Health systems strengthening in fragile settings: experiences of international NGOs

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Welcome

This webinar is being recorded

Please post any questions in the chat

Health system strengthening (HSS) remains an elusive concept – even more so in fragile and conflict-affected settings. This session reflects on HSS in FCAS, from an **operational experiential perspective**, combining **conceptual thinking, photos**, **stories**, and **participatory discussion**.

The findings presented are based on a study conducted by the FCDO-funded research consortium **ReBUILD for Resilience**, with **World Vision** and **IRC**. We also present one example from an IRC project in Northern Nigeria.

Speakers

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Health systems strengthening in fragile and conflict-affected settings: experiences and operational perspectives of international NGOs

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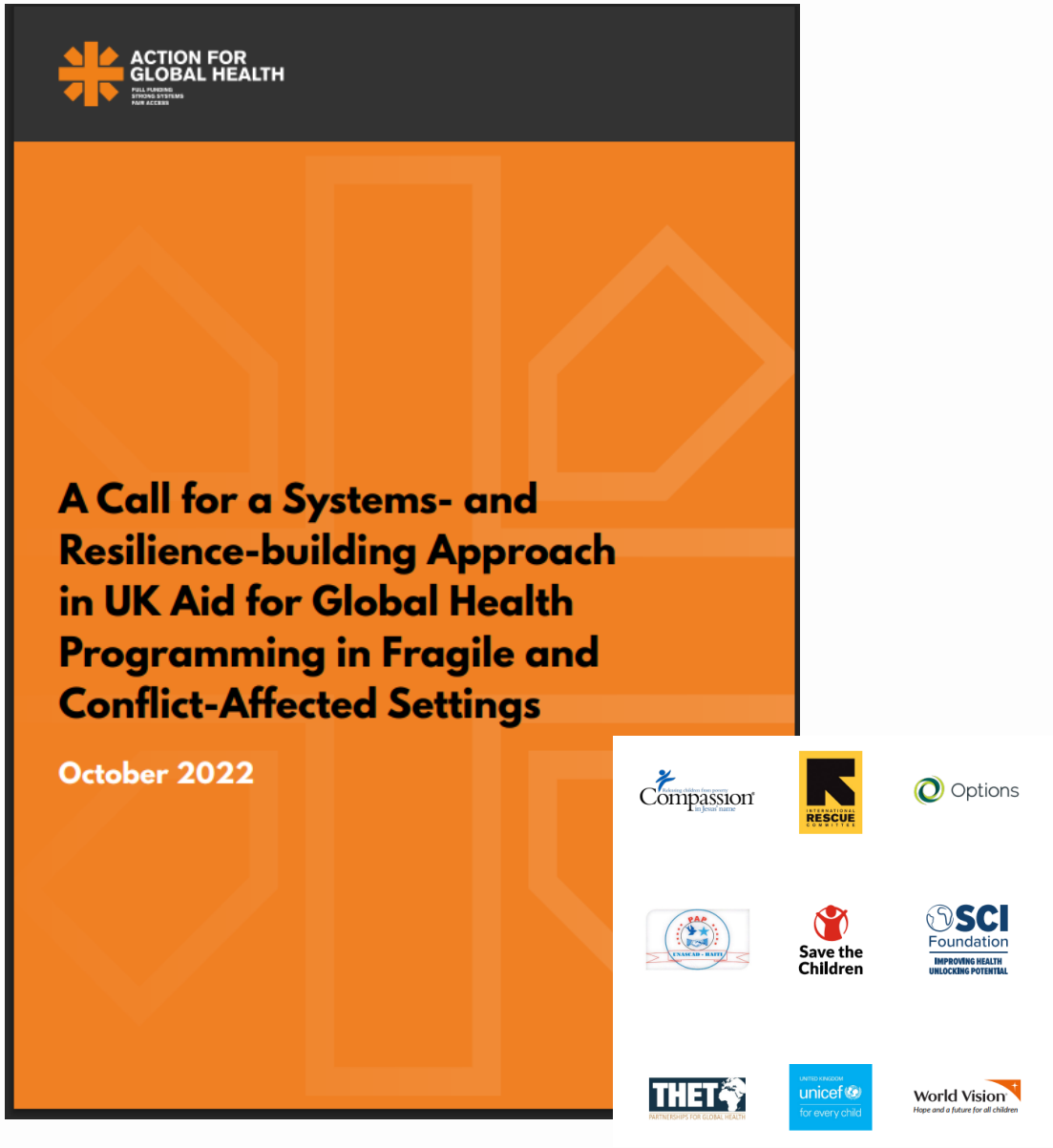
Background

- Health systems strengthening (HSS) is seen as **essential** to ensure **sustainable improvements** to health outcomes
- HSS is at the heart of the Nexus in the health sector, **connecting emergency response** to **recovery** and **long-term development**
- However, HSS programming remains elusive and **fraught with challenges**
- Even more so in fragile and conflict-affected settings (FCAS), where HSS efforts are complicated by **weak governance** and **fragmented response**

Background

- Study builds on 2022 AfGH brief on "what works" for HSS in FCAS
- Focus on "how to" questions for HSS programming in FCAS at the intersection of humanitarian and recovery phases
- Present operational, experiential perspectives ('real stories' and images) from implementing agencies
- HSS definition in relation to scope, scale, sustainability, effects (Witter et al, 2019) ≠ health system support



Methods

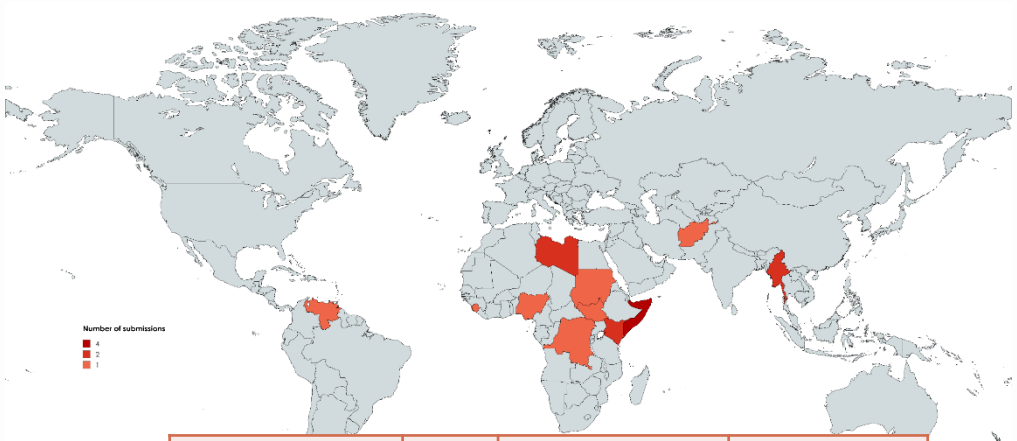
Data collection

- Expert interviews at global/regional levels (n=25)
- Photo elicitation at country level (n=17, 11 countries and 8 NGOs), incl. photos and interviews/sense-making
- Document review (n=63)

Development partners	9
NGO / CSO / implementing agencies	9
Researchers / consultants	7
Total	**25**

Limitations

- Purposeful and limited sample of participants – mostly international humanitarian/service delivery-focused NGOs
- Did not include MoH or development-oriented local and international agencies



Somalia	4	Sudan	1
Myanmar	2	Venezuela	1
Libya	2	Afghanistan	1
Kenya	2	Nigeria	1
South Sudan	1	Sierra Leone	1
DRC	1	**Total**	**17**

Findings

Main themes

- Challenges
- Entry points and promising HSS approaches
- Blind spots and open questions

Fragility, insecurity, humanitarian priorities

Challenges

- Challenges in doing HSS due to insecurity, lack of access, missing basic hardware elements of the health system (destroyed infrastructure, collapsed supply and information systems, shortages of HWs and drugs, etc.)
- General uncertainty that makes planning including for HSS difficult

"You can also see the paint coming off, which is a reminder that, as much as we want to talk about health systems strengthening, there are still the basics which needs to be addressed". *Photo elicitation: NGO, Sierra Leone*

Fragility, insecurity, humanitarian priorities

Entry points

- Priority is saving lives
- Focus on service delivery and health system support at most

> "We need to have a clear understanding of what is possible in each setting. We have to be realistic about what is possible in terms of HSS. It is very contextualised" (KII).

- Potential to leverage the humanitarian phase for HSS
- In some cases, crisis can even provide windows for reforms / HSS:
  - COVID-19
  - Ukraine
  - Vulnerabilities are more visible

> "Emergencies are cyclical in a setting like eastern DRC. We need to be able to capitalise on the emergency response for HSS" (KII)

> "Humanitarian actors are not mandated to do HSS but [should] at least "do no harm"" (KII)

Fragility, insecurity, humanitarian priorities

Open questions

- **"That wretched Nexus stuff"** (KII8)
- Nexus is the framework of reference for embedding HSS in humanitarian response, but it needs better operationalisation.

> "The Nexus is a positive idea, it opens up a conversation, but in practice it is difficult to harmonise and operationalise" (KII)

> "The Nexus is a blind spot. There is a lot of talk about it, but no one knows how to operationalise it, it is not happening at all" (KII)

- **Blind spot:** how to operationalise the Nexus? What does it mean in practice?
  - Start with **financing**: transparency on funding (both humanitarian and development) and on activities carried out
  - How to bring in the knowledge of more **development-oriented implementing agencies** working in FCAS?

Governance

Challenges

- Lack of political peace and weak governance and leadership make HSS more difficult.

- If there is no government leadership/stewardship, how can local ownership be fostered which would make interventions sustainable?
  - Sustainability is a **core element** of HSS, but interventions are often planned and implemented in ways that are not sustainable.
  - Trade-off between “getting work done” directly and working through the government.

Photo elicitation: NGO, Sierra Leone

Approaches to address governance issues

Entry points

- Work with local (health) authorities, *de facto* or ethnic authorities where national governments are absent, contested or not recognised
- Work with non-public actors and with a multisectoral approach
  - Community actors and civil society
  - Faith based organisations/providers
  - Private sector
- In some cases, more *donor flexibility* is required to do so. It is also *politically sensitive*

Photo elicitation: DR Congo

Approaches to address governance issues

Entry points

- Ensure ownership of local actors
- Plan 'transitions' carefully and from the beginning
- Let government/public health authorities lead, or at least *increase their visibility*

"NGOs can be the recipients of funds where the government/ public system has no capacity, but their role should be shrinking not expanding. There should be a focus on complementarity can" (KII)

"Community engagement meetings are organized as a feedback mechanism. This has increased the ***visibility of the government*** in the health sector leadership which is crucial in system strengthening in fragile context." *Photo elicitation: NGO, Somalia*

Aid architecture

Challenges & entry points

- Key bottlenecks for HSS programming are in the funding and implementation of programs:
  - Conflicting mandates, agendas and interests
  - Which correspond to different activities, timelines, funding sources and coordination approaches, as well as different understanding of HSS as well as fiduciary rules and risk taking.
  - Results in fragmented, short-term funding, focus on service-delivery and countable outputs.
  - NGOs focus on visibility and fundraising: reticence to effectively support HSS and government ownership?

- HSS should be *intentional* and intentionally embedded into health programming
- Focus on PHC and service integration to address fragmentation

Aid architecture

Open questions

- Lack of coordination emerges as a major challenge
  - Health cluster approach: working better?
  - Coordination of humanitarian and development actors?
  - Different approaches among partners (World Bank, GHIs, bilateral actors)

> "Humanitarian actors should be more aware of the system effects of their interventions. For example, in South Sudan there was a process to harmonise the incentives for health workers to which all NGOs subscribed. But humanitarian actors did not accept it." (KII)

- If government is too weak to take leadership in coordination, development partners should have a more decisive role
  - But *who* should do it? WHO and UN agencies sometimes seen as weak and with potential conflicts of interest (vis-à-vis MoH and/or GHIs); others? And *how* should it be done?
  - Who and how should set incentives for coordination?
  - Do *you* have examples to share where coordination worked well?

Risk management and support structures for NGOs

Entry points

- Relation between funders and implementers is problematic at times and not conducive to HSS
- Programmatic and fiduciary risk shifted to NGOs without the corresponding support structures and flexibility to 'do' HSS.

- Supportive structures allow for intentional, flexible approaches to HSS programming that entails room for experimentation and adaptation, and foster a culture of learning:
  - PDIA in Nigeria
  - hand-holding in NW Syria
- Longer-term funding
- Different approaches to HSS measurement
- Right balance of risk management
  - Setting aside a % of budget for activities that carry programmatic risk?

"Donors should put more emphasis on integrating HSS into project more systematically. At the moment, it is left to the NGOs to decide how to integrate HSS. Often HSS is facilitated when projects are long, where there is not much staff turnover, where the NGO can build a good relation with the government" (KII).

"Adaptability to context is key. NGOs often operate in the same way, with the same models across contexts and overtime. We talk about localisation and empowering local partners but this is still not happening" (KII)

Next steps

Where do we go from here?

- Insights into important, often overlooked perspectives and experiences of implementing actors (“middle level” of the ecosystem)
- Findings highlight challenges (not unknown), entry points and promising approaches, and gaps in evidence or blind spots in policy and practice that need to be addressed
- Set of recommendations developed based on findings
  - Need to work together with different partners to refine and operationalise them in practice, address the open questions and blind spots

Photo elicitation: NGO, Libya

Knowledge agenda for HSS programming in FCAS

- There is need for more understanding and capacity building around HSS
  - Varying definitions and level of conceptual reflections
  - Also reflecting mandates and funding sources (e.g. humanitarian or GHI funding)

- Engage with and support NGOs across the humanitarian-development spectrum to better understand and work on HSS
  - Move from delivery focus to support areas beyond traditional expertise (such as public finance management, public procurement systems, integrated health management information systems, etc.)
  - Ensure that NGOs' operational experiences and needs are integrated in the knowledge generation agenda

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Many thanks to my co-authors Jieun Lee, Ezinne Peters and Sophie Witter.

Thank you also to the Thematic Working Group on Health Systems in Fragile and Conflict Affected Settings for facilitating this research.

Scan here for access to policy brief and photo booklet

This project is funded with UK aid from the British people

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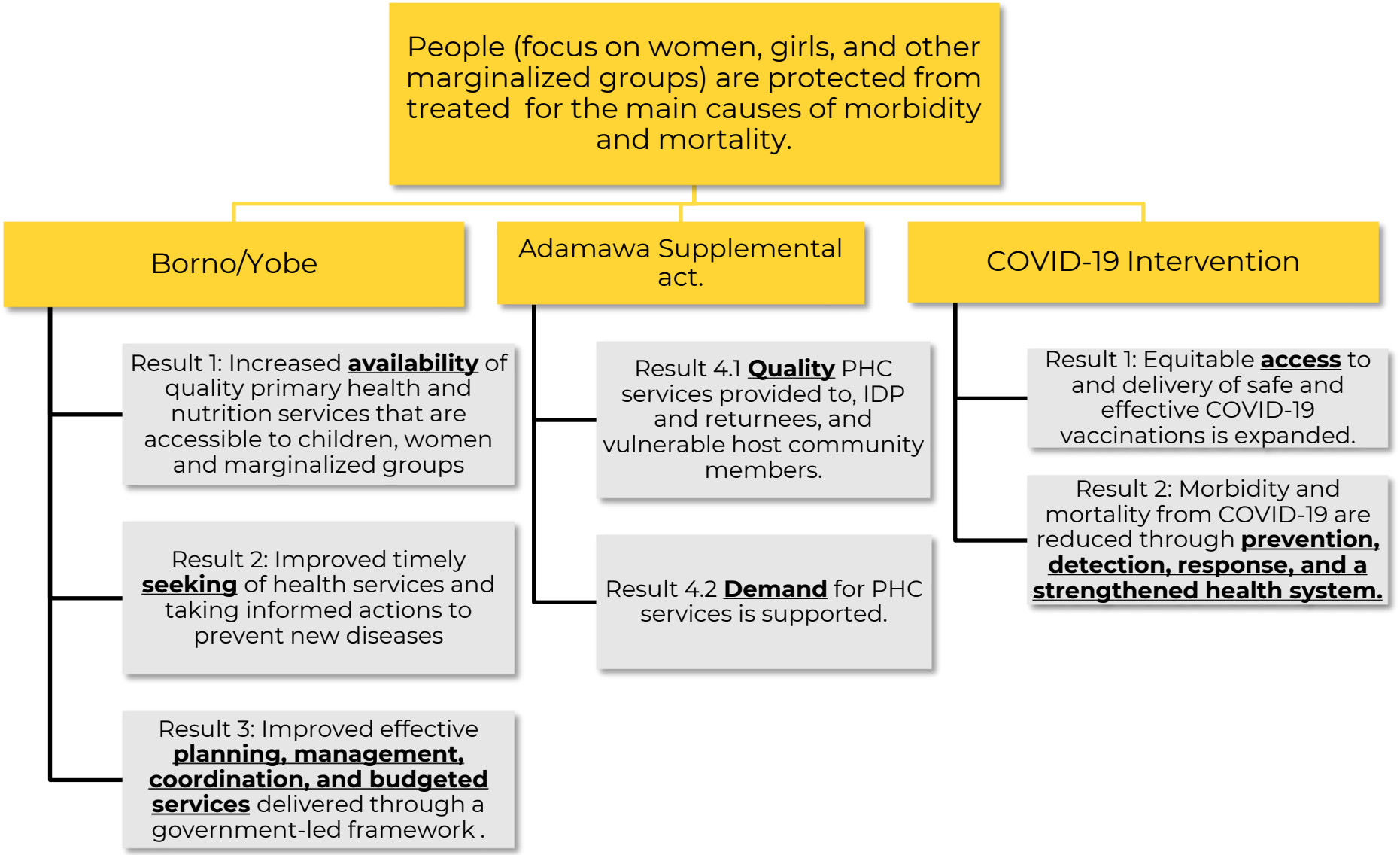
Health Resilience of North East Nigeria (HeRoN)

Key facts

- **Prime Implementing Partner** – International Rescue Committee (IRC)
- **Sub awardees –** Action Against Hunger(AAH) and Society for Family Health (SFH)

- **Locations:** Borno and Yobe
- **Budget:** $12, 075, 195. Funded by USAID and FCDO (+ USD 4.2m. Supplemental activity in Adamawa funded by USAID).
- **Timeframe:** February 2020 – October 2024

Objectives


People (focus on women, girls, and other marginalized groups) are protected from treated for the main causes of morbidity and mortality.
Borno/Yobe
Result 1: Increased availability of quality primary health and nutrition services that are accessible to children, women and marginalized groups
Result 2: Improved timely seeking of health services and taking informed actions to prevent new diseases
Result 3: Improved effective planning, management, coordination, and budgeted services delivered through a government-led framework .
Adamawa Supplemental act.
Result 4.1 Quality PHC services provided to, IDP and returnees, and vulnerable host community members.
Result 4.2 Demand for PHC services is supported.
COVID-19 Intervention
Result 1: Equitable access to and delivery of safe and effective COVID-19 vaccinations is expanded.
Result 2: Morbidity and mortality from COVID-19 are reduced through prevention, detection, response, and a strengthened health system.

Key components and activities

Facility Strengthening:

- Rehabilitating and equipping primary healthcare facilities to ensure the delivery of essential services. Providing drugs, medical supplies, and infrastructure support to bridge critical gaps.

Capacity Building:

- Training health workers to improve service quality and adherence to national health standards.
- Strengthening the organizational capacity of state and local health authorities through technical assistance and mentorship.

Community Engagement:

- Conducting awareness campaigns to educate communities about available health services and the importance of preventive care.
- Establishing feedback mechanisms to ensure that community voices inform service delivery improvements.

Health System Governance:

- Supporting the development and implementation of accountability frameworks and monitoring systems.
- Facilitating the integration of project activities into government-led health programs to ensure sustainability.

Process evaluation

Objectives

1. Assessing the success of transitioning components
2. Identifying lessons learned to inform future partnership-based health system strengthening programs.

Focus

The research examined:

- Operational processes (coordination, resource management, technical assistance, staff capacity, and sustainability planning)
- The transition of sustainability domains to government partners, including CHIPs financial support, MoH staff incentives, Nutrition Stabilization Centers, and essential drug procurement for PHCC.

Focused on partners' perspectives to identify successes and areas for improvement.

Recommendations

Integration of program components (e.g., the ETS), **into existing operational agencies**

Program design	**Alignment**	Aling project activities with Government partner priorities (captured in government policies, plans, programs). **Jointly prioritize program activities** and **co-design** them with government stakeholders.
	Boosting and catalyzing	Help deliver existing government programs and policies. **Inject funding** and **provide capacity building** to relevant stakeholder to stimulate and enable the implementation of programs and policies that existed 'on paper' and for which government partners demonstrated willingness to implement but needed help to kick start.
	Scaffolding	Once the boosted Government programs or policies are operational, **let the Government partners run it, monitoring, supervising and/or providing feedback** as needed.
	Visibility and attribution	Consider the **importance of optics** of government partners leading implementation **for government legitimacy.** Support from behind and let the **Government partners visibly lead** the effort, advising for success along the way.
	Adaptiveness	Activities and approaches should be **analysis based**, including **user research / design research methods** when considering the introduction of innovative components. Analysis, including stakeholder analysis, should be **regular** to support responsiveness to changes in the context and to enable **iterative project design.**

Recommendations (2)

Funding for sustainability is an area that requires improvement: HeRON was still delivered largely as a humanitarian project in that it was originally designed without partner inputs, with IPs initially delivering the components then trying to transition these to Government partners.

Identification and boosting of mechanisms that have higher sustainability potential, such as the **market-based DRF**, also increases the potential for sustainable outcomes

Partnership approach	**Politically smart(er)**	Identify who the **ultimate powerbroker** is and **secure their buy-in and support** for program implementation. **Leverage existing hierarchical relationships, local institutions and ways of working** to facilitate program implementation.
	Responsiveness	The program should be responsive to and **address Government partner needs.** While operating at the system level, a SS program should also **remain outcome focused and client-centered.**
Transition funding	**Comprehensive and diversified sources**	**Map all available funding sources,** including underutilized Government funding streams, and support partners to tap into these.
	Conditionality and matching	**Require greater financial commitment and ownership** from Government partners from the get-go. Note that State level Government partners are used to meeting conditions and funding matching requirements when working with the Federal government and/or private sector funders.
	Prioritize self-sustaining approaches	Include **market-based approaches that don't exclusively rely on government funding** into system strengthening programs. **Facilitate public-private partnerships** and equip government partners with the skills necessary to **manage private sector partners.** Jointly **devise regulations** to ensure market-based approaches are responsive to the needs of the most vulnerable.

What INGOs need in order to be able to go beyond Health Systems Support

- **Impact measurement**: focus less on lives saved/morbidity/mortality and more on systems strengthening indicators. Reframing: See HSS as an end in itself first, so that it can then become a means to an end.

- **Accept complex processes** to get to an end. Consider dropping logframes and using the "Searchframe" (check it out by googling "Searchframe PDIA")

- Find ways to bring humanitarian partners and development partners together and hold them accountable for it.

The SearchFrame: A PDIA Tool for Iterative Adaptation

See: Andrews, Matt, Pritchett, Lant, and Woolcock, Michael. 2016. Doing Iterative and Adaptive Work. CID Working Paper 313. Cambridge, M.A.: Harvard Kennedy School. http://bsc.cid.harvard.edu/files/bsc/files/adaptive_work_cid_wp_313.pdf?m=1455911748

Where to start and how to progress? (3 key steps in creating the SearchFrame (1,2,3) and 3 reverse steps to use the SearchFrame in a dynamic and adaptive way (4,5,6))

1. Initial problem analysis (See Andrews, Matt, Pritchett, Lant, and Woolcock, Michael. 2015. Doing Problem Driven Work. CID Working Paper 307. Cambridge, M.A.: Harvard Kennedy School.

1a. Construction (Ask "What is the problem?" and "Why does it matter?" and "Who does it matters to?" and "Who does it needs to matter to more?" and "What will it look like solved?' This yields the overacharching aspirational goal = a measure of "problem solved")

1b. Deconstruction and sequencing (Ask 'why is the problem festering? Or what is causing the problem? And build a fishbone diagram (or related mechanism) to show all the causes, and sub-causes you can. Then ask 'what acceptance, authority and ability do we have to act in certain areas"? This yields an informed idea of the change space in each area, of what needs to be done to build this space, and of opportunities for action. This yields 'pit stops' or 'focal points' en route to "problem solved" (which will reflect step by step progress in addressing the problem's causes and sub-causes)

2. Identify ideas and act (This involves crawling the design space for ideas and action steps to start with; asking what opportunities exist to act in current practice, latent practice, external best practice, and internal positive deviance. These are the first iteration 'experiments')

Notional goal: 'what is problem solved'?

Ultimate check-in

(Proposed) Focal Point 3

Iteration 3.iii

Iteration check-in 3.iii

Iteration 3.ii

Iteration check-in 3.ii

(Proposed) Focal Point 2

Iteration 3.i

Iteration check-in 3.i

Iteration 2.iii

Iteration check-in 2.iii

Iteration 2.ii

Iteration check-in 2.ii

(Proposed) Focal point 1

Iteration 2.i

Iteration check-in 2.i

Iteration 1.iii

Iteration check-in 1.iii

Iteration 1.ii

Iteration check-in 1.ii

Iteration 1.i

Iteration check-in 1.i

3. Identify your assumptions at all major focal point stages, and ensure you write them down in as much detail as possible in the first section of the Searchframe Reflection section (using question form is probably best, so you are actively questioning your assumptions from the start: list assumptions about the authority you expect to enjoy, who will be engaged, what capacity they will have, what kinds of progress you see happning, and much more. List more rather than less).

SearchFrame Reflections to Focal Point 1				SearchFrame Reflections to Focal Point 2				SearchFrame Reflections to Focal Point 3				
Assumptions we have made	Assumptions we have made	Assumptions we have made	Assumptions we have made	Assumptions we have made	Assumptions we have made	Assumptions we have made	Assumptions we have made	Assumptions we have made	Assumptions we have made	Assumptions we have made	Assumptions we have made	Assumptions we have made
Lessons we have learned	Lessons we have learned	Lessons we have learned	Lessons we have learned	Lessons we have learned	Lessons we have learned	Lessons we have learned	Lessons we have learned	Lessons we have learned	Lessons we have learned	Lessons we have learned	Lessons we have learned	Lessons we have learned
Adjustments we have made	Adjustments we have made	Adjustments we have made	Adjustments we have made	Adjustments we have made	Adjustments we have made	Adjustments we have made	Adjustments we have made	Adjustments we have made	Adjustments we have made	Adjustments we have made	Adjustments we have made	Adjustments we have made

4. Reflect by learning as you go (every step leads to experiential learning, yields lessons that need to be reflected upon; after every part-iteration (like 1.i) and full iteration (like 1) the teams should ask what they have learned about assumptions, and record these)

5. Make adjustments (adapt) as you learn, in the SearchFrame and in practice (with each lesson, the team should adjust thinking about the problem, aspirational goals, focal points, ideas and action steps, and assumptions in future periods)

6. Adapt and act again, in the next iteration (or part-iteration) (based on lesssons and adjustments, teams should determine the next step and then take this as the next iteration (part-iteration or full iteration)

Time 0	First major time check	Second major time check	Third major time check	Aspirational time end

Q&A and discussion

- How can INGOs working at the intersection between humanitarian and recovery phases in FCAS move from **health system support to health systems strengthening**? What is needed?
  - internal processes and organizational structures of INGOs
  - right incentives and supportive environment from funders
  - knowledge gaps within INGOs and beyond

- What is the relevance of **health systems strengthening** in FCAS within the new (much reduced) aid landscape?

Thank you for attending

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