Recovery of health systems during protracted humanitarian crises: a case for bridging the humanitarian-development divide within the health sector

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INTRODUCTION

The global increase in the magnitude and impact of protracted crises is a matter of concern. From 2005 to 2017, the number of protracted crises which required international humanitarian assistance and their average duration increased from 16 to 30 and four to seven years respectively.1 In 2017, eight protracted crises accounted for more than 80% of all the global humanitarian requirements; likewise, the humanitarian funds spent on protracted crises increased from US$2.3 billion in 2005 to US$14.2 billion in 2017.1 A crisis is protracted when a significant percentage of the affected people face an increased risk of disease, erosion of their livelihoods and death over a prolonged period mostly due to human-made disasters or natural hazards.2 3

The largely emergency-driven approach to the management of protracted crises focuses on the provision of selected humanitarian interventions to the detriment of health system recovery and resilience-building interventions. Durable development solutions are hardly considered as they are long term and may not contribute to the immediate humanitarian objectives. The 2016 World Humanitarian Summit recognised this imbalance and called for the bridging of the Humanitarian and Development Divide (HDD) as a top priority during protracted crises.1 Consequently, the United Nations and other actors penned and signed a new ‘Commitment to Action’ which committed all stakeholders to reform their internal operations to integrate humanitarian and development programming and financing to achieve collective outcomes.3 The consequent launch of new initiatives galvanised hope that this new approach would strengthen systems and reduce vulnerabilities among populations affected by protracted crises. One of these initiatives, ‘putting health at the centre of collective humanitarian action’ aimed to improve access to essential health services and promote emergency preparedness and response while also strengthening health systems in protracted crisis contexts.5 In the same vein, there have been calls for collaborative approaches using an integrated primary healthcare-based model to rebuild health systems in protracted crises.6

In this commentary, we make a case for effectively bridging the HDD and make
recommendations to accelerate the implementation of the ‘Commitment to Action’ in the health sector.

THE NEED TO BRIDGE THE HUMANITARIAN-DEVELOPMENT DIVIDE IN THE HEALTH SECTOR OF COUNTRIES IN PROTRACTED CRIPES

Protracted crises are characterised by peculiar challenges which undermine the ability of the health systems to deliver good healthcare services and recover their functions and resilience. The shortfall in healthcare services in the face of increased demand results in excess morbidity and mortality. The presence of large numbers of humanitarian (and sometimes development) actors in protracted crises results in the fragmentation of planning, implementation and coordination of health services delivery. For instance, the operation of two distinct coordination mechanisms namely the health sector working group and the humanitarian health cluster fragments the oversight functions of the health system. Through their impact on social services, protracted crises increase the risk of public health emergencies which undermines good health outcomes. Humanitarian and development actors mostly operate in silos; humanitarian actors and donors are hardly interested in health system strengthening while development actors present in such situations are far too few and underfunded to make any meaningful impact. Most available funds (which are largely humanitarian) are allocated to vertical humanitarian programmes at the detriment of health system recovery and resilience-building programming.

Rebuilding the health system functions, and resilience is a near-impossible task against the backdrop of the foregoing. Bridging the HDD in such contexts is therefore imperative. This requires a two-pronged approach which ensures synergy in addressing the immediate health impact of the crises and preventing the occurrence of new problems while also recovering and rebuilding the fragmented health system simultaneously. This is the basis for the ‘New Way of Working’ which emerged from the ‘Commitment to Action’. It aims to bring humanitarian and development actors closer and to address any barriers to working together. While this concept is not new, it embodies the principles of earlier initiatives but also commits several stakeholders to its implementation. Several years after it was initiated, the concept is yet to take hold due to a lack of the required knowledge, technical capacity and suboptimal commitment of stakeholders to implement it.

THE WAY FORWARD

To effectively bridge the HDD in the health sector of countries in protracted crises, the health development and humanitarian coordination mechanisms must work together to ensure holistic and synergistic planning, implementation and coordination of both emergency and development health interventions. First, in crises where sector coordination mechanisms do not exist, the humanitarian health cluster should integrate elements of transition and early recovery into its function and engage both humanitarian and development actors. Where they exist, health sector coordination mechanisms should actively engage the health cluster and ensure synergy with humanitarian programming and coordination. Second, joint assessments and planning of humanitarian, transition and early recovery programmes are critical. Initial rapid health assessments and health sector reviews should include elements of postdisaster/conflict needs assessment so that the humanitarian, transition and early recovery requirements are simultaneously identified. Third, health transition and early recovery programming should be integrated into the humanitarian response plan likewise health sector strategic plans should have elements of all-hazard emergency preparedness, response, transition and early recovery. On the partners’ side, HDD programming should be incorporated into all international humanitarian and development assistance frameworks. Fourth, health system recovery and resilience-building programmes should be instituted early as a platform to systematically rebuild the health system. Fifth, the financing mechanisms for HDD initiatives should be clearly defined with both humanitarian and development financing streams having components of transition and early recovery. Sixth, community engagement and participation in defining HDD priorities should be encouraged to foster ownership and sustainability. Seventh, the capacity of all national health stakeholders should be built on how to jointly conceptualise, implement, monitor and evaluate HDD programmes. Humanitarian and development actors should negotiate collective objectives and outcomes to which both parties will contribute and define benchmarks for monitoring progress to facilitate collaboration. Lastly, actors who have dual humanitarian and development mandates should ensure the synergy of both workstreams.

CONCLUSION

HDD, a common feature of protracted crises, impedes the effective rebuilding of the health system. There is a global consensus on the need to bridge this divide and the appropriate framework for doing so exists. However, the political commitment, technical capacity and clarity on how to effectively implement such interventions are lacking. We urge all health stakeholders who manage protracted crises to commit to the principles of bridging the HDD, ‘the Commitment to Action’ and the ‘New Way of Working’ by working together to synergistically implement both humanitarian and development programmes. We call on the donors to fund such initiatives and the health leadership of countries in protracted crises to embrace and provide the enabling environments for the implementation of HDD initiatives.

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