NOVEMBER 2017

SYNTHESIS OF RESPONSES TO DFID QUESTIONS ON RESILIENCE

Resilience is increasingly used in health policy and systems discussions by both researchers and policymakers, yet there is no clear or common understanding about what resilience is, or about its potential for improving health systems and health outcomes. In July 2017, three research consortia - Future Health Systems, ReBUILD and RESYST, held a workshop to discuss and share their experience and insights around health system resilience. After the workshop, DFID colleagues identified a series of questions about resilience for which they sought answers. This note provides responses to those questions, drawing on the workshop discussions. It has been prepared jointly by the three research consortia.

1. What is the difference between a resilient and a strong health system?

A strong health system might be one that, for example, is well resourced, well governed, equitably distributed, able to deliver effective, high quality services and benefiting from a high level of population confidence.

We see resilience as part of a strong health system – that specifically directs attention to the system's capacity to be resilient in the face of stress and shock, whether chronic, acute or both. To different degrees, such disruption is always present and resilience emphasizes the specific attributes of a health system that allow it to adapt to, accommodate and learn from disruption. Resilience is nurtured by managing resources effectively across the whole system and breaking down silos within it, relationships among people and groups across the system, community engagement and co-production with communities, distributed leadership, and knowledge and information use to anticipate and prepare for disruption.

Preparing for future shocks may require changes in the 'hardware' of the system (such as a new skills mix to respond to the increasing burden of Non-Communicable Diseases). However, the core attributes of resilience speak to what can be seen as the 'software' of the system – requiring consideration of history, power, politics, including gender power relations. Importantly also, we see resilience as about more than 'bouncing back' (which in a weak system might mean recovery to a position of weakness). It is, instead, a health system characteristic that supports adaptive and transformative responses to shock and crisis that generate new ways of functioning and improved outcomes.

Scale is relevant in thinking about resilience as stress/shocks often work across global, national or local levels, affecting those at different levels – although commonly impacting on the marginalized to the greatest extent. Interactions between different levels and sectors must, then, be taken into account, e.g. does resilience in some areas/levels allow weakness elsewhere to be perpetuated? Responses to stress and shock must, however, always be rooted in local realities – resilience is nurtured from the bottom up. An intersectional lens importantly supports understanding of the differential impact of stress or shocks and how people respond to them.

2. How does resilience that benefits an individual differ from resilience that benefits an institution or whole system?

Individual resilience tends to focus on individual capabilities and outcomes, and is nurtured through intervention and support systems focused on individuals. Whilst these may have some system-wide impacts, strategies for building organisational or system resilience go beyond individuals to consider the teams in which they work, the networks of which they are a part and the broader organisational software that sustains and enables relationships and organisational response to stress and shock. Organisational and system resilience is likely to support individuals but the value of this resilience goes beyond individuals to the wider society. It is, nonetheless, important to consider how the resilience of different entities and at different levels interact with each other and whether there are trade-offs or complementarities.

3. How do you measure the impact of health system and resilience strengthening initiatives?

Measuring resilience in quantitative terms is not straightforward given the nature of the phenomenon. Similarly, attributing impact to particular resilience strengthening initiatives is always likely to be difficult given the likely complex nature of the initiatives and of the system itself. Measurement is perhaps most feasible and appropriate within mixed method studies, in which complementary qualitative work is undertaken to assist in making meaning of and explaining quantitative assessments of resilience. Taking account of the interactions between initiatives and context in attributing impact points, meanwhile, points to the potential value of realist evaluation methods.

However, given the difficulties of measurement and attribution, other topics and forms of research in relation to resilience should also be encouraged. Relevant topics might include: studying institutional responses to chronic stress or to chronic stress events that become crises; and assessing the capacity of organisations to become learning systems.

In terms of the relevant forms of research, at the July 2017 workshop we agreed that all resilience research should be interdisciplinary, engaged, longitudinal and comparative. Participatory or action learning processes of implementation and evaluation, working with community groups and/or staff and managers and based on trustworthy partnerships, are, therefore, important. Indeed, the act of engaging users and providers may itself nurture resilience and build ownership of initiatives.

Finally, bringing an intersectionality lens will be important in lifting out the voices of marginalized groups and critically evaluating those in power – and also:

- Supporting a deeper analysis of and understanding of inequality and its drivers, examining power relations across levels.
- Understanding the differential impact of stress/shocks within the health system, and individuals' coping mechanisms.
- Encouraging action across multiple levels to ensure people's rights, including the right to health, are met in resilience strengthening initiatives.

4. What is the role of the development donor in resilience, and what is it about resilience that would enable donor partners to be more effective?

Donors play a role because they bring resources to, and exercise power in, health systems. This includes supporting knowledge production.

However, a focus on resilience indicates the need for donors to work differently and to avoid falling back on quick-fix, short-term, imposed and one-size-fits all approaches to health system development.

First, donors must work with the principle of 'doing no harm' in responding to crisis – recognizing that rapid entry/departure during crisis creates its own shocks, and that coordination with other development partners is always important. Also important are new donor practices of programme development, support and appraisal that recognize diverse sets of risks, and ensure resilience is considered in SWAp-type reviews. Investing in

knowledge production that can support these new ways of working is also important.

Second, recognising the deeply embedded and contextual challenges of health systems is vital – and requires that donors adopt a supportive and enabling role in relation to national and local stakeholders. Indeed, donors should not usurp national or local leadership and should, rather, work with national governments, where possible, or local actors, to create an enabling environment for front-line staff, managers and communities – to recover from stress/shock themselves and lead responses to it (e.g. as shown by COMDIS' work in Nepal's districts worst affected by the 2016 earthquake).

Third, and related, donors should invest in strengthening health system software – such as enabling connecting roles in health systems (e.g. supporting people responsible for linking parts of the system, or meetings and fora which bring different groups together, or multi-sectoral responses), and developing processes and strategies to understand the needs of, and work with, different groups (communities, private providers within local settings, frontline staff etc). Policy coherence is also always important.

Fourth, donors must pay attention to their own organisational practices and ways of working in order to be more effective in nurturing resilience. This includes stronger coordination between those working in humanitarian and development departments, also allowing longer-time frames for responses.

5. How does resilience differ when seen through a development versus humanitarian assistance lens?

Building on the last point of response to Q4, we judge that more effort should be put into bridging the existing gap between humanitarian assistance and development aid.

Although the types of stressors being considered in times of crisis vs. the everyday may vary, the nature of resilience itself does not change – and so, the issue is more how humanitarian assistance can support the emergence of resilience over the longer term and in the immediate response to crisis.

From this perspective, the potential problems of current humanitarian assistance include that it may:

- Overlook the potential for indigenous organisations to direct and use resources more effectively than donors in relief situations.
- Stay focused on a particular shock or crisis rather than taking a broader systems lens in responding to that crisis.
- Implement services that end quickly (e.g. support for survivors of violence) although the underlying needs have much longer trajectories (e.g. ongoing psychosocial and livelihood support to address gendered needs).
- Overlook key issues in the history and future of the settings in which interventions are being implemented, as well as in longer-term development needs that, from a resilience perspective, include social cohesion, trust between actors and with communities, autonomy and decision-space.

One opportunity in times of crisis (and over the long-term) is to support and strengthen embedded researchers and trustworthy partnerships to ensure research is responsive and in itself supports resilience (e.g. Ebola in Sierra Leone and earthquakes in Nepal; everyday resilience research in Kenya and South Africa).

6. Where can DFID add value to the development of mid-level cadres?

Given the importance of frontline staff and distributed leadership to resilience, it is very important to invest in developing leadership among mid-level cadres (nurses, clinical officer etc) and mid-level managers (at district, sub-district and facility level) working in government and in NGOs. Indeed, in times of crisis these cadres are more likely to be retained locally than those working at higher levels or with more portable skills – and so investing in them is a good investment in the local health system. The leadership of these actors is also critical in responding to stress and crisis and so, in nurturing system resilience. Such investment needs to consider both formal training needs and support for complementary workplace based leadership development (such as group coaching, or team development).

DFID can add value, first, by more deliberately thinking through a strategy for investment in this area - giving it profile and emphasising its importance even for national level actors. However, leadership development for mid-level workers and mid-level managers has to be undertaken by those based in specific settings, who can work over the long-term and with the setting's realities. Such an approach is in line with our proposals for how donors must work differently in the future to nurture resilience (Q4).

Second, DFID could take a lead in encouraging innovative approaches to leadership development. For example:

- Recognising the under-representation of women in health leadership positions and ensuring future leadership development does not further disadvantage women.
- Including reflective and values based training in leadership development.
- Including a focus on leadership for health equity, starting with understanding current causes of inequity.
- Encouraging the co-design of leadership development interventions with the potential beneficiaries, and action learning strategies.
- Working with the incentives likely to attract and retain people in local settings during times of stress and crisis.
- Supporting a sharing of experience and innovation around leadership within and across countries.

Third, DFID has an important role to play in supporting related research, promoting innovative methodologies for this research and sharing the knowledge generated.

Further information

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RESOURCES ON RESILIENCE

Future Health Systems

www.futurehealthsystems.org

- George A, Scott K. (2016) Unlocking community capability: key to more responsive, resilient and equitable health systems. FHS Key message brief
- Bloom G, MacGregor H. (2016) Resilient health systems and social resilience. IDS Blog
- Paina L. (2016) How learning-by-doing can help cut through complexity in health service delivery. FHS Key message brief
- Sen B, Dhimal M, et al. (2017) Climate change: health effects and response in South Asia. *BMJ* 2017; 359

ReBUILD

http://rebuildconsortium.com

- Ager A, Lembani M, Mohammed A, et al (2015) Health service resilience in Yobe state, Nigeria in the context of the Boko Haram insurgency: a systems dynamics analysis using group model building. *Conflict and Health* 2015 9:30
- ReBUILD (2017) Resilience of health systems during and after crises – what does it mean and how can it be enhanced? Briefing paper
- ReBUILD (2017) Understanding health systems resilience in contexts of adversity. ReBuild video
- ReBUILD (2017) Health systems resilience: a complex adaptive systems analysis. Country reports & methodology paper.

RESYST

http://resyst.lshtm.ac.uk

- RESYST (2016) What is everyday health system resilience and how might it be nurtured? RESYST key findings sheet
- Gilson L, Barasa E, Nxumalo N, et al. (2017) Everyday resilience in district health systems: emerging insights from the front lines in Kenya and South Africa. *BMJ Glob Health* 2017;2
- Barasa E, Cloete K, Gilson L. (2017) From bouncing back, to nurturing emergence: reframing the concept of resilience in health systems strengthening. *Health Policy and Planning*, Volume 32, Issue suppl_3
- Ditlopo P, Blaauw D. (2017) What makes a resilient health workforce? RESYST video