International Roundtable on Health Systems Strengthening in Fragile Settings

ITM, 12 Feb 2015

An initiative of the Institute of Tropical Medicine co-organized by the Ministry of Development Cooperation and Because Health, the Belgian Platform for International Health

Final Report

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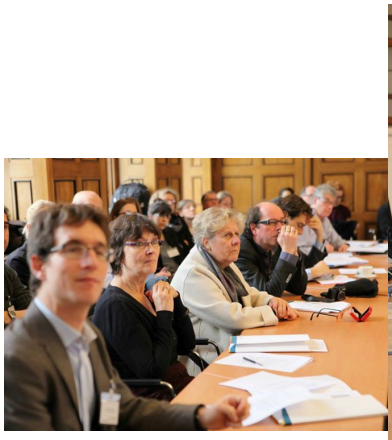

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Introduction

This report provided an overview of the International Roundtable on Health Systems Strengthening in Fragile Settings, which was organised on 12 February, 2015, the day's proceedings, its conclusions and recommendations for the organizers and funders, i.e. the Institute of Tropical Medicine, Because Health and the Belgian Ministry of Development Cooperation. The list of registered participants is can be found in the annex, while the presentations can be found on the Because Health website under "events".

Background and objectives of the Roundtable

Background

The Belgian Ministry of Development Cooperation published its strategy note on situations of fragility in June 2014, accompanied by a toolbox to assist in analysis of fragile situations. The focus on fragile settings was re-affirmed by Minister of Development Cooperation Alexander De Croo in the policy declaration of November 25, 2014.

During recent years, a number of international organisations, multilateral agencies and funds, and bilateral aid actors issued sets of guiding principles and recommendations for interventions in fragile states. OECD-DAC set the norm in 2007 with the Principles for Good Engagement in Fragile Situations and the New Deal in 2011. In 2012, GAVI issued an organisational policy introducing a country-tailored approach that called for more flexibility for the delivery of programmes during emergencies. In June 2014, the Board of the Global Fund introduced the concept of "challenging operational environments", expected to be mainstreamed in the Secretariat's operations. Bilateral actors such as Danida and DFID, and regional players such as the EU and the African Development Bank, increasingly focus on "situations of fragility" or on "fragility as a condition, and not a category of countries" and strive for coherence between development, humanitarian and defence approaches. In the Netherlands, the Inspection Service for Development Cooperation evaluated the impact of Dutch interventions in fragile states in 2013.

Despite the current attention of donors to fragile settings, a number of questions remain, among which the most important one may be *how actors can* ***translate these guiding principles*** *and policy recommendations* in ***health system strengthening interventions*** and how the variety of actors currently involved in interventions in fragile settings can ***work together to further operationalize these recommendations and effectively learn from experience***. This question has become all the more urgent in the face of the current Ebola outbreak, and the breakdown in health systems it has brought to the surface in the West-African countries affected by the epidemic.

In order to assess how actors could collaborate to operationalize international guiding principles on interventions in fragile states in health system strengthening interventions, and initiate mutual learning, the Ministry of Development Cooperation, the Institute of Tropical Medicine and Be-cause Health Platform, organise a Roundtable for **policy-makers, Belgian and international NGOs & humanitarian actors, multilateral and bilateral actors, and researchers** from a variety of disciplines working on health in fragile settings.

Objectives

The objectives of this **Roundtable** were:

1. to **exchange** on past experiences of HSS interventions in fragile settings.
2. to initiate **mutual learning** between a range of development, humanitarian, bilateral, multilateral actors involved in health care delivery in challenging operational environments.
3. to assess how actors can **collaborate to operationalize** guiding principles on engagement in fragile settings in strengthening the health system and to improve health care delivery.

The participants

The event was widely publicized, including announcements on the website of the Ministry of Foreign Affairs (diplomatie.be), the Institute of Tropical Medicine and the website from Because Health. International actors and NGOs outside of the health sectors were contacted personally.

The Roundtable was primarily intended for the Belgian actors working in fragile settings, within the health sector and beyond. Key international actors were also invited. The list of registered participants can be found in Annex.

- The Roundtable reached a wide audience. Approximately 70 participants attended the Roundtable, more than we expected.
- There was a wide interest and representation from the Belgian Ministry of Development Cooperation, including attachés both from the health and from the governance sections. Yves Dricot, the Director Thematic Expertise from the Ministry opened the Round Table together with Bruno Gryseels, Director of ITM. Staff of the Flemish Cooperation also attended the meeting.
- Key international actors - policy makers, INGOs and academia - were present, such as the European Commission, academics and NGOs from the Netherlands (KIT, Cordaid, Heathnet TPO) and the UK (Queen Mary University, Liverpool School of Tropical Medicine). International networks were also represented. Health researchers from the Belgian universities participated as well.
- Despite ample publicity beyond actors in the health sector, it proved more difficult to attract staff of NGOs and researchers working on governance,

rule of law, human rights or peace-building, or from other sectors, although some governance researchers from Belgian universities were present.

- Humanitarian actors were also invited, but only players in humanitarian health responded (MSF).

Summary of the day's presentations and discussions

Summary of the presentations

Sara Van Belle's (ITM) presentation set the scene, considering the current drive for aid reform, taking the UK as an example and the flurry of "fragile states" policies of both bilateral donors and GHI's. She also stated that the "state-building" perspective is showing cracks, leaving donors puzzled on how to improve governance through technical assistance. Evaluations show evidence of "isomorphic mimicry", donor-induced changes prove only to be skin-deep. Moreover, the fluidity between the state, the market and civil society has oftentimes been ignored in state building programmes. A change in discourse is warranted, a "deterritorialization" of the concept of fragility, looking at governance arrangements "from within and below". The presentation further discussed some determinants of fragility and ways to operationalize health systems strengthening in fragile settings, e.g. through problem-driven iterative analysis and local problem-solving.

Karel Gyselinck (BTC) urged to move beyond the binary logic of traditional development discourse (there is a "continuum in fragility") and to embark on a continuous learning cycle as a way to organizational change, and ultimately sustained institutional change in fragile settings. The learning cycle could be used as an analytical framework and should ideally bolster democratic decision-making processes. Fragility was defined as the "restricted capacity of governments to learn from actual field situations, and transform this learning into policies' and the "restricted capacity of the operational level to adapt policies to practice and to provide evidence or feedback". Donor support might lead to increased fragility. One of the major inroads to build robust (health) systems is to strengthen the articulation / relationships between actors, levels and sectors, contributing to building trust.

Enrico Pavignani (Independent consultant) presented his (& colleagues') study on six "under-governed" and violent health care arenas: Afghanistan, the Central African Republic; RDC, Haiti, Palestine. He made the case for an innovative "arena" framework as a way to appreciate the "constellations" of spontaneously emerged (governance arrangements) and health systems. This arena framework brings actors and their relationships at multiple levels to the forefront, moving the fragility concept away from a focus on demarcated territories to a focus on people. The Ebola epidemic seems to confirm some of the findings of the study and its analytical approach, i.e. the importance of the trans border dimension and the inadequacy of the "state" as entry point of analysis, the urban slum as

undergoverned "incubator" of future shocks, the rigidity of the aid industry, and the importance of the social sciences to bring light to the issue. Pavignani pleaded for a best fit approach in function of context, instead of a best practice approach, with the recognition that the future (in these settings) is unpredictable. Dominant results-based management in the aid sector should make way for intelligence-based opportunism. Resilient health systems are not to be built from models, but through a hands-on approach grounded in experimentation and learning.

Dr Didier Chuy Kalombola presented (on behalf of Gisele Mizele, Maria Mashako and Ernest Lualuali and Sara Van Belle) "Configurations complexes de fragilté. Analyse Comparative des systèmes de santé locaux en RDC: Maniema, Equateur, Katanga-Nord et Kinshasa", a comparative analysis of determinants of fragility at the level of the local health system in four provinces, providing a more complex view of what fragility means in relation to context, governance arrangements, the health system and the communities. As such, the fragility concept is broken down into multiple dynamic processes ("fragilities") with certain key determinants, i.e. structural violence at the level of communities (a survival culture affects the social fabric) and a governance deficit in terms of an absence of trust between governing actors, absence of formal regulation and the absence of a culture of public orientation. Therefore, a mosaic of strategies need to be explored to strengthen health systems in these settings, identifying entry points of change at multiple governance levels at the same time, grounded in learning by trial and error.

Peter Salama, UNICEF Global Ebola Emergency Coordinator, joined the Roundtable in the afternoon, live from UNICEF Head Quarters in New York. Salama first made the case for the "fragile settings" agenda as unfinished MDG business by means of an analysis of health outcomes in Ethiopia and Zimbabwe. He emphasized the need for case studies, uncovering to key mechanisms to results achieved in these contexts. He stressed the importance of joined-up approach and a long term commitment from donors, and the need for decentralized monitoring and local accountability.

The second part of his presentation was devoted to the Health Transition Fund, which has been applied by UNICEF in post-conflict contexts in SSA as an innovative financing modality. The Transition Programming model has the following tenets: 1) ministerial leader- and ownership 2) donor and partner membership of a management mechanism 3) alignment to government programmes, policies and systems 4) civil society and private sector partnerships, 5) competitive tendering and 6) a focus on monitoring and evaluation. The third part of the presentation considered the Ebola epidemic and UNICEF's community action approach through pro-active community engagement, the immediate creation of community care centres and rapid response teams, including care for child survivors and orphans, and on the longer term, revitalizing health and education systems.

Summary of the discussion

The Roundtable concluded with some **key reflections**. It is clear that no single actor intervening in a fragile setting has "the" answer, there is no standardized response or recipe that can be applied to a "fragile" setting. Many aid actors are puzzled by the uncertainty and unpredictability (and "complexity") of fragile contexts, which cannot easily be fitted in aid planning and implementation processes (e.g. results based management), and for which aid expertise does not provide the answer.

The way out would be to accept that in these situations we are "muddling through", admit that we do not always know, and be more open to learn, test and explore, even when this means failure. Instead of relying solely on plans, tools and guidelines, we need to work jointly on "scenario-building" Each aid actor contributes from his own perspective, test out different scenarios, and avoid "analysis paralysis". We need to build innovative knowledge management strategies to make better use of "local contextual intelligence", including the political economy / the politics of aid in that particular context – the decision making processes, the actual governance arrangements, hidden agendas and accountability practices of aid actors into account. Donors need researchers and NGOs, as these provide linkages to what is happening on the ground.

Embracing uncertainty means that aid instruments need to be adapted according to the context, within the remit of the possible. Donor risk aversion might be tempered by innovative financing modalities, such as pooled funding.

The terminology "fragile states / fragile settings / contexts" is used differently according to different aid paradigms (human security, state building, etc.) and according to actors' interests (cfr. self-labelling by some LDCs). Any categorization /heuristic is interesting analytically, but cannot be used as a blueprint. It is also not easy to distinguish when a certain setting enters a post conflict phase. What is important to retain that fragile contexts are highly dynamic situations. Fragile settings do not necessarily have fragile health systems, and it is a major challenge to uncover the causal effects of fragility of communities or political instability on health outcomes. Innovative research and evaluation designs might be useful, such as realist evaluation, contribution analysis, comparative methods, etc.

The next points summarise some of the conclusions:

- Look critically at our own practices: What are the main obstacles to change our practices?
- Go with the grain: How do we best use opportunities in situations of crisis or fragility?

- Start locally: there are good experiences – how do we best benefit from local anchorage
- Do we really want to coordinate? How can we create a consensus when there are clear divergent interests?
  - A way forward is joint context analysis
- Need for more documentation both of success stories (positive outliers) and failures
  - Appreciative inquiry: looking more into what constitutes success
- Need for flexibility, redundancy and overlap
  - Try out different channels, complement each other

Impact of the Roundtable

The workshop's timing coincided with the World Bank's Fragility Forum, demonstrating its timeliness.

The Because Health Forum held a meeting with Minister De Croo on Thursday 11 June 2015, where the recommendations of the Roundtable in relation to the health system were presented.

The event and the presentations were posted on the Health Systems Global Thematic Working Group. Comments in its aftermath were posted on the site and the website from the Rebuild Consortium, Liverpool School of Tropical Medicine.

The workshop is one in a series, including a webinar organized by the Thematic Working Group on Health Systems in Fragile Settings to Help Define a Research Agenda (May 28, 2015).

Recommendations at policy level

- Standardized responses in fragile settings are counter-productive: there is no magic bullet; contextualized responses are required
- Ways to flexibilize aid modalities / operational engagement in fragile settings need to be further explored
- Policy makers / aid actors need to work together and exchange as there is a dearth of evidence / information
- Policy makers should continue the dialogue with the research and civil society organizations and networks on the implications of the Belgian policy note on interventions for bilateral health programmes in Belgian partner countries such as Burundi, Mali, RDC, Guinée-Conakry, Niger, Burkina Faso

Recommendations for research

The research agenda is still in full development and there is an urgent need for research to back up current donors' policy choices.

Semantics

- Fragility of what? Need to look beyond health systems to the determinants of fragility
- Importance of an actor-oriented perspective and retain the focus on fragility of communities and people
- The discussion on fragile contexts/ states / settings easily gets mired into discussion on semantics. A clear overview of use of the different terms by different categories of actors could be useful.
- The deterritorialization of "fragility": a human security paradigm increasingly takes centre stage, focusing on the "fragility and resilience" of communities. How can aid actors flexibilize their approach to effectively address the specific needs of "pockets" of fragility and insecurity?
- How to manage "regional pockets of insecurity / instability": regional zones of insecurity – parallels in effects of insecurity on health systems, e.g. East Kivu, border RDC-Uganda

Global policy and global health actors' practices

- Human Security and SDGs: what are the implications of and links between the post 2015 / SDG agenda and fragile settings?
  - Global Health Actors' policy development on fragile and conflict-affected settings – how to operationalize general principles regarding flexibility?
  - Policy space for bilateral actors to modulate aid modalities in fragile settings vis à vis risk aversion linked to accountability
  - How to strengthen civil society response versus risk of regime cooptation (cfr. GFATM CCM model)
  - How to organize accountability towards marginalized groups-crucial part of people centred health systems

Regional, national and local responses (fragilized regions, states and communities)

- What are the implications for countries of labeling themselves as fragile states?
- What are the implications for least developed countries distancing themselves from the labels of "failed" and "fragile" states?
- How does this self-labeling have an impact on global health actors' practices in these countries, cfr. GAVI's and GFATM's specific policies for conflict-affected settings?

- Global health actors' engagement / role in national policy formulation ("cooptation"?) and implementation and the impact on accountability towards citizenry / local communities in fragile / conflict-affected states
- The implications of framing fragility regionally for Global Health Actors' response
- Effects of "fragilized" communities (weak social fabric) on the organization of health services
- What are the effects of political insecurity / instability on (historically) robust local health systems?
- "The Empty Void is a Crowded Space" - what are national / local governance arrangements (and which actors play what role) which fill the governance vacuum?

Research

- Challenges for conducting a research agenda on fragile settings (as presented by Egbert Sondorp during the Health Systems Global webinar): the agenda is frequently set by outsiders and is not responsive to local needs; the dearth of researchers in these countries; no country ownership of the research; lack of HMIS data and evidence
- Innovative methods for data collection and analysis: context analysis, comparative analysis, contribution analysis, causal loop diagrams, complexity, complex governance models & social network analysis, exploring causal mechanisms in contexts marked by fragility ("programme theory")
- Setting up regional knowledge networks and communities of practice

Annex: list of registered participants

Arrey	Agnes	VUB
Bertone	Maria Paula	AEDES
Biron	Mailys	Etudiante ESP-ULB
Boeynaems	Jan	Institute of Tropical Medicine
Bosmans	Marleen	Belgian Development Agency (BTC)
Brouwers	Nathalie	Institute of Tropical Medicine
Clément	Anita	Chain of Hope Belgium
de Lamalle	Jean-Pierre	AEDES
De Paepe	Frank	Memisa
De Potter	Annelies	Institute of Tropical Medicine
De Preter	Jan	Directorate-general Development Cooperation and Humanitarian Aid
De Vos	Pol	Institute of Tropical Medicine
Deconinck	Hedwig	Université Catholique de Louvain
Decoster	Kristof	Institute of Tropical Medicine
Degomme	Olivier	Ghent University
Delvaux	Thérèse	Institute of Tropical Medicine
Depoortere	Evelyn	Institute of Tropical Medicine
Dricot	Yves	Directorate-general Development Cooperation and Humanitarian Aid
Dubbeldam	René	HERA
Dujardin	Catherine	FPS Foreign Affairs / DG Development Cooperation
Einhorn	Maurice	News4Med - Mevipro
Fustukian	Suzanne	Institute for International Health and Development, Queen Margaret University
Galle	Anna	ICRH
Geens	Hilde	Artsen zonder Vakantie
Gerard	Seco P.	MSF OCB
Gijsel	Stien	International Rescue Committee
Gryseels	Bruno	Institute of Tropical Medicine
Gyselinck	Karel	Belgian Development Agency (BTC)
Hermans	Ivan	UNFPA
Ingelbeen	Brecht	Institute of Tropical Medicine
Ivanova	Olena	ICRH Belgium
Joppen	Hans	Directorate-general Development Cooperation and Humanitarian Aid
Joris	Lut	Institute of Tropical Medicine
KNAUTH	Dr. Christopher	European Commission - International Cooperation and Development
Krumeich	Anja	Maastricht University
Laga	Marie	Institute of Tropical Medicine
Laleman	Geert	Directorate-general Development Cooperation and Humanitarian Aid
Leclercq	Sidney	ACROPOLIS Aid Effectiveness in Fragile situations
Leus	Xavier	Independent
Madeo	Marina	HERA
Marchal	Bruno	Institute of Tropical Medicine
Martineau	Tim	Liverpool School of Tropical Medicine/ReBUILD consortium
Martini	Jessica	ESP-ULB
Matagne	Geoffroy	ACROPOLIS/ULg

Mayaka	Serge	Économiste de la santé - PHD Student IRSS/UCLouvain
Ogbe	Emilomo	Ghent University
Ooms	Gorik	Institute of Tropical Medicine
Pavignani	Enrico	Public Health Consultant
PHASI	Ndudi	Benelux AFro Center
Philips	Mit	MSF
Pirard	Marjan	Institute of Tropical Medicine
Ramahatafandry	Voahangy	Be-cause Health
Ronse	Ignace	Directorate-general Development Cooperation and Humanitarian Aid
Scholtalbers	Roeland	Institute of Tropical Medicine
Smets	Lola	Médecins du Monde (BE)
Snijders	Rian	Institute of Tropical Medicine
Sondorp	Egbert	KIT Amsterdam
Spanoghe	Sander	Departement internationaal Vlaanderen
Van Belle	Sara	Institute of Tropical Medicine
Van Belle	Elies	Memisa
Van de Pas	Remco	Institute of Tropical Medicine
van de Weerd	Jennie	Cordaid
van den Oever	Barbara	HealthNet TPO
van der Veen	Remco	Cordaid
Vanbastelaere	Stefaan	Belgian Development Agency (BTC)
Vandendriesche	Lise	Chain of Hope Belgium
Vanlerberghe	Veerle	Institute of Tropical Medicine