Health systems during and after crisis: evidence for better policy and practice | Brief 9

Responding to humanitarian crises in ways that strengthen longer-term health systems: What do we know?

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Increasing global conflict and fragility means the health of the world's poorest and most vulnerable populations are at risk. To address this, it is crucial that the international community can respond to humanitarian crises in a way that also leads to sustainable long-term development.[1,2] This is not a new problem, but one with challenges of differing principles and ways of working between relief, rehabilitation and development agencies. Within the health sector, the humanitarian provision of short-term health needs can have an immediate or longer-term impact on the development of sustainable health systems and longer-term health goals.[3,4] Most actors see the value in achieving Sustainable Development Goals (SDGs) in conflict and crisis-affected settings, however, there are tensions between delivering emergency services in a timely and flexible manner and achieving longer-term, country-led, health goals.[5] Whilst there are efforts to improve connectivity between humanitarian and development actors through better coordination, shared outcomes, financing streams and engaging in longer-term planning,[6] differences in working principles, mandates and cultures present challenges to achieving this.[2,7] In addition, protracted crisis situations, such as South Sudan and Syria, require humanitarian and development sectors to act simultaneously.[2,5,7,8] This brief outlines what is known about how to respond to humanitarian crises in ways that also contribute to subsequent stronger health systems.

The humanitarian-development nexus for aid delivery

Historically, the separation between relief, rehabilitation and development assistance has often resulted in a vacuum of service delivery between emergency services and longer-term health reforms.[6,7] To address this, partners at the 2016 World Humanitarian Summit agreed a 'New Way of Working' (NWoW) based on a shared understanding of sustainability, vulnerability and resilience.[9] The 'NWOW' supports having pooled data, analysis and information frameworks with better joined up planning and programming processes,[9] that aspire to support national and local ownership with capacity development spanning multiple years. The G7+ have published examples of health projects inspired by the New Deal.[10]

Key messages

There is a new global momentum to address the transition gap from emergency aid to development. The existing literature and experiences outlined in this brief suggest some overarching areas for consideration if interventions are to contribute to (or at least not undermine) long-term health systems for vulnerable populations while meeting immediate health needs.

- **Identify commonalities in the principles behind humanitarian and development efforts**
- **Identify how donors can support implementing partner organisations and their workforce to better link relief, rehabilitation and development**
- **Consider how resource distribution may support or hinder linkages between governments, humanitarian and development actors**
- **Apply health development principles early on in emergency settings, with longer-term perspectives and planning**
- **Where there is no legitimate government in place, consider decentralised planning, analysis and funding**
- **Involve local partners in needs assessments and decision making to strengthen capacity at national and sub-national levels**
- **Track the intentions of international actors at the local level to predict gaps in service delivery and minimise potential threats to longer term health outcomes**
- **Be aware of the impact that power relations and vertical programming may have on longer-term health systems strengthening**
- **Evaluate and share practical examples of how programmes have achieved better connectivity between aid sectors without compromising quality of service delivery**

All the briefing papers in this series can be accessed at http://bit.ly/2rUPRH9

This briefing paper series has been developed by the **ReBUILD Research Programme Consortium** to inform a number of key issues around health systems in crisis-affected settings, and draws both on ReBUILD's own work and wider sources. The issues were identified in a **research agenda-setting study** carried out by the **Health Systems in Fragile and Conflict-Affected States Thematic Working Group** of Health Systems Global.

Whilst this focus on the 'humanitarian-development nexus' is welcomed by many, it is not without contention.[5,11] Some international non-government organisations (NGOs) argue strongly that efforts to converge humanitarian and development goals present risk to delivering timely and responsive emergency services.[12] There are also concerns regarding the disconnect between humanitarian principles of neutrality and independence, and development goals that require a partnership approach with potential political and governmental allegiances.[5,13] Caution is needed when advocating for principles such as government ownership, when humanitarian partners are often required to work with illegitimate agencies to ensure vulnerable people receive services. Engaging humanitarian actors in discussions early on may help alleviate concerns and encourage productive communication.[2,13] Furthermore, the 'NWoW' has been criticised for having no clear implementation process, milestones or benchmarks to monitor the process.[11] However, projects aligned with the NWoW and the New Deal principles are already being developed and implemented.[10,14,15] **(See Box 1)**

Box 1 – NWoW and New Deal principles in practice

Designing collective outcomes to address the ongoing protracted crisis while contributing to longer term SDGs

The financing strategy mission in **Sudan** brings together multiple donors from humanitarian, development and peace agencies to set collective goals with clear financing streams for immediate needs such as nutrition, building health facilities and infrastructure, as well as longer-term goals associated with strengthening the ministries and laying the groundwork for delivering against the SDGs.[14]

Applying heath development principles early on in emergency settings to set the ground for development

The DARES collaboration, operating in **Yemen**, **Central African Republic**, **Somalia** and **Libya**, defines short, medium and longer-term targets and results, with specific activities to identify national and sub-national capacity requirements including strengthening health systems and the health workforce.[15]

Limited practical examples of bridging humanitarian and development principles

Literature highlights the need for new ways of working but there is limited guidance about how to do this in practice.[16] Practical examples of how donors, NGOs and governments have implemented change, no matter how small, are needed to help implementers understand ways of better connecting without risking quality of service delivery.[16] Aspirational programmes in health which are trying to align humanitarian, recovery and development goals will need evaluation and dissemination to share lessons learned and highlight best practices.[5,16]

Limited crosscutting experience within implementing organisations

With few professionals having experience across relief, rehabilitation and development assistance, there is a deficiency of expertise and capacity to work across different forms of aid and coordinate activities.[16] Encouraging organisations to develop their workforce to gain experience of delivering health services in all stages of fragility would benefit joint programme planning. Shared offices and programmes of implementation could facilitate this process.[1] Donors could also help transition by funding the same organisation to deliver humanitarian and development programmes, incentivising them to link strategies, and supporting them to develop opportunities for follow-up funding.[2]

With the above limitations in mind, it is also important to recognise the challenges already raised by the development sector around building sustainable health systems after conflict or crisis. The examples discussed below draw both on literature and lessons from protracted crisis and post-conflict/crisis development sectors, and wider lessons on challenges for sustainable health systems in low and middle-income countries. **See also accompanying brief on sustainability of health systems**.

Risks associated with vertical programming led by international agencies

The distribution of finances and resources from donors to local providers is a key issue for sustainable health systems with ongoing humanitarian work **(see accompanying brief on types of healthcare provider)**. Often, donors fund local NGOs to provide pre-determined services with vertical systems for monitoring, reporting and budgeting with minimal state involvement.[1] Interventions are delivered as isolated programmes (e.g. maternal and child health, HIV/AIDS) focused

on short-term results.[17] As governments become more functional and legitimate, they inherit a verticalised, fragmented health system with minimal skill development of the health workforce.[18] A social network analysis assessing organisational infrastructure for service delivery in post-conflict northern Uganda found much less support for workforce strengthening compared with programme-specific agendas for HIV and maternal health services.[18] Wider literature highlights a lack of appropriate policies in conflict and crisis-affected settings related to governance and administration systems including organisational planning, financial and human resource management for deployment, incentives and gender equity – all needed to ensure a fair balance across sectors and geographical distribution.[4,8,19]

See also accompanying briefs on inclusive health systems and sustainability of health systems; also the **'Building Back Better' e-resource on gender and post-conflict health systems.**

A long-term approach to health system reconstruction and strengthening, aimed at consolidating the state, supporting government legitimacy and ensuring effective, equitable service delivery, is required in conflict/crisis-affected settings.[20] Health service visibility can enhance credibility and legitimacy, whereas bypassing government health systems for long periods of time can mean communities develop negative perceptions of government services, as found in Nigeria and Sierra Leone.[20] Legitimacy of governments is further exacerbated when NGOs recruit health workers on terms that are not sustainable by the host government.[21] A better understanding is needed of how international resource flows affect long-term health goals at the national and sub-national level. Identifying effective ways to track the intentions and potential disengagement of international actors (e.g. using social network analysis) would enable local governments to predict gaps in service delivery and make adaptations to protect longer-term outcomes.[18]

Managing the power of international aid and supporting country ownership

Whilst the abundance of international aid actors in emergency settings can help deliver much-needed services, actors need to be aware of the power they hold and the risk of creating dependency. Lessons should be heeded from countries such as Cambodia, where the vast amounts of aid resulted in a dependence on international donors at both national and district level.[21,23,24] This fostered a belief that outsiders have 'better' knowledge, resources and power, creating an internalised inferior position within the health workforce.[25,26] Power imbalances have also been reported in Sierra Leone over access to financial resources and information between NGOs and district level managers.[21,27]

To counter such power disparities, actors could better support country ownership of activities by working with governments, where legitimate. Particularly in protracted crises, there is a need to identify concepts and methods for working with pluralistic, under-governed, trans-national health systems.[6] Early development of policies for delivering a set of core health services with performance indicators and a foundation for a sustainable health system can facilitate the process.[28] In Afghanistan, USAID engaged in health diplomacy with both the Ministry of Public Health and Ministry of Finance to promote global health and forward national interests. By supporting such interactions they strengthened the health sector and potentially helped wider state-building.[28]

Decentralised planning and funding in areas with no legitimate government

In conflict-affected settings, there may not be a clear, legitimate government to develop accountable health systems, especially where there are violations of human rights or incapacities.[6,19] Steets et al.[2] suggest decentralised planning, analysis and funding to address issues of national governance. In some cases, bypassing national ministries to work directly with regional level staff and partners has been effective.[17] In South Sudan, larger donors have split their efforts into states to avoid duplication, reporting positive experiences working at this level to analyse data and plan services.[3] Benefits include proximity to the local population, increased motivation to help and a tendency for partners to outlive political change at a personal level.[6] A review of reports from programmes working in conflict/crisis-affected settings found a need for more focus on accountability and participation from affected communities, concluding that the 'NWoW' cannot succeed without accountability to and by those most affected by protracted crises.[6] Global health programmes in Afghanistan that delivered at the local level found improvements in quality and service delivery.[29] **(See Box 2.)**

Box 2 – Involving local partners in needs assessments and decision-making

Global health programmes in **Afghanistan** that delivered at the local level improved both quality assurance and service delivery. This included amendment of educational materials for rural populations, religious awareness in gender groupings for health educational interventions and recruitment of local staff, educated in languages and customs.[29]

Support capacity building of mid-level management

Capacity building processes are often not targeted at mid-level managers by either humanitarian or development sectors, but research suggests strengthening of district health-management teams can quickly improve performance of front-line health workers.[30] Yet in Uganda, district level managers reported a lack of authority to make decisions about their workforce, with minimal control over resources, restricting their capacity to implement decisions.[31] Working at local level can better connect humanitarian aims to longer term development and promote ownership. However, international organisations should ensure they are not simply sub-contracting local partners to carry out pre-designed plans with little input and ownership from partners on the ground, as has been found in Uganda, South Sudan and Burundi.[32] Building capacity of the health system at the district level, together with tracking of resources to ensure ownership of longer term performance, should be considered when delivering aid across humanitarian and development sectors.[17,33]

References

1. Otto R, Weingärtner L. (2013) Linking Relief and Development: More than old solutions for old problems? IOB Study no. 380. Netherlands: Ministry of Foreign Affairs; 2013. **http://bit.ly/2JdBXbj**
2. Steets J, Preysing D, Shapiro G. (2011) Donor Strategies for Addressing the Transition Gap and Linking Humanitarian and Development Assistance: A Contribution to the International Debate. Berlin: Global Public Policy Institute. **http://bit.ly/2N3tY30**
3. Jones A, Howard N, Legido-Quigley H. (2015) Feasibility of health systems strengthening in South Sudan: a qualitative study of international practitioner perspectives. BMJ Open 5(12). **http://bit.ly/2L5DKRz**
4. Martineau T. et al. (2017) Leaving no one behind: lessons on rebuilding health systems in conflict- and crisis-affected states. BMJ Global Health 2(2). **http://bit.ly/2JeclWn**
5. De Castellarnau M, Stoianova V. (2018) Bridging the emergency gap: Reflections and a call for action after a two-year exploration of emergency response in acute conflicts. Barcelona: Médecins Sans Frontières. **http://bit.ly/2NGLj2Q**
6. Affun-Adegbulu C. et al. (2018) Contexts and Crises: Evidence on Coordination and Health Systems Strengthening in Countries under Stress: a literature review and some reflections on the findings. Antwerp: Health Policy Unit, Institute of Tropical Medicine, Belgium. **http://bit.ly/2m7FXRJ**
7. Kocks A. et al. (2018) Building bridges between international humanitarian and development responses to forced migration. German Institute for Development Evaluation and The Swedish Expert Group for Aid Studies. **http://bit.ly/2L8H3HG**
8. Downie R. (2012) The State of Public Health in South Sudan: Critical Condition. Washington: Center for Strategic and International Studies. CSS Global Health Policy Centre. **http://bit.ly/2KXuu5p**
9. OCHA (2016). New Way of Working **http://bit.ly/2L4kUxB.**
10. Rabinowitz G. et al. (2016) Aid instruments for peace-and state-building: Putting the New Deal into practice: G7+ **http://bit.ly/2JdB8j4.**
11. ICVA (2017). The "New Way Of Working" examined: An ICVA briefing paper. Geneva: International Council of Voluntary Agencies. **http://bit.ly/2ub9PBg**
12. Medicins Sans Frontieres (2016). EMERGENCY NOW: A call for action beyond summits MSF's reflections on the World Humanitarian Summit. MSF. **http://bit.ly/2JamV6d**
13. DuBois M (2016). Don't blur the lines between development and humanitarian work. The Guardian. **http://bit.ly/2m7wf1D**
14. OECD (2017). 'From Funding to Financing' Financing Strategy Mission Report Sudan. **http://bit.ly/2JdlPGM**
15. DARES (2017) Deliver Accelerated Results Effectively and Sustainably: Operational Framework to Guide Collaboration in Fragile, Conflict and Vulnerable Settings. WHO with WFP, UNICEF and World Bank. **http://bit.ly/2JdlPGM**
16. Hinds R. (2015) Relationship between humanitarian and development aid (GSDRC Helpdesk Research Report 1185). University of Birmingham, UK. **http://bit.ly/2KXJKiJ**
17. Ssengooba F. et al. (2017) Sub-national assessment of aid effectiveness: A case study of post-conflict districts in Uganda. Globalization and Health 13(1):32. **http://bit.ly/2NFeELj**
18. Ssengooba F. et al. Application of social network analysis in the assessment of organization infrastructure for service delivery: a three district case study from post-conflict northern Uganda. Health policy and planning 32(8). **http://bit.ly/2N5ooNz**
19. Roome E, Raven J, Martineau T. (2014) Human resource management in post-conflict health systems: review of research and knowledge gaps. Conflict and Health 8(1):18. **http://bit.ly/2L7GHVj**
20. Eldon J, Waddington C, Hadi Y. (2008) Health systems reconstruction: Can it Contribute to State-building? Health & Fragile States Network. 58. **http://bit.ly/2umHkjm**
21. Bertone MP, Witter S. (2015) An exploration of the political economy dynamics shaping health worker incentives in three districts in Sierra Leone. Social Science & Medicine. 141:56-63. **http://bit.ly/2L7GHVj**
22. ReBUILD (2014) Benefits of Social Network Analysis for District Performance Assessment. ReBUILD Policy Brief. ReBUILD RPC & Makerere University, Kampala. **http://bit.ly/2NasqEm**
23. Chanboreth E, Hach S. (2008) Aid Effectiveness in Cambodia Phnom Penh: Wolfensohn Centre for Development.
24. Ui S. et al. (2010) Strengthening Community Participation at Health Centers in Rural Cambodia: Role of Local Non-governmental Organizations (NGOs). Critical Public Health. 20(1):97-115. **http://bit.ly/2L0k8lf**
25. Ear S. (2013) Aid Dependence in Cambodia: How Foreign Assistance Undermines Democracy. New York: Columbia University Press.
26. Cooke B, Kothari U. (2001) Participation: The New Tyranny? London: Zed Books Ltd.
27. ReBUILD (2016) Institutions for strong and equitable health systems after conflict and crisis: lessons from ReBUILD research. ReBUILD Briefing Paper. ReBUILD RPC, Liverpool. **http://bit.ly/2JhhlcZ**
28. Wells J. (2017) US Health Diplomacy in Afghanistan: A Development Tool in Health System Reconstruction of a Fragile and Conflict-Affected State. Journal of International Relations and Foreign Policy. 5(1). **http://bit.ly/2L0qpNO**
29. Kevany S. et al. (2014) Global Health Diplomacy Investments in Afghanistan: Adaptations and Outcomes of Global Fund Malaria Programs. Medicine, Conflict and Survival. 30(1):37-55. **http://bit.ly/2NHevH9**
30. Rowe AK et al. (2005) How can we Achieve and Maintain High-quality Performance of Health Workers in Low-resource Settings? The Lancet 366(9490):1026-35. **http://bit.ly/2KKy5o5**
31. Alonso-Garbayo A. et al. (2017) Decision space for health workforce management in decentralized settings: a case study in Uganda. Health Policy and Planning 32 (suppl 3): iii59-iii66. **http://bit.ly/2KPZncl**
32. Frerks G, Douma P (2013). Fragility by Choice? A Scoping Mission in Burundi, South Sudan and Uganda. The Dutch Consortium for Rehabilitation. **http://bit.ly/2KPZlBC**
33. ReBUILD (2015) Incentives to improve health workers' retention and motivation: implementation challenges and informal practices at district level. The role of DHMTs and NGOs. ReBUILD Policy Brief. ReBUILD RPC & LSHTM. **http://bit.ly/2uoClsV**

ReBUILD Consortium

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