Background paper

Leaving no one behind; how can evidence-based approaches support progress towards UHC and global health goals during conflict and protracted crises?

Prepared for Fifth Global Symposium on Health Systems Research, Liverpool 2018

Photo: Frontline health workers in Ikotos, South Sudan
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Delivering healthcare and supporting resilient health systems during protracted crises involves many complexities. Multiple actors with different perspectives and approaches work towards goals that cut across the humanitarian-development spectrum. Although there is broad agreement that addressing immediate health needs of vulnerable populations should be done in a way that supports longer-term equitable health system development, how to ensure an evidence-based approach to this end is not clear. A shared evidence base is lacking, and how evidence is generated and used in complex crisis settings is not well understood. Practical lessons are needed to inform practice and policy.

***This briefing paper** has been produced to inform a session at the Fifth Global Symposium on Health Systems Research. This participatory session will collate experiences and insights from those working in these challenging settings, and help develop recommendations for better evidence use for long-term, equitable health outcomes.*

The session, taking place on 11th October (11.00–12.30) has been co-organized by the ReBUILD Research Programme, Chatham House Centre on Global Health Security, UHC2030, Evidence Aid, DAI Global Health, Integrity Research and Consultancy, Crown Agents and the HSG Thematic Working Group on Health Systems in Fragile and Conflict Affected States.

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Leaving no one behind; how can evidence-based approaches support progress towards UHC and global health goals during conflict and protracted crises?

Paper prepared by Rachel Thompson, Nick Hooton and Katie Bigmore, October 2018.

This is a working paper, produced as a background paper for a session at the Fifth Global Symposium on Health Systems Research, with the aim of stimulating discussion and critical comment, and providing context and preliminary information for session participants. It represents the opinions of the authors, not of the organisations involved.

Introduction

Conflict and protracted crises have an impact on all the pillars of health systems, as well as on individual and collective health security. In the Millennium Development Goals (MDG) era, conflict-affected countries achieved the least progress in health indicators; 'we need to redouble our efforts' or this situation will not change by 2030[1]. At the same time, there is an increasing number of protracted crises and huge population displacements[2]. Moreover, the proportion of the world's extreme poor living in conflict-affected situations is projected to rise to more than 60% by the end of the Sustainable Development Goals (SDG) era.[3] These populations represent some of the most 'left behind', and it is clear that the SDGs cannot be achieved without a focus on both the short- and long-term needs of the 134 million people currently in need of humanitarian assistance, and that 'UHC will only be achieved with a strong focus on fragile and conflict-affected states'[4].

Striving for development goals in conflict contexts is not uncontroversial: if universal health coverage (UHC) is a project for the state, what happens if the state is absent, unwilling, or complicit in human rights abuses?[5,6] There may be tensions between delivering emergency services in a timely and flexible manner and achieving longer-term, country-led health goals Yet protracted complex crisis situations such as South Sudan require humanitarian and

[1] http://www.who.int/mediacentre/events/governance/wha/en/

[2] In 2017, at least 55 armed conflicts occurred in 29 states and territories from Afghanistan to Yemen (https://www.geneva-academy.ch/joomlatools-files/docman-files/The%20War%20Report%202017.pdf). Twenty people a minute are forcibly displaced as a result of conflict or persecution, totaling 65.6 million people, including 22.5 million refugees (www.unhcr.org/uk/figures-at-a-glance.html). The average refugee displacement is now 26 years (www.state.gov/j/prm/policyissues/issues/protracted). The burden of forced displacement falls disproportionately on fragile contexts – the poorest contexts generate the largest numbers of refugees and also host the largest shares of refugee populations and internally displaced (http://www.oecd.org/dac/conflict-fragility-resilience/docs/States_of_Fragility_2018.pdf).

[3] https://www.oecd-ilibrary.org/development/states-of-fragility-2015_9789264227699-en

[4] http://www.healthsystemsglobal.org/blog/81/Universal-Health-Coverage-will-only-be-achieved-with-a-strong-focus-on-fragile-and-conflict-affected-states.html

[5] http://www.healthsystemsglobal.org/blog/254/Universal-Health-Coverage-in-crisis-affected-contexts-the-rhetoric-and-the-reality.html

[6] Challenges for UHC include access issues, poor knowledge of needs and other data-related issues, lack of standardised service packages, politicisation of funding, lack of recognition of local actors such as informal providers

development sectors to act simultaneously. Coordination between actors is a major issue in crisis settings[7]. Poor coordination in the field may lead to inefficiencies in the short-term but less is known about the long-term impacts in, for example, contexts where parallel systems are established. Discussions around the so-called **humanitarian-development nexus** capture these debates, issues and opportunities[8].

In 2018, building on momentum in global health generated around UHC, we are witnessing a new impetus and political commitment to improve health care and health systems in conflict- and crisis-affected settings. The evidence to inform efforts is improving but remains limited and challenging to obtain. Where evidence is available it may not necessarily be shared between actors or sectors. Evidence may be disconnected from policy and practice, especially with the diverse range of actors working in these settings. There is a need to ensure that the opportunities to generate new evidence and learning are supported, and that global policies and commitments are informed by wide range of existing and emerging data.

Summary of policy context

Agenda 2030 and leave no one behind

As mentioned above - and reflected in the theme of this Symposium – the world has committed to 'leave no one behind', as member states and other actors work to achieve the SDGs. Building on progress made during the MDG era, Agenda 2030 focuses more explicitly on equity, both between and within countries. Health is recognized as integral to achieving the SDGs and has key targets in Goal 3. Although the pledge to leave no one behind has been embraced by development, health and humanitarian actors[9], there is no clear guidance on how to define or operationalize this pledge, and there remain gaps in evidence-based policy for health and other sectors[10].

Universal Health Coverage

UHC is now a dominant mantra in global health. Although post-conflict UHC reforms have helped societies recover and thrive (for example, the UK, Japan, Rwanda), UHC reforms that focus on domestic resource mobilization (the expectation that the state should fund and

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[7] 'Evidence on Coordination and Health Systems Strengthening (HSS) in Countries under Stress: a literature review and some reflections on the findings' https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/UHC2030_Working_Groups/2017_Fragility_working_groups_docs/ITM_-_Final_Report__v7_.pdf

[8] https://www.alnap.org/help-library/exploring-the-humanitarian-development-nexus

[9] ODI, International Rescue Committee launching new analysis that highlights the need for urgent, accelerated action on the 2030 Agenda's promise to leave no one behind. See https://www.odi.org/publications/11194-sdg-progress-fragility-crisis-and-leaving-no-one-behind

[10] https://www.odi.org/publications/10956-defining-leave-no-one-behind
Also see new research from Overseas Development Institute and International Rescue Committee that highlights need for accelerated action on the 2030 Agenda's promise to leave no one behind in fragile and conflict affected contexts: https://www.odi.org/publications/11194-sdg-progress-fragility-crisis-and-leaving-no-one-behind

manage healthcare provision) may not be feasible or appropriate in active/ongoing conflicts. Equity, quality and financial protection are key principles of UHC, and these are all more difficult to implement in disrupted settings. Approaches towards UHC in crises are not established.

Furthermore, while UHC sits comfortably within the development community, it is not universally embraced by humanitarian actors. While health systems can provide security and stability to communities, during conflict, 'neither health system nor state are impartial bystanders'; there are warnings that blurring the lines between humanitarian and development objectives can jeopardize health's protected status in conflict[11].

Agenda for Humanity and localisation

Complementing Agenda 2030, the Agenda for Humanity - introduced at the 2016 World Humanitarian Summit (WHS) - sets out the major actions and changes needed to reduce humanitarian need, risk and vulnerability. The 'Grand Bargain' subsequently developed is an agreement between donors and aid agencies that include commitments to greater funding for national and local responders: signatories have pledged to provide 25 percent of global humanitarian funding to local and national responders by 2020, along with more unallocated funds, and increased multiyear funding to ensure greater predictability and continuity in humanitarian response. These commitments are part of the wider localisation agenda[12].

The UHC goal represents an opportunity to advance commitments around the localisation agenda. Conflict- and crisis-affected settings are often dominated by largely unregulated local healthcare providers that may not have any interaction with the formal public or private healthcare sectors. Achieving UHC for crisis-affected populations will not be possible without working with an increased range of healthcare providers that have access to, and the trust of, vulnerable populations. There is a need to engage with the plurality and complexity of health systems that emerge in crisis settings. However, there is very limited research looking 'beyond the aid horizon'[13], and evidence-based approaches for incorporating local actors into the achievement of global goals are lacking.

'The new way of working'

Also introduced at the 2016 World Humanitarian Summit, the 'New Way of Working' (NWoW) aims to bridge the separation between relief, rehabilitation and development assistance that has often resulted in a vacuum of service delivery between emergency services and longer-term reforms[14]. The NWoW supports having pooled data, analysis and information frameworks with better joined-up planning and programming processes that

[11] https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-015-0039-4
[12] https://charter4change.org/
[13] https://conflictandhealth.biomedcentral.com/articles/10.1186/1752-1505-8-20
[14] https://rebuildconsortium.com/media/1607/rebuild_briefing_9_july_18_health_systems.pdf

aspire to support national and local ownership with capacity-development spanning multiple years[15]. Humanitarian health interventions should focus on integration, early recovery and transition to local authorities as early as possible; at the same time, development programmes should target fragile and conflict-affected areas in a more operational manner[16]. The G7+ have published examples of health projects inspired by the New Deal[17]. One practical approach to operationalising this is the DARES collaboration between the World Bank, UNICEF, World Food Programme (WFP) and World Health Organization (WHO)[18].

UHC in emergencies

Bringing together the above, UHC in emergencies is a new agenda/initiative that is gaining traction. The concept was launched at the 2018 World Health Assembly (WHA 71) side-event on advancing UHC in emergency settings. During this event, countries including Somalia, Central African Republic and Afghanistan presented their experiences and ambitions around UHC, and the importance of generating evidence to inform UHC to inform approaches during and after crises was noted[19].

Since the meeting at WHA 71, the Swiss and Afghanistan governments have led a Call to Action for UHC in Emergencies, which in addition to calling for protection of healthcare during conflict, emphasizes the need for coordinated humanitarian and development approaches to support progress towards UHC in the longer term in protracted crises, and that such efforts should be based on good evidence. This Call to Action was launched at the United Nations General Assembly on 27th September 2018, where a number of member states, as well as global health institutions including WHO and GAVI, supported the agenda.

Focus on evidence

Despite the gaps and issues highlighted, there is nevertheless increasing work and commitment to ensure evidence-based approaches are implemented in crises. Evidence Aid[20] and ELRHA[21] are examples of the organizations and programmes working to increase the availability and use of best evidence in humanitarian and emergency responses. There is also an increasing body of health systems research focusing on health systems challenges and strengthening in fragile and conflict-affected states, including the work of the ReBUILD programme, as well as initiatives to improve the generation, availability and use of this

[15] OCHA (2016). New Way of Working http://bit.ly/2L4kUxB.
[16] http://www.who.int/health-cluster/about/structure/new-way-working.pdf
[17] http://www.g7plus.org/sites/default/files/basic-page-downloads/New%20Deal%20Innovations%20-%20Complete%20-%205-.pdf
[18] 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
[19] https://www.uhc2030.org/news-events/uhc2030-news/article/a-call-to-action-advancing-uhc-in-emergency-settings-481478/
[20] http://www.evidenceaid.org/
[21] See http://www.elrha.org/0ujpo

evidence, notably by the Health Systems Global (HSG) Thematic Working Group on Health Systems in Fragile and Conflict Affected States[22].

Evidence is currently being collated by this Thematic Working Group as an open access Collection of Resources and Key Issue Guides[23].

Although some of this work addresses the particular challenges of the humanitarian-development interface, evidence that informs the relative importance and potential conflicts between short-term needs and long-term outcomes is limited, and numerous questions remain on how the humanitarian provision of short-term healthcare needs may be done in a way that supports development of sustainable health systems and longer-term health goals[24].

In summary, there is a diverse and fertile policy context, with multiple agendas and initiatives moving forward, and a widespread interest and appetite for evidence. Yet the evidence to inform this potential progress is not sufficient. Knowledge of how long-term outcomes can be translated and effectively accessed and used in complex and contested areas is especially limited. The aim of this session, and of future work, is to help improve this situation.

Evidence for emergency settings: issues and questions

Across all sectors, work around the humanitarian-development nexus has not been well documented and the **published evidence base is weak**. The **complex operational challenges** of crises, such as poor access and insecurity, make any kind of data collection challenging and may make academic research especially difficult[25]. Evidence that can inform the humanitarian-development nexus for health is thus a work in progress.

An alternative evidence source is research carried out in post-conflict settings. While still challenging, these settings can allow robust research using 'historical' approaches, producing evidence not only on how the health system performed during and immediately after the conflict, but on long-term health system development and access for vulnerable populations. Evidence from high-income countries may also be relevant. But how valid is it to extrapolate robust findings from such contexts to today's very different protracted-crisis settings?

The **mix of actors** in settings of protracted crises, with differing focus and objectives means evidence can be sought, accessed and viewed differently. For example, humanitarian actors have focused on intervention-related evidence around effectiveness and efficiency.

[22] See http://bit.ly/TWGFCAS
[23] See http://www.eldis.org/collection/health-systems-fragile-and-conflict-affected-states.
[24] https://rebuildconsortium.com/media/1607/rebuild_briefing_9_july_18_health_systems.pdf
[25] https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-017-0204-x

Evidence is for current practice and programme improvement primarily – to assist saving lives and improving short-term health outcomes.

The Sphere project[26] provides a shared knowledge base for humanitarian healthcare. However, high staff turnover within humanitarian organizations can lead to **loss of institutional memory** and evidence around implementation may be forgotten or lost. Due to operational and institutional constraints, **sharing of data, research and lessons learned between agencies is not well organized** (see coordination issues mentioned above).

Poor practices around health data in crises have been documented: even the most basic information such as the '4W matrix' (who does what, where, when) was only collected in two out of thirteen recent armed conflicts[27]. In such 'data-poor' contexts, the generation and use of evidence, for example to inform future policy, would be a challenge.

Yet at the same time, every humanitarian health project has a robust monitoring and evaluation system in place and generates data daily. There is often a wealth of programme specific related data which lies unused and unshared, which has the potential to be harvested and synthesized. New technologies are facilitating real-time analysis, enabling a 'data rich' way of working within organizations in the field, such as *Médecins Sans Frontières*[28]. The next opportunity is thus to capitalize on digital innovations, raising the question of **how to translate programme data into 'evidence'** (i.e. how to 'extract' and share programmatic data from the field) that be more widely accessed and analysed. Shared evidence generation is important but so too is sharing 'lessons learned', and there is an opportunity to expand on virtual initiatives such as the HSG TWG-FCAS Collection of Resources.

Although humanitarian actors are using social science and anthropological methods more widely[29], much humanitarian evidence is quantitative in nature. Ensuring a wide range of data is generated is important when thinking about the transition from short to long-term approaches.[30]

Development actors, interested in the longer-term sustainability of programmes, may place more weight on longer-term academic research as robust evidence. While research in more stable post-crisis settings is possible, and there is a growing body of evidence that may now inform UHC approaches[31], insecurity means proposals for research in active conflict settings such as Syria and Yemen are unlikely to pass ethical review boards. Local researchers can help but may themselves be displaced or unable to conduct research in line with academic standards.

[26] http://www.sphereproject.org/sphere/en/handbook/revision-sphere-handbook/
[27] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30702-X/abstract
[28] www.scientificamerican.com/article/out-of-the-syriancrisis- a-data-revolution-takes-shape/
[29] http://groundtruthsolutions.org/
[30] For example, ReBUILD have used social networks analysis and life histories
[31] https://rebuildconsortium.com/media/1537/rebuild_briefing_3_june_17_uhc.pdf

There is thus a need to **reconsider what forms of data and research count as evidence** in protracted crises, and to support **new ways of generating data.** There is also an opportunity to use the common aim of better evidence generation and use as a way of bringing together actors who may disagree about other issues.

Moving on from evidence generation, many questions remain around the use of evidence to inform policy and practice in crises. These questions are not unique to the health sector, and there is a **need to better understand processes around the application of evidence in crises**.

With the critical importance of improving both short and longer-term health outcomes in protracted crises, and the challenges – contextual and practical – to finding evidence-informed approaches, as described above, this short session at HSR2018 has been designed to contribute to filling this gap.

See session description on following pages.

Leaving no one behind; how can evidence-based approaches support progress towards UHC and global health goals during conflict and protracted crises?

Thursday 11th October 2018, 11.00 – 12.30. ACC Liverpool, Hall 2L

Session overview

The session is designed to draw on practical experiences to inform the overall question: ***'How do we support evidence-based approaches to the provision of healthcare in emergencies and crises, which incorporate a long-term view of progress towards universal health coverage, whilst still delivering essential immediate healthcare needs?'***

The session has three elements:

1. Firstly, we will present some brief case studies as examples of how evidence on longer-term health systems strengthening has been generated and used in settings of protracted crisis, and some practical lessons that emerge from these.
2. This will be followed by break-out discussions to hear and record participants' own practical experiences of the generation, communication and use (or otherwise) of research evidence in these settings, including lessons on where this has gone well and not so well. These experiences and insights will be captured and collated to be included in the session outputs.
3. Lastly this will be brought together with a panel discussion, focusing on access to and use of evidence by implementers and decision makers in protracted crisis settings.

N.B. All session elements will be based on guiding questions, to help stay focused on the challenge of evidence generation and use in policy and practice, without getting into the detail of specific health system issues and challenges.

Your own role:

We encourage anybody with experience or interest in this area to join the session, as the emphasis is on sharing experiences of processes around evidence generation and use. As the background paper demonstrates, this is a context where evidence-based approaches face multiple challenges, and where there is limited published learning, yet where there is significant political will to make meaningful progress towards the SDGs for some of the poorest and most vulnerable populations.

If you have material and further information to share during or after the session, please bring this with you. We can link to this in session outputs, as well as highlighting particular relevant knowledge for actors working on particular issues or in particular settings.

The session has been co-organized by the ReBUILD Research Programme, Chatham House Centre for Global Health Security (CGHS), UHC2030, Evidence Aid, DAI Global Health Ltd, Integrity Research and Consultancy, Crown Agents and the HSG Thematic Working Group on Health Systems in Fragile and Conflict Affected States (TWG-FCAS).

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Session programme:

Team, presenters and panellists:

Organizers:

- **Nick Hooton** – ReBUILD Research Consortium
- **Rachel Thompson** – Chatham House Centre for Global Health Security

Moderator:

- **Ben Heaven Taylor** – Evidence Aid (Director)

Presenters and panellists:

- **Fatima Adamu** – National Programme Manager, Women for Health programme, Northern Nigeria (DAI Global Health Ltd)
- **Katie Bigmore** – Integrity Research and Consultancy (Senior Expert)
- **Abdulkarim Ekzayez** – Syrian medical doctor; consultant to Idleb Health Directorate, NW Syria (Kings College London)
- **Campbell Katito** – Health Pooled Fund, South Sudan, Health Systems Strengthening Manager (DAI Global Health Ltd)
- **Haja Wurie** – ReBUILD Research Consortium (College of Medicine and Allied Health Sciences, Sierra Leone)

Programme:

11.00 – 11.25: Session overview and case study presentations:

- Session moderator Ben Heaven Taylor (Evidence Aid)

Case study presentations:

- Health worker remuneration and movement in South Sudan
  - Campbell Katiko (Health Pooled Fund & DAI)
- Implementation research on rural midwife incentives in Northern Nigeria
  - Fatima Adamu (Women for Health programme & DAI)
- Research on health worker incentives from post-conflict settings
  - Haja Wurie (ReBUILD Research Consortium)

11.25 – 12.00: Table discussions:

A facilitated sharing of participants' own experiences of the use of research evidence to inform long-term health system strengthening (HSS) in conflict and protracted crisis settings – including the demand for and use of evidence, as well as the generation of evidence through research.

Table facilitators will guide the process, and note takers will record all contributions. Experiences shared will be used in session outputs. **Guiding questions** will include: Were long-term HSS considerations recognised and prioritised by decision makers and implementers? Was there a recognition that evidence could inform appropriate

approaches, and was evidence looked for? In conducting research, where did data come from? How was this accessed? How was this used to inform policy and practice? How was evidence received and used by different types of actors?

12.00 – 12.30: Panel discussion:

Access to and use of relevant evidence in protracted crises, to support long-term equitable health systems development while delivering immediate needs.

Moderator: Ben Heaven Taylor (Evidence Aid)

Panellists:

- Dr Abdulkarim Ekzayez (Syrian medical doctor, and Kings College, London)
- Katie Bigmore (Integrity Research and Consultancy)
- Campbell Katiko (Health Pooled Fund, S. Sudan and DAI Global Health)

Session outputs and way forward:

Organizing partners for this session are involved in a number of ongoing processes in support of progress towards UHC in protracted crises, and ensuring the most vulnerable people are not left behind. This session will provide insights which can feed into these processes, and outputs will reflect this.

- An initial session report will be produced, which will include the insights and any recommendations shared during the table discussion element. This will be shared and publicised by the session partners.
- A specific activity building on this session and drawing on the outputs will be developed for Humanitarian Evidence Week on 19th – 25th November. With a wide reach into the humanitarian community, the plan is for this to feature blogs on key issues raised during the session, and probably a webinar to present and discuss the issues and experiences raised during the meeting.
- Additional outputs, drawing on contributions during the session, and further follow-up as relevant, will be tailored towards the needs of actors and processes in the lead up to the 2019 UNGA High Level Meeting on UHC, to ensure considerations of UHC in emergencies and protracted crises are as evidence-informed as possible.

For further information on this session, its outputs and the links to ongoing processes towards UHC in conflict and crisis settings, please contact Nick Hooton (nick.hooton@lstmed.ac.uk).