to emergency, affected the security of aid workers and has had a major influence on the funding flow which has become more and more driven by the international security agenda. This is significant for our understanding of the health sector.

This 'security-development nexus' ("there can be no security without development and no development without security") was, and still is, framed by donor governments as thinking that development had to be preceded by security. Arguments for the reverse, development strengthens security through growth, productive interaction, legislation and trust, was ignored. The concept of 'humanitarian intervention' now also includes military intervention - the risk of 'mission creep' was felt most in the Kivus after the Rwandan genocide<sup>125</sup>. The security-development nexus provides a productive lens with which to look at the struggle of the aid sector, because it links the political effects of aid to conflict which is in itself to be seen as a social determinant of health. If the hypothesis of Tim Reid - donors bear a legal responsibility for their support to Rwanda and Uganda, because they knew that funds were used to finance gross violations and serious abuses of human rights, including potential crimes of genocide in the DRC - holds, then what about the health interventions that took place in this constellation?<sup>126,127</sup>

### *Linking Relief, Rehabilitation and Development*

The post 9/11 development firmly shifted the focus from the poverty alleviation that had dominated international development collaboration to emergency response. The 'humanitarian-development

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122 Rachel Scott (2014) *Imagining More Effective Humanitarian Aid: A Donor Perspective* OECD DEVELOPMENT CO-OPERATION WORKING PAPER 18

123 Neuman and Weissman, *Saving Lives and Staying Alive: Humanitarian Security in the Age of Risk Management*.

124 Jones, "US Foreign Policy After 9/11: Obvious Changes, Subtle Similarities."

125 Borton et al., "Humanitarian Aid and Effects."

126 Reid, "Killing Them Softly: Has Foreign Aid to Rwanda and Uganda Contributed to the Humanitarian Tragedy in the DRC?"

127 There is debate around the relative merits of humanitarian and development assistance with critics arguing that humanitarian action, particularly when it becomes a substitute for state service delivery, has the potential to undermine the state and sustainability more generally. However, this has to be weighed against the fact that humanitarian organizations are often the first agencies on the ground in fragile post-conflict states and offer both flexibility and a capacity to scale up responses in the absence of government capacity (Gordon, 2013).

128 Gordon, "Health, Conflict, Stability and Statebuilding: A House Built on Sand?"

divide' or 'relief-development nexus' has been subject to policy debates since the late 1980s<sup>129,130</sup>. There have been concerns on whether it is possible to interlink the different styles, mandates and objectives of relief and development in practice, and this led to the start-up of new agencies (e.g. MSF started Aedes in Belgium and HealthNet in the Netherlands). It is indeed hard to see how the humanitarian principles fit into a developmental approach<sup>131,132</sup>. On the other hand, it is difficult to conceive of situations where humanitarian actors have a monopoly on services<sup>133</sup>.

It has been argued that humanitarian aid and development aid are two different fields of work with different objectives: "Relief intends to relieve suffering in a person or community, relief involves a narrow, quick and largely reparatory ethical goal. Development intends to develop the full potential of a person or community, development involves a broad, slow-building, creative and liberationist ethical goal"<sup>134</sup>. Seeing that many contexts constantly swing between emergency and 'development', South Sudan is a good example, one could ask whether for practical and moral reasons, it might not be advisable to stop the separation of humanitarian from other services in planning, legitimation and accountability. Simply understanding how the creation of the gap was a product of political and ideological thinking does not make it go away, new ways of dealing with specific circumstances and specific available resources need to be found. Indeed many recommendations to dust off and improve the 'Linking Relief, Rehabilitation and Development' (LRRD) tools have been made recently.

### How to Move Forward: Best Practice Rather Than Evidence?

Important lessons can be learned from the reports produced and/or commissioned by, among others, the 'ReBUILD Research Programme Consortium'<sup>135</sup>, the UNEG Humanitarian-Evaluation Interest Group (UNEG-HEIG)<sup>136</sup>, NORAD<sup>154,137</sup>, ALNAP<sup>138</sup>, DANIDA<sup>139</sup> and the German Federal Ministry for Economic Cooperation and Development (BMZ)<sup>140</sup>. These are practical tools for a range of different settings, and the guidelines are regularly criticised and improved upon<sup>141,142</sup>. We have analysed the

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129 Health interventions in fragile and conflict-affected states are limited to humanitarian relief, which does not advance either health systems development or state legitimacy. Moreover, there is a mismatch between organization of health assistance and programs. The traditional distinction between humanitarian and development aid is often unresponsive to real needs.

130 Haar and Rubenstein, "Health in Postconflict and Fragile States."

131 Partnerships have presented dilemmas for some aid actors, particularly those committed to upholding the humanitarian principles of neutrality and impartiality. One such is Médecins Sans Frontières (MSF), which cites its 'emphasis on preserving a distinct working space in order to maintain its access to civilians' as a barrier to greater capacity building (Metcalf-Hough et al, 2017).

132 Metcalfe-Hough et al., "NORAD Report 2/2017: How to Engage in Long-Term Humanitarian Crises : A Desk Review."

133 Hilhorst and Serrano, "The Humanitarian Arena in Angola, 1975-2008."

134 Slim and Bradley, "Principled Humanitarian Action & Ethical Tensions in Multi-Mandated Organizations."

135 Witter, Hunter, and Theobald, "Developing Health System Research Capacity in Crisis-Affected Settings : Why and How?"

136 The UNEG-Humanitarian Evaluation Interest Group aims at identifying, signalling and improving practice on the specificities that characterise the Evaluation of Humanitarian Action. The HEIG also serves as a resource for UNEG members by: (a) developing technical guidance on identified priority themes such as on reflecting Humanitarian Principles when evaluating Humanitarian Action; (b) providing links to relevant information and analysis on topical issues of interest to Humanitarian Evaluation practitioners within UNEG – and beyond – as in the case of the Emergency-Development nexus. <http://www.unevaluation.org/event/detail/480>

137 The NORAD report stresses that the divide between emergency and development response is essentially producing gaps, duplication and inefficiencies in the overall response.

138 Stoddard et al., "The State of the Humanitarian System: ALNAP Study."

139 Mowjee and Fleming, "Evaluation of the Strategy for Danish Humanitarian Action 2010–2015: Syria Response Case Study Report."

140 Mosel and Levine, "Remaking the Case for Linking Relief, Rehabilitation and Development: How LRRD Can Become a Practically Useful Concept for Assistance in Difficult Places."

141 World Humanitarian Summit 2016, "Transcending Humanitarian-Development Divides Changing People's Lives: From Delivering Aid to Ending Need."

142 United Nations, World Bank, and European Union, "Joint Recovery and Peacebuilding Assessments (RPBAs): A Practical Note to Assessment and Planning."

recommendations of these reports and we see consensus on more or less all issues: governance, collaboration, contextual information, local participation (see table below).

The recommendations are similar not only in their content, but in their ‘political correctness’ - no radical changes are suggested, instead suggestions on best practices are made. There is a general consensus on the need for documenting experience, producing evidence, improving guidelines and subsequently improving results<sup>143,144</sup>. One example is the ‘New Way of Working’<sup>145</sup> which recommends working towards collective outcomes; working over multi-year timeframes; working based on comparative advantages; and delivering results in context. The aim is that that all parts of the aid system recognise their comparative advantages and work together towards jointly defined collective outcomes, over the short-, medium-, and long-term, and set out clear roles and responsibilities around delivering against those outcomes<sup>146</sup>. This important effort to improve coordination mechanisms between the different actors across the spectrum of emergency and development, is taken on with admirable positivism, as shown in a report on one of the first missions guided by the New Way of Working, aimed to improve coordination of financial streams for Sudan.<sup>147</sup>

These recommendations, all relevant for the health sector, are nevertheless mostly formulated as good intentions. The basis for these recommendations are often interventions with mixed results; promising in one context and disappointing in others. Attempts to link the recommendations with the constraints we have discussed and reported can help towards achieving progress, if not in finding hard evidence, then at least in understanding how the interpretation of ‘best practice’ can help to find guidance to meet the humanitarian challenge.

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143 The production of guidelines is one thing, the use of the guidelines another. Concern about the use of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, published in 2007, led to a study published in 2014. The guidelines had positive effects, but it was also found that the “influence of the Guidelines on programmes and activities in the field depends on resources, context and capacity.” Furthermore, “the structure of the humanitarian system was identified as a key challenge to integration of MHPSS activities....Respondents noted that integration of MHPSS within clusters has been somewhat limited and challenging. ‘Cross-cutting issue’ fatigue, and lack of clarity as to the strategy through which cross-cutting issues are integrated into the cluster system, has limited the integration of the Guidelines within the cluster system.” (IASC, 2014)

144 IASC, “Review of the Implementation of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings: How Are We Doing?”

145 Dolan, “Letting Go of the Gender Binary: Charting New Pathways for Humanitarian Interventions on Violence.”

146 United Nations Working Group on Transitions and Inter-Agency Standing Committee Task Team on Strengthening The Humanitarian-Development Nexus In Protracted Settings, “The Development Nexus : A New Way of Working.”

147 Financing Strategy Mission Report ‘FROM FUNDING TO FINANCING’, reporting on a mission in May 2017 to Sudan by OECD, UN MPTFO and UNOCHA financing specialists.

**Table 1.**

<i>Title of Document / Reference</i>	<b>How do different types of provider affect access to effective and affordable healthcare during and after crises?</b>	<b>Remaking the case for linking relief, rehabilitation and development: How LRRD can become a practically useful concept for assistance in difficult places</b>	<b>The Humanitarian-Development Nexus: A New Way of Working</b>	<b>On the Road to Istanbul: How can the World Humanitarian Summit make humanitarian response more effective?</b>	<b>Changing People’s Lives: From Delivering Aid to Ending Need Proposed core commitments</b>
<i>Author</i>	Witter and Hunter (2017) – ReBUILD	Mosel and Levine (2014) - HPG	United Nations Working Group on Transitions and Inter-Agency Standing Committee Task Team on Strengthening the Humanitarian-Development Nexus in Protracted Settings	CHS Alliance (2015)	Grogan (2016) – OCHA Policy Development Branch
<i>Implementation Principles / Recommendations</i>	<p><i>Supportive Interventions</i></p> <p>Utilization of community-based care</p> <p>Contracts and regulation (i.e. expansion to non-public providers)</p> <p>Maintain coherent health workforce policies during and after crises (i.e. task shifting)</p> <p>Build government capacity to manage and provide health services in the long-term</p>	<p><i>Key principles of a good “linking relief, rehabilitation, and development” (LRRD) program:</i></p> <p>Flexibility and responsiveness</p> <p>Risk-taking and openness to learning</p> <p>Thorough context and political analysis</p> <p>Working with local institutions</p> <p>Joint analysis/planning and learning at country level</p> <p>Realistic programming</p>	<p><i>Four priority areas should guide the early phases of implementation:</i></p> <p>Predictable and joint situation and problem analysis</p> <p>Better joined-up planning and programming</p> <p>Leadership and coordination</p> <p>Financing modalities that can support collective outcomes</p> <p>While principles may differ, the centrality of human-rights provides the foundations required to work towards shared development goals with peace dividends in a rights-based manner.</p>	<p>Good humanitarian action is led by the state and builds on local response capacities wherever possible.</p> <p><i>National government strategies for immediate humanitarian assistance include:</i></p> <p>Information and risk management;</p> <p>Coordination with government agencies and humanitarian organizations;</p> <p>Development of mechanisms to adapt the assistance to the particular needs of the victims</p>	<p><i>A New Way of Working:</i></p> <p>Working towards <b>collective outcomes</b></p> <p>Working over <b>multi-year timeframes</b></p> <p>Working based on <b>comparative advantages</b></p> <p>Delivering results in <b>context</b></p>

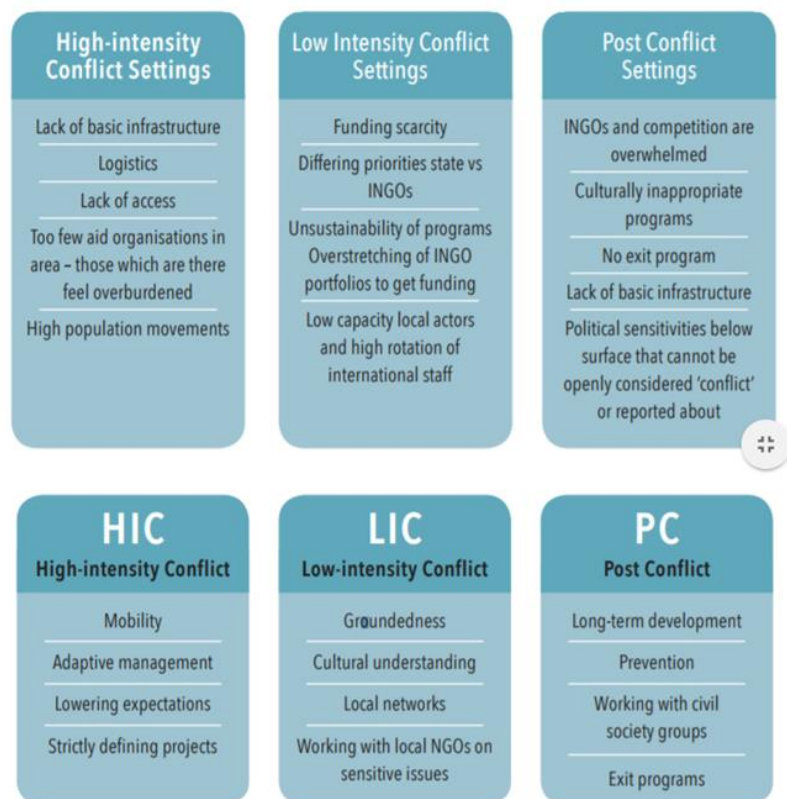
<p><i>Success factors</i></p>	<p>Directing more resources to the frontline providers in the public system, coupled with stronger supervision</p> <p>Negotiating access for specific groups to use health facilities run by domestic or international military forces, or by other ministries</p> <p>Supervising international NGOs to ensure capacity transfer to local partners using a structured transition plan that includes managers at all levels of the health system</p> <p>Ensuring a level playing field for mission-based and other NGO providers in terms of inputs such as staffing, but also in relation to national standards and performance against national goals (also for private-for-profit facilities, where feasible)</p> <p>Using community health workers to connect informal providers to training and supervision systems</p>	<p>At the strategic level, it will be important to develop a single common strategy at the country level. Such a strategy must be based on a joint analysis by emergency and development actors of the interplay between chronic problems, underlying structural causes and acute vulnerabilities or needs.</p> <p>At the program/thematic level, it will hopefully be used for innovative programming, experimenting with and learning from different implementation modalities and flexible, longer-term approaches that 'track' and respond to changes in the local situation.</p> <p>Relationships and partnerships should be premised on the overall goal of improving the lives of affected people. Building the capacity of a governmental or any other institution is not in itself necessarily of any benefit.</p> <p>The need for program management tools which can handle flexibility, risk and change has been stressed.</p>	<p>For the New Way of Working to be successful, agencies must address the root causes of conflicts and crises, which often stem from violations and neglect of human rights, including inequality, persistent discrimination, impunity and violence.</p> <p>In practice, the New Way of Working will require strong leadership and a coherent approach in analysis, planning, and programming.</p> <p>It will also require a renewed investment in participation on affected populations. The New Way of Working cannot succeed without accountability to and by those most affected by these protracted crises.</p> <p>Inclusivity through shared responsibility also means bringing the private sector closer into the fold. Humanitarian and development actors alike must acknowledge that some comparative advantages lie beyond the international aid community.</p>	<p>To implement these strategies, the government provides permanent technical assistance to the municipalities as part of a continual process of learning and improvement. In addition, the government promotes mechanisms that involve the participation of victims. These mechanisms, which are backed by civil society organizations, the Constitutional Court and the National Congress put in place a comprehensive and continuous accountability process.</p> <p><i>On development funds and accountability:</i></p> <p>Promote consistently improved accountability, equity, inclusivity and conflict (AEI/CS) sensitivity upfront by supporting standards similar to existing programs rather than only investing in ex-post evaluations.</p> <p>Pooled fund mechanisms should support the incentivisation of AEI/CS quality and capacity development</p> <p>Reinforce institutionalization and application of best practice for these principles within pooled funding mechanisms. This also means researching and developing more sophisticated tools for supporting change and measuring the effectiveness of aid provision in mixed complex aid environments.</p>	<p><i>Commitment 1:</i></p> <p>Commit to a new way of working that meets people's <b>immediate</b> humanitarian needs <b>while also</b> reducing risk and vulnerability and increasing their <b>resilience</b>.</p> <p><i>Commitment 2:</i></p> <p>Commit to support and enable a new and <b>coherent way of financing</b> that ensures humanitarian needs are met, reduces people's risk and vulnerability and increases their resilience.</p>
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### Different settings, different response

Between an immediate disaster and long-term conflict is of course a range of different scenarios, and it is well known that the complexity of conflict and disaster dynamics can only be understood when grounded in specific contexts<sup>148</sup>. Natural disasters, conflict and fragility affect each other in multiple ways. The scenarios sketched in the terms of reference for this report (low capacity-lack of government-conflict) is one way among many of bringing order into chaos. A different approach is proposed by ‘When Disasters Meet Conflict’, a large research project on humanitarian aid in settings of conflict and disaster<sup>149</sup>. The project tried to understand, from a practitioner’s view point, the “complexity and perverse outcomes that characterise the engagement of the international aid sector with local political realities in conflict settings” and how best to deal with them.

As mentioned previously, challenges in disaster aid programs, and the projects and strategies used to create and run successful programs, differ significantly in different conflict settings. This schematic overview, is helpful because it links each situation with (features of) the type of interventions that work best.

- “In HIC settings, projects that are mobile and adaptive work best. While it is a common belief that in HIC settings, humanitarian aid should be prioritised over development programs, about half of our panel members believed otherwise. They suggested that despite conflict, donors and aid actors should prioritise conflict resolution and development programs over humanitarian aid, as aid is perceived to be unsustainable and ineffective in these settings or even counterproductive - because it may feed into conflict. Always struggling with access and overwhelmed, a common strategy used by practitioners in HIC settings, in order to make sure their projects are regarded as successful by peers and donors, is to lower expectations and/or strictly define projects.



- In LIC settings, the most effective projects are the ones that are firmly grounded in local context and characterised by cultural understanding of the country experience. A common success strategy for practitioners is to work on sensitive issues under the surface, through local networks and local NGOs, in order to avoid disturbing good relations with the government.

148 Katie Harris, David Keen and Tom Mitchell (2013) When disasters and conflicts collide Improving links between disaster resilience and conflict prevention. ODI.

149 Funded by the Netherlands Research Council (NWO) and facilitated by the International Institute of Social Sciences (ISS), The Hague



- In PC settings, projects focusing on long-term development and prevention are evaluated as best. Successful strategies include working with civil society groups, ideally with clear exit plans, though this is rather rare.<sup>150</sup>

This schematic overview also illustrates how situations may evolve over time, requiring maximal flexibility in organising an adequate response. In the literature review, we noticed a distinct lack of exploration of these changes over time in health systems. In order to assess countries fragile health systems, research over the years has to cover the long-term developments of the recovery process, and the tendency to relapse into crisis should be highlighted whenever reforms and recovery are being discussed.

“...health systems are not simply static technical constructs that are reducible to predefined health systems’ building blocks’ (i.e., services, systems, products) or ‘essential service packages’. On the contrary, (...) health systems are also dynamic social constructs that are highly sensitive to the transitional forces of social, economic, and political change of which they form a vital subset”.<sup>151</sup>

### *The importance of ‘contextual flexibility’*

No outcome arises from a single intervention, but rather from a variety of them, and from multiple forces shaping the field, is the conclusion of an exercise in systems thinking for Health Systems Strengthening (Savigny & Adam 2009)<sup>152</sup>. Perhaps one should accept as valuable evidence a number of findings repeated over time in different circumstances, even if they are not experimental, but rather observational. There seems to be sufficient arguments to support this stance. One way of putting it is this: “Because wicked problems are in essence ‘expressions of diverse and conflicting values and interests’, the process of working with them is fundamentally social”<sup>153</sup>.

Another example of how ‘comprehensiveness and a combination of interventions drive performance’ is Rwanda. The country’s remarkable achievements in the domain of health have been recommended in papers that link the improved performance to governance (including donor coordination and the alignment of external aid to government policy), concrete initiatives such as community health insurance (mutuelles de santé) and performance-based financing (PBF), the health research infrastructure, PBF and community-based health insurance<sup>154</sup>. Sayinzoga and Bijlmakers looked for the explanation of this success at the operational level of Rwandan district health managers. Being the main drivers of improved health sector performance, those who ‘have less voice in conferences and in journal articles’, they are the key agents of change in the realisation of better overall health sector performance. Sayinzoga and Bijlmakers conclude that, ‘rather than a single health systems strengthening intervention or a set of interventions that target a specific disease, it is a combination of interventions that is seen as the most important driver of change – from the perspective of the operational mid-level.’ There is need for policy makers and scholars to acknowledge the complexity of

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150 Voorst and Hilhorst, “Humanitarian Action in Disaster and Conflict Settings: Insights of an Expert Panel.”

151 Grundy et al., “Health System Strengthening in Cambodia-A Case Study of Health Policy Response to Social Transition.”

152 Savigny and Adam, “Systems Thinking for Health Systems Strengthening.”

153 Xiang, “Working with Wicked Problems in Socio-Ecological Systems: Awareness, Acceptance, and Adaptation.”

154 See for example: Binagwaho A, Farmer PE, Nsanzimana S, Karema C, Gasana M, Ngirabega J, et al. Rwanda 20 years on: investing in life. *Lancet*. 2013;384(9940):371–75; and Farmer P, Nutt CT, Wagner CM, Sekarabaga C, Nuthulaganti T, Weigel JL, et al. Reduced premature mortality in Rwanda: lessons from success. *British Med J*. 2013;346:f65. doi:10.1136/bmj.f65. and Bucagu M, Kagubare JM, Basinga P, Ngabo F, Timmons BK, Lee AC. Impact of health systems strengthening on coverage of maternal health services in Rwanda, 2000-2010: a systematic review. *Repr H Matters*. 2012;20(39):50–61. Epub 2012/07/14; and Logie DE, Rowson M, Ndagije F. Innovations in Rwanda’s health system: looking to the future. *Lancet*. 2008;372:256–61. Rwandan Research and Implementation Writing Group. Building health research infrastructure in Rwanda. *Lancet Global Health*. 2014;2:e9–10; and Basinga P, Gertler PJ, Binagwaho A, Soucat AL, Sturdy J, Vermeersch CM. Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation. *Lancet*. 2011;377(9775):1421–8. Epub 2011/04/26.

health systems, and the fact that they are dynamic and influenced by society's fabric, including the overall culture of performance management in the public sector.<sup>155</sup>

### *Evidence or good practice?*

The reviewed material was scanned for evidence, but what in fact is 'evidence'? The NORAD report (2017) recommends practices and interventions such as cash responses, education in emergencies and security of tenure programming. Other promising interventions include new coordinating opportunities, strengthened in-country financial services and social safety nets (NRC, 2011; GCER, 2016a; CAFOD et al., 2016). More comprehensive and joint context and vulnerability analyses could also enhance collaboration and partnerships through building a shared contextual understanding between humanitarian and development actors (ICRC, 2016; CAFOD et al., 2016). However, despite the UN Secretary-General's call for such efforts to be 'a collective obligation' (UNSG, 2016: 17), they still remain the exception rather than the rule (UNOCHA et al., 2016b: 12)<sup>156</sup>. It is also worth noting that institutionalising more integrated approaches will require the creation of 'mixed humanitarian and development teams with the right incentives and senior leaders with joint responsibility'<sup>157</sup>.

In other words, recommendations are not always based on 'scientific evidence', especially since what constitutes evidence is different in different academic disciplines. Empirical evidence in the social sciences is often based on the two most common types of relationships in this type of research: correlational – where two concepts are related so that variance in one coincides with variance in another, and causal – where two concepts are related so that variance in one leads to variance in the other. This type of research can empirically elucidate cross-level mechanisms that, for example, associate community social capital with disaster mental health. In an example of Wind and Komproe (2012)<sup>158</sup>, their findings imply that interventions which foster structural and cognitive social capital may reduce disaster mental health problems. This is the type of fundamental evidence that one could use to improve health services. The kind of evidence that is the foundation for Evidence-Based Medicine is not the same, it is based on a dynamic balance between basic and applied research, where 'the best applied research studies are often founded on excellent basic science findings, even if basic research is neither necessary nor sufficient for the management of most medical problems'<sup>159</sup>.

We bring this forward in some detail here because one of the important ways of moving forward is finding complementary research designs that can produce results which are comparable to the 'gold standard' of the randomised control trial in medicine. Applying research methods better suited for specific problems the aid sector must deal is part of the 'traditional scientific approach'. At the same time, working in crises in a globalised world warrants a need for at least an awareness of the contrasting ontological and epistemological perspectives that are needed to understand each other. In these days of 'fake news' it seems important to apply academic rigor, which includes using the full range of research methodologies.

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155 Sayinzoga and Bijlmakers (2016) Drivers of improved health sector performance in Rwanda: a qualitative view from within. *BMC Health Services Research* 16:123

156 Metcalfe-Hough et al., "NORAD Report 2/2017: How to Engage in Long-Term Humanitarian Crises : A Desk Review."

157 Mowjee and Fleming, "Evaluation of the Strategy for Danish Humanitarian Action 2010–2015: Syria Response Case Study Report."

158 Wind and Komproe, "The Mechanisms That Associate Community Social Capital with Post-Disaster Mental Health: A Multilevel Model."

159 Haynes, "What Kind of Evidence Is It That Evidence-Based Medicine Advocates Want Health Care Providers and Consumers to Pay Attention To?"

An example of the need for critical reflection on the nature of acceptable evidence is the experience that women are often the best sources for sensitive indicators of hard-to-assess dimensions of changes in gender relations. Reducing recorded experience to “anecdotal” evidence means loss, and tools that will take into account these perspectives and allow them to be assessed in an acceptable way have been developed. Batliwala and Pittman (2010) give examples of some of these in “Capturing Change in Women’s Realities: A Critical Overview of Current Monitoring & Evaluation Frameworks and Approaches”<sup>160</sup>.

A very useful overview of the use of evidence is given in Knox & Darcy (2014): “Insufficient evidence? The quality and use of evidence in humanitarian action”, where one can find key principles for improving the quality of evidence in the humanitarian sector<sup>161</sup>.

### *The use of data*

Data is the very foundation of any research, and the lack of data is one of, if not the most cited problem of finding reliable information. Apart from the contextual reasons that will be mentioned below, there is an issue in the application of the so-called ‘big-data’ approach. A Global Partnership for Sustainable Development Data has been started to connect the full range of data producers and users working to harness the data revolution for sustainable development<sup>162</sup>. A number of these digital solutions have encountered barriers to scaling up and adoption across the agencies in the humanitarian, emergency sector<sup>163</sup>. In spite of evidence that it works, deployment in multiple countries, publicity and the promise of improved collaboration and coordination, even some of the more established and well-known solutions are struggling to attract scaling up funding and adoption by other agencies.<sup>164</sup>

*“Humanitarians largely stayed on the sidelines while the development industry began its own data transformation several years ago. The nature of the work didn’t lend itself to numerics, some argued”*

*“There is an emergency culture in which timeliness and effectiveness are seen as a trade-off... for example, just a small fraction of recent impact evaluation studies — 100 out of 2,000 — took place in humanitarian settings, according to the International Rescue Committee.”<sup>165</sup>*

Initiatives on new technology are everywhere, and humanitarian action has experienced a proliferation of new apps, tools, data analysis platforms, drones and other tech-solutions. See initiatives like the Dutch Coalition for Humanitarian Innovation<sup>166</sup>, Humanitarian Innovation Conferences on ‘facilitating innovation’, and much more. Two caveats should be given here: there is a concern that the enthusiasm for collecting data is vastly outstripped by the capacity to meaningfully analyse it<sup>167</sup>, and although the potential of new technology has been acknowledged, World Bank Group President Dr Jim Yong Kim warned in a lecture at the Joep Lange Institute on 6 July 2016, that technology will never be the solution itself, rather it is the people using the technology that make the difference.

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160 Batliwala and Pittman, “Capturing Change in Women’s Realities: A Critical Overview of Current Monitoring & Evaluation Frameworks and Approaches.” Published by the Association for Women’s Rights in Development (AWID).

161 Clarke and Darcy, “INSUFFICIENT EVIDENCE? The Quality and Use of Evidence in Humanitarian Action: ALNAP Study.”

162 <http://www.data4sdgs.org/>

163 Betts and Bloom, “Humanitarian Innovation : The State of the Art.”

164 Ramalingam et al., “Strengthening the Humanitarian Innovation Ecosystem.”

165 Dickinson, “Is Now the Moment the Humanitarian Data Revolution Begins?”

166 The Dutch Coalition for Humanitarian Innovation is comprised of governmental actors, knowledge institutes, academia, businesses, and humanitarian organizations in the Netherlands who develop innovative solutions to increase the impact and reduce the costs of humanitarian action. <http://dchi.nl/>

167 Read, Taithe, and Mac Ginty, “Data Hubris ? Humanitarian Information Systems and the Mirage of Technology Mirage of Technology.”

### *The options for research*

The following factors are often mentioned as barriers to research in conflict and fragile settings:

- difficulties of operating in such settings including security challenges
- issues with travel restrictions imposed by academic institutions
- challenges in obtaining appropriate ethical review and permissions
- lack of local research capacity;
- loss of data and records;
- mistrust of outsiders carrying out research
- research funding from powerful foundations aimed at disease specific issues according to pre-set mandates not much interest in health system and policy issues<sup>168</sup>.

It should be noted that these barriers all come from *within* the world of research, its institutions, managers and funding mechanisms. At first sight, there seems to be an exception in the 'lack of local research capacity', but even that can be contested - has it ever been properly funded? have local scientists been taken seriously? is there competition for funding between "north" and "south" academic institutions?<sup>169</sup>.

If progress is to be made in the light of the urgent need to feed a changing aid sector with new findings and evidence, some radical moves are needed. Given that 'nothing is as practical as a good theory', we must start by being concerned with the workability and legitimacy of representation - the result of any outcome of applied research methodology<sup>170</sup>. John Law argues that methods don't just describe social realities but also help to create them. This implies that methods are always political, and raises the question of what kinds of social realities we want to create<sup>171</sup>.

At a practical level, guidance is needed across the sector to access complexity-oriented approaches e.g. problem-driven iterative adaptation, collaborative intelligence, realist inquiry combined with participatory action-research. These approaches have been amply tested in domains other than health such as climate change (adaptation apps) and governance/public administration but have not found inroads into HSS in fragile states. If the final outcome of this exercise is to have guidance for the sector, these approaches need to be explored further.

Apart from the 'technical methodological' incentives to cross boundaries between different research traditions, there are also good arguments for connecting indigenous or local knowledge with these modern perspectives. As noted by Martineau:

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168 Bornemisza and Zwi, "Neglected Health Systems Research : Health Policy and Systems Research in Conflict-Affected Fragile States Alliance for Health Policy and Systems Research Significance of Conflict-Affected Fragile States."

169 At the scientific advisory committee of EMRO it was duly noted in 2008 that a 50m grant of the Gates Foundation was given to the LSHTM in London, and not to any of the research institutes in the five countries within EMRO where the malaria is endemic. A member, ex-minister of health of Egypt, commented that the former colonial power would remain 'in charge' as long as the combined output of peer reviewed articles from the 27 EMRO countries stayed below the number that Portugal produced Personal notes of WvdPut as member of SAC-EMRO

170 Law, *Organising Modernity: Social Order and Social Theory*.

171 Law, *AFTER METHOD: Mess in Social Science Research*.

*“Understanding the impact of conflict/crisis on the intersecting inequalities faced by households and communities is essential for developing responsive health policies. Both communities and health workers, and the systems that support them, are variously debilitated by conflict; this should be the starting point in each context for policy development and systems strengthening to achieve universal health coverage”.<sup>172</sup>*

This debilitation needs to be really understood, and not just noted, if it is to be addressed effectively. The health sector is made up of people who have gone through the same ordeals as all others, and are part of the same set of health beliefs and world-views as all the others, and this is often left out of the equation when the sector is expected to respond to new initiatives. One way of addressing the issue is to engage these people in the full cycle of assessments, design, implementation and the continuous evaluation of interventions. The way to do this, is to include them in action research.

### *Opening the perspective beyond ‘fragile settings’*

There is thus ‘good practice’ for new ways of moving forward to be found, and we found it mainly in the added literature (see below). This literature was not captured in the systematic review, probably because the specific protocol that was employed, excluded publications that did not have the keywords that were used. An example of a publication that did not make it through the filters is the helpful overview that includes all aspects of health service delivery, the Cochrane Governance arrangements for health systems in low-income countries: an overview of systematic reviews<sup>173</sup>. This review is not focused on fragile settings, and excludes the humanitarian system, but still has relevant results such as these:

- collaboration between local health agencies and other local government agencies may lead to little or no difference in physical health or quality of life (low-certainty evidence);
- Contracting non-state, not-for-profit providers to deliver health services may increase access to and use of these services, improve people’s health outcomes and reduce household spending on health (low-certainty evidence). No evidence was available on whether contracting out was more effective than using these funds in the state sector.
- training programmes for district health system managers may increase their knowledge of planning processes and their monitoring and evaluation skills (low-certainty evidence);
- participatory learning and action groups for women probably improve new-born survival (moderate-certainty evidence) and may improve maternal survival (low-certainty evidence);
- No studies evaluated the effects of stakeholder participation in policy and organisational decisions.

Given that the emergency-development nexus is not helpful per se, it makes sense to include these findings when looking for guidance. The general relevance of these findings seems limited when the specific aspects of fragile contexts and the variety of conditions is taken into account. On the other hand, it seems that even in stable conditions the evidence base is weak. This helps in the sense that it underlines the wickedness of the studied issue, and our search for ‘hard evidence’ has delivered one clear outcome at least: in these complex settings, ‘hard’ evidence is elusive. We will have to make do with ‘best practices’ based on shared ideas of what works in which circumstances.

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172 Martineau et al., “Leaving No One behind: Lessons on Rebuilding Health Systems in Conflict- and Crisis-Affected States.”

173 Herrera et al., “Governance Arrangements for Health Systems in Low-Income Countries: An Overview of Systematic Reviews.”

## Conclusions & Recommendations

The original literature review could only identify hints towards hard evidence, and explanations on how it was impossible to obtain, rather than delivering a robust set of evidence-based recommendations that could be the basis for new guidelines. An additional search that covered a wider range of publications on response to emergencies, across the relief-development divide, without a specific focus on health, yielded more results. Most of these results are not really 'evidence-based' either, but they gave suggestions based on consensus on 'lessons learned' and best practices endorsed across the field.

We found that overall the emergency-development nexus was not seen as helpful and that there is an array of attempts to 'close the gap' between a development and an emergency approach. There is an on-going discussion on humanitarian principles in the health sector. Given the original focus on saving individual lives of emergency health interventions versus improving overall conditions of life of a system approach, this is not strange. The Hippocratic Oath is important in this respect: it helps one to understand and appreciate the emphasis on the 'humanitarian impulse' that one finds in some of the emergency organisations.

There is unanimity about the need for more and better coordination, and closer and more effective collaboration within and across sectors, yet it is noteworthy that most of the conclusions of the most impressive reports are formulated as intentions, and not as clear goals with indicators for success, clear timelines and approved methodologies.

There is consensus on what needs to happen, but apparently still confusion on how to move forward, and much less consensus on who would coordinate what, which indicators can be made binding, and how to come to a more solid evidence base.

A potential way forward should respond to both the need to engage with the populations at risk, the need for collaboration beyond the emergency-development divide, the need for cross-sectoral collaboration, and the need to establish not only better knowledge but also better legitimacy and accountability.

### *What to do: a suggestion*

There is an agenda that can be set to address recommendations made on best practices, develop new methods of working, and connect with the people whose fate is at stake. It is in essence an operational model that connects intervention with establishing real connections with local actors and local knowledge. It includes the application of a whole set of approaches ‘out there’, and make them work operationally to come to better answers for the health challenge in fragile states, combining solid experience in ‘pure’ research (longitudinal designs, etc.) with locally-contextualised knowledge and new methodologies. Three things are essential: new evaluation methods; the data revolution, and research. If put together there may be an escape ‘out of the box’.

‘Theory of Change-based evaluation’, ‘impact evaluation and ‘realist evaluation’ provide tools to find out ‘how things work in complex settings’<sup>174,175,176</sup>. There are many new ways to measure ‘positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended’<sup>177</sup> to provide the policy and practice community with the kind of rich, detailed and highly practical understanding of complex social interventions which is likely to be of much more use to them when planning and implementing programs at national, regional or local levels<sup>178</sup>. The lack of application of these techniques is often attributed to the barriers to research, but given that they are located in the research-world rather than in the fragile settings, they can be overcome, and given the intentions for collaboration formulated, they should be overcome. The production of ‘Security guidelines for field research in complex, remote and hazardous places’ should also help overcome these barriers<sup>179</sup>.

Blanchet et al<sup>180</sup> call for the creation of a global humanitarian evidence platform where data and evidence can be accessible to all communities (national authorities, donors, academics, and humanitarian agencies). The same report calls for the development of innovative integrated funding mechanisms to enable the combination of research projects with humanitarian assistance. ‘Digitalisation’ is so far, underutilised and this hampers the data collection that is necessary for the application of advanced statistic modelling and structural equation modelling (SEM).

The overall recommendation to engage people in the full cycle of assessments, design and implementation and continuous evaluation of interventions can be followed by using a practical, scientifically sound, activating and rewarding way to ‘bring the people in’: action research.

Action research, almost completely missing in the reviewed materials, is an important way of including the voices of the people who count<sup>181</sup>. “Over the last two decades, a lot of effort has gone into repositioning people we used to call aid beneficiaries as partners in the design and implementation of relief programmes, however, calls for greater accountability have not done nearly enough to induce change in an aid sector that is reluctant to embrace it. Still, there is compelling evidence that

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174 Marchal, Belle, and Westhorp, “Realist Evaluation.”

175 International Institute for Environment and Development (IIED), “Theory-Based Impact Evaluation: Better Evidence in Action.”

176 OECD, “Outline of Principles of Impact Evaluation.”

177 Ten Hoorn and Stubbe, “Resultaat- En Impactmeting Voor Goede Doelen.”

178 <https://realist2017.org/>

179 Hilhorst et al., “Security Guidelines: For Field Research in Complex, Remote and Hazardous Places.”

180 Blanchet et al., “Evidence on Public Health Interventions in Humanitarian Crises.”

181 For suggestions and guidance on action research: The Participatory Action Research Website, located at Cornell University, Ithaca. <http://www.parnet.org>, The Participatory Learning and Action Website, located at the Sustainable Agriculture programme, IIED, London, UK <http://www.oneworld.org/iied/resource>, The Eldis Development Information Gateway. Contains links to databases, library catalogues and participation case studies. <http://www.ids.ac.uk/eldis/eldis.html>

continuously tracking affected people's perceptions and learning from their feedback improves performance." 'Social domains'<sup>182</sup> provide a good framework for analysis. Nick van Praag suggests a hybrid method to improve the use of feedback in program development, which is good example of applied action research<sup>183,184</sup>.

If the existing recommendations are followed and monitored in a modern, rigid way, using methods and techniques, made possible on the basis of collaboration across the sector, that shows itself in the drive to make UHC possible, there is a way forward. Operational action research using modern data techniques and accompanied by rigid, realist evaluation responds to both the need for collaboration beyond the emergency-development divide, the need for cross-sectoral collaboration, the need to engage with the populations at risk and the need to establish not only better knowledge but also better legitimacy and accountability. It is a process that can start any time and will yield results immediately and along the way. Evidence can be made.

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182 Hilhorst, "Responding to Disasters: Diversity of Bureaucrats, Technocrats and Local People."

183 CHS Alliance, "On the Road to Istanbul: How Can the World Humanitarian Summit Make Humanitarian Response More Effective?"

184 Stasse et al., "Improving Financial Access to Health Care in the Kisantu District in the Democratic Republic of Congo: Acting upon Complexity."



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