Health Systems Strengthening and Conflict Transformation in Fragile States

Amsterdam, Thursday, 11 October 2012

Medicus Mundi International Network Expert Meeting
hosted by Cordaid and the Royal Tropical Institute

Meeting Report

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Executive Summary

The Mauritszaal in KIT was filled to capacity on the 11th of October. Medicus Mundi International (MMI) members and representatives of a range of NGOs and academic institutions came together and were welcomed by Nicolaus Lorenz, President Medicus Mundi International Network, who chaired the day. The purpose of the meeting was to explore if it is possible to strengthen health systems and address fragility at the same time, or as Egbert Sondorp (Senior Advisor, KIT) summarized it: "Can we kill two birds with one stone? How and what are the various pathways? And can we measure and get funding for it?".

Rene Grotenhuis (Director Cordaid) argued that building state institutions is not enough in bringing a state out of fragility. Cordaid believes that the answer to conflict and fragility is in build flourishing communities, and that health should not be looked at merely as a technical delivery of services, but also as a social intervention with the potential to affect social change. This way, quality health care can become a bridge to overcome differences and conflicts.

Rachel Slater (ODI, Research Director SLRC) discussed the current lack of evidence for the intuitively made connection between the delivery of social services, state legitimacy and state building. She warned for the danger that through the focus on conflict transformation, other duties and responsibilities are heaped on the health system, thus loosing focus on the main priority of a health system – curing sick people and preventing disease. While keeping service delivery as our focus, it is important however to look at the context one is working in and keep on asking ourselves the question whether we "do not do harm" with our intervention.

Egbert Sondorp (KIT, Senior Advisor Health Systems) placed the issue in a historical and political perspective. He noted that 'health as a bridge for peace' is not a new concept, and that it proved difficult to operationalize and apply in the past. At the same time we need to be mindful that political actors such as ministries of defense are increasingly engaged in health service delivery and 'development' efforts as part of their effort to win 'hearts and minds'.

Based on an open call for case studies, eleven of the selected country case studies were discussed in three parallel working groups on community and district interventions, national health systems and performance based finance as a mechanism for health systems strengthening. The experiences from countries such as DRC, Afghanistan and Sierra Leone seemed to point in the direction that you probably could kill two birds with one stone, as long as you strategize and position yourself properly. For example, they indicated that health interventions can contribute to a dynamic of trust and recovery at a community level, can contribute to good governance and state legitimacy, and increased accountability and participation. The case studies also raised many questions; for example can a health intervention in a conflict context really be neutral? How do you put into practice a 'do no harm approach', and how does your health system intervention, at local and/or national level, affect power relations?

In the Pecha Kucha presentations, presenters agreed that there is a relation between health systems and conflict transformation but that we need to be more precise and explicit about what the nature of this linkage is and how we want to address this in our interventions. In the academic world, the relation between conflict and health systems strengthening is a newly emerging theme as illustrated

by Susan Fustukian (Queen Margret University). Xavier Bosch-Capblanch (SwissTPH) showed the lack of evidence and guidance on health systems in fragile states at the moment and the need to create this in order to inform policy and programming. Sylvia Serveas (FriEnt) described the wider set of linkages between health and conflict, including health as a form of reparations. She made clear that health interventions are embedded in society and should be conducted in a conflict sensitive manner (e.g. through building trust), the health sector can learn from peacebuilding efforts in this regard. Remco van der Pas (Wemos) emphasized also that we should see health interventions in a larger framework, through the lens of the social determinants of health, being mindful of local and global inequalities and the role international actors play in this. It may be that factors outside the traditional health care system (e.g. land issues) have a much larger influence on people's health and well-being, and he argued that health NGOs should therefore take a political stance, break through silo's and look for creative solutions. Lastly, the experience of HealthNetTPO on mental health and psychosocial interventions presented by Willem van der Put also broadened the concept of what a health intervention is. HealthNetTPO uses a dual approach of community systems strengthening and mental health interventions through the conventional health system. The organization's case studies illustrate the transformative potential of this approach at a community level. The different presentations showed that there are many different approaches to what the health system is and entails. Can we develop this into a meaningful framework in the context of health system strengthening and conflict transformation? Working in conflict makes the work inherently prone to political considerations; what does this mean for how the intervention is organized? Should this be used, addressed, stayed away from, worked around?

During the last part of the day, a discussion was organized on the main conclusions and the ways forward, facilitated by Nicolaus Lorenz (MMI President) and Bruno Meessen (ITM Antwerp). The main outcome was that there seems to be plenty of anecdotal or "intuitive" evidence that health system strengthening can contribute to conflict transformation, but that we need to build and review the evidence base to get a deeper understanding of the issue. This will allow us to develop a common framework which can help to make interventions conflict-sensitive without compromising the main goal of health system strengthening – the improved provision of health services. Thus, can we kill two birds with one stone? Probably, under specific circumstances. This expert meeting was only a first step in getting a more conclusive answer to this question.

To ensure that the link between health system strengthening and conflict transformation is prioritised, gains more visibility and is further discussed, it will be important to strengthen the networks of organisations working on this issue. This can partly be done through building on existing structures; the Health and Fragile States Network[1] is one such network, to which we encourage interested parties to sign up.

Henri van Eeghen, Director of Cordaid, closed the day. He stressed the need for developing a deeper understanding of health as an instrument of change and that various types of research will be needed for this. He noted Cordaid would like to organize an event again around this issue, and that Cordaid hopes that we can venture on this journey with MMI members; that we can share and learn together so that when we meet next year, we have more answers.

All conference documentation including the case studies and presentations are available on:
www.bit.ly/mmi-amsterdam2012

[1] To become member of the Health and Fragile States Network and to be part of its mailinglist, simply send an email to healthfragilestates@gmail.com

Introduction

On the 11th October 2012, the Medicus Mundi International (MMI) Network organised a one day expert meeting, hosted by Cordaid and the Royal Tropical Institute (KIT) in Amsterdam, on the theme of 'Health Systems Strengthening and Conflict Transformation in Fragile States'. The meeting brought together approximately ninety MMI members and representatives of a range of NGOs and academic institutions.

The purpose of the meeting was to explore if it is possible to strengthen health systems and address fragility at the same time. It intended to facilitate learning and information sharing on health sector initiatives that aim to improve health outcomes, contribute to longer term, sustainable health system strengthening and conflict transformation, in order to inform programming, policy, advocacy and further research.

The participants were welcomed by Nicolaus Lorenz, President Medicus Mundi International Network, who chaired the day. In its "Network Strategy 2011-2015" adopted in May, the Medicus Mundi International Network 2010 defined the creation of joint ventures on issues related to health systems strengthening as one of its main strategic directions. HSS strengthening and fragile states was one of the research areas identified as being important for MMI partners. This conference was organised to help MMI partners to translate NGO practice in research questions and forge partnerships between NGOs and the research community in line with the above mentioned Network Strategy. See also www.medicusmundi.org/en/network-programs.

The day consisted of a mix of plenary presentations, working groups and discussion. The day was then started with a set of introductory remarks by Cordaid and KIT and a keynote speech by ODI to introduce the theme of health system strengthening and conflict transformation. In three working groups, a total of 11 country case studies were presented and discussed covering real life examples around this theme. In the afternoon, a range of different perspectives came across through five short Pecha Kucha presentations, followed by a plenary debate and concluding remarks.

This report aims to capture the essence of these various presentations and discussions. All conference documentation, including the presentations and descriptions of all accepted case studies (presented and not presented), is available on: www.bit.ly/mmi-amsterdam2012

1. Welcome

Rene Grotenhuis, General Director Cordaid

Rene Grotenhuis reminded us of the importance of focusing on fragile states, considering that they generally have the lowest development indicators and unlike other low income countries, have few opportunities to come out of the poverty trap. Therefore the New Deal for Engagement in Fragile States which was presented and endorsed by a number of governments and multilateral donors at the Fourth High-Level Forum on Aid Effectiveness in Busan, South Korea provides an opportunity to move beyond this.

> Rene Grotenhuis:
> *"To address fragility, it is crucial to build flourishing communities."*

Rene Grotenhuis argued that building state institutions is not enough to bring a state out of fragility, and the large scale initiatives in for example Afghanistan have failed at this. Cordaid believes that the answer to conflict and fragility is in strengthening communities, rather than state entities. Health

service delivery should be looked at as not merely technical delivery of services but also as a means to build flourishing communities. Cordaid defines health service delivery as a social intervention with the potential to make social changes, building on its impartiality, it can help to overcome divides. Quality health care can then become a bridge to overcome differences and conflicts.

2. Introduction to health system strengthening and conflict transformation in fragile states

Egbert Sondorp, Senior Advisor, Royal Tropical Institute

Egbert Sondorp provided a historical and political perspective on how the link between health care and peace has been and is being addressed by various actors at different times. For long, there have been so called 'days of tranquillity', when a cease fire during conflict is negotiated to provide health services such as an immunisation campaign. Apart from the health objective, there is a peacebuilding objective in that the cease fire may last longer and creates space for peace talks. Days of tranquillity are often mentioned in discussions around 'Health as a Bridge for Peace', a concept based on the notion of health providing neutral space to bring warring parties or different ethnic groups together. The various conflicts in Central America in the 80's and the former Yugoslavia in the 90's led to elaboration of the concept of Health as a Bridge to Peace and was even formally accepted by the World Health Assembly as a 'multidimensional policy and planning framework which supports health workers in delivering health programmes in conflict and post-conflict situations and at the same time contributes to peace-building'. By and large, it proved difficult to operationalise the concept and there was the critique that activities may place health in the political, peace-building sphere, thereby politicising health.

> Egbert Sondorp:
> *"Can we kill two birds with one stone? Improve health and build peace?"*

Egbert Sondorp described the politicisation of health, that we have seen in more recent conflicts, whereby the relation between health and peace is being increasingly used by the military in their efforts to win hearts and minds. Also donor agencies have started to frame provision of health and other basic services more and more in the realm of contributing to enhanced state legitimacy and state-building. This has led, for instance, to various '3D programmes', combining defence with diplomacy and development.

He also discussed the concept of a health system in relation to conflict transformation. The WHO Health System building blocks are now widely known. However, there is a tendency to use these in a rather technocratic way addressing block by block without looking at the linkages, and especially, without looking at the context and social determinants of health which underlie the system. Fragility and poor governance is one of those determinants and should be included in efforts to strengthen health systems.

Egbert Sondorp raised a number of questions that set the stage for the discussions during the day. Can we kill two birds with one stone? Is there any evidence that it works? What are the challenges? How do we measure results? Is it 'what' we do or rather 'how' we implement activities? Many of these questions are still unanswered and in particular we lack empirical evidence. Does this work 'on the ground'?

3. Keynote speaker: how can delivering basic services lead to conflict transformation?

Rachel Slater, Overseas Development Institute & Research Director of the Secure Livelihoods Research Consortium

Rachel Slater focused on the evidence around state building and the question of whether delivering basic services can contribute to enhancing the legitimacy of the state. She noted there is a strong intuitive logic that delivering basic services contributes to state legitimacy and by extension to state building. This has become a received wisdom and a lot of international agencies base their programming on this assumption. The Secure Livelihoods Research Consortium reviewed the evidence base for this through consultations and a systematic literature review process. Overall the evidence base proves to be very thin. This lack of evidence had a number of causes: it is a relatively new agenda; at a theoretical level the causal chain between perceptions, legitimacy and statebuilding has not been fully unpacked; the complexity and heterogeneity of the problem; political pressures of the stabilization/securitization agenda; and difficulties of doing research and impact evaluation in these environments.

Rachel Slater:
"Get the priorities right: Provide services! Do no harm! State building is a secondary objective"

With regards to health the large investments in Afghanistan show that health care can be improved and people rated them as good. However, these levels of funding are unprecedented. How large does a health investment need to be in order to change people's perceptions? It also led to the conclusion that while health systems strengthening can in some cases contribute to state-building within that sector, there is very little robust evidence that it can contribute to wider state-building processes (e.g. state-society relations).

In conclusion, Rachel Slater drew three implications from the review; (1) It is important to get the role of health in perspective; it only tackles one source of legitimacy: output or performance legitimacy rather than other forms such as input legitimacy (rules & regulations) and international legitimacy. (2) it is important to get the priorities right: she warned for the danger that other duties and responsibilities are heaped on the health system, thus loosing focus on the main priority of a health system – curing sick people and preventing disease. While keeping service delivery as our focus, it is important however to look at the context one is working in and keep on asking ourselves the question whether we "do not do harm" with our intervention. (3) It is important to set realistic expectations and timelines: are we trying to tackle mortality and morbidity driven by conflict, or everything?

4. Parallel working groups on country case studies

The eleven country case studies were discussed in three parallel working groups on community and district interventions, national health systems and performance based finance as a mechanism for health systems strengthening. These case studies were selected by the organizing committee out of the twenty submissions received. In addition, a number of country case studies were selected but the authors were unable to present this at the meeting. Two of these were made available as posters at the meeting, all papers are listed in annex II and are available on the conference website.

The experiences from countries such as the Democratic Republic of Congo (DRC), Afghanistan and Sierra Leone seemed to point in the direction that you probably could kill two birds with one stone, as long as you strategize and position yourself properly. For example, they indicated that health interventions can contribute to a dynamic of trust and recovery at a community level, can contribute

to good governance and state legitimacy, and increased accountability and participation. The case studies also raised many questions; for example can a health intervention in a conflict context really be neutral? How do you put into practice a 'do no harm approach', and how does your health system intervention, at local and/or national level, affect power relations?

The case studies are available on the website of MMI, www.bit.ly/mmi-amsterdam2012.

4.1 Case studies related to community and district level interventions

Facilitator: Ankie van den Broek (Royal Tropical Institute)

In **Afghanistan** (Jain Holsheimer, Cordaid) Cordaid implements a number of interventions towards health system strengthening and is planning a study on its possible contribution to conflict transformation. Cordaid has identified a number of pathways through which this could be taking place. One pathway is the benefits of future health care are an incentive for dialogue, and the cessation of fighting can be made a condition for health care. Also, the provision of health care itself brings people together around joint activities and shared interest through health committees. Furthermore, it may contribute to state legitimacy as discussed by others as well, and strengthening leadership in health care could also lead to providing a voice of the population towards the state or international community. In **Tajikistan** (Joao Costa, SwissTPH) the health workforce is sufficient in quantity, but lacks quality. Programmes exist to strengthen the health system through training and top-ups for health workers to boost performance. Perhaps this technical intervention could be qualified as a 'do no harm' approach, but it also begs the question of whether investing external resources to strengthen the government systems is also giving a possibly corrupt government more legitimacy. In **Pakistan** (Zaeem Ul Haq, Save the Children), following the humanitarian response after the earthquake (2005), a health systems strengthening approach was adopted in Battagram Province by Save the Children focussed on primary care (2008). Despite the challenges posed by the conflict in the province, independent evaluations showed that the interventions contributed significantly to rebuilding of district health services. In the East of the **Democratic Republic of Congo** (Elies van Belle, Memisa) Memisa prioritized support for health existing facilities, reopened them and guaranteed permanence of services. This contributed to a dynamic of hope, trust and reconstruction; and motivated people to return home to their villages. Refugees in Uganda even crossed lake Albert to come back to the hospital on the Congolese side in case of illness, rather than mounting the hill to go to the Ugandan hospital. The technical support to the district management teams and the intermediary level motivated and helped them to regain leadership and to work united despite the conflict. The support to the laboratory was important to generate a fast response to epidemics, helping to decrease fear amongst the population.

The country case studies raised further questions. One of the central themes of the discussion was neutrality; it was argued by some that health care is immune for conflict and is perceived as neutral (e.g. Cordaid in Afghanistan). However, this may depend on the context and the history and position of health actors in the regions; e.g. this may be the case if ICRC were providing health, but if it was government they could be a target. Also there were examples of cases (like in DRC) where health facilities were targeted during the conflict. In addition, the health workers are not always neutral, they may have different political positions and conflicts from community may even play out within a health facility. Similarly it is important to question who your partners are and what their positions are. This is one of the main lessons; how do you ensure the intervention does not drive conflict? In Afghanistan the community development councils and health committees are an attempt at more democratic governance, but they also still reflect to a large extend the influence of old power structures (shura's).

Ankie van den Broek: "*Can health interventions in conflict areas really be 'neutral'?*"

4.2 Case studies related to national health systems

Facilitator: Christina de Vries (Cordaid)

In **Sierra Leone** (Erin Chu, Charlie Goldsmith Associates) interventions were undertaken to improve the pay and payment mechanisms for health workers through active staff management. This initiative was called for by the President and backed by the donors. It demonstrated good leadership, good governance and created goodwill, and led to the perception that the government is in the driving seat. It also contributed to a sense of fairness and transparency, including through strengthening the capacity of civil society organisations to provide oversight. Health workers provide services but have a dual function as they are also respected community members and therefore represent both government and community and can contribute to improved perceptions from both sides. A number of lessons were learned from the experience in **Myanmar** (Paul Sender, Merlin) in providing a coordinated township approach to health service delivery in the aftermath of Cyclone Nargis. It showed that it is very important to consider the perspective of time, every context has a 'timeline' – events follow up in a logical sense, it is key to recognize this and to identify the logical next steps. The presentation triggered a discussion on appropriate health service models for sustainability, and on supporting organizations in 'conflict'; how can you best work with community on concepts of equity and rights-based approaches. It was also concluded that in this regard it is important to identifying roles, mandates and some form of accountability. The case study on **Nigeria** (Andrew Mckenzie, Health Partners International) focussed on the federal working relations in the Nigerian health sector and what can be done to strengthen the policy implementation gap. In Nigeria, the health system and service delivery is very fragmented, but they all 'share' from the same pool of resources (human, financial). Therefore if you want to strengthen health systems you need to review the balance of power between actors and create a single management body and enabling legislation.

The discussion focussed on a few key themes:

- Models; organizations may have the ability to carry out tasks despite conflict, but how do these models contribute to reduction of conflict? We try to do this for the health systems, but do we know if models are also being copied to other sectors (i.e. education, transport sectors); this would be a key test indicating its success.
- What does power mean? How do weak health ministries usually interact with other ministries? What about power balance? What are the rules of the game? Where are the power struggles? How do local powers and national powers work together rather than against each other? And how does this play out at local level?

It was concluded that it would be naïve to think that health system strengthening automatically leads to conflict transformation. Health system strengthening need to address local power balances and time is needed.

4.3 Case studies related to performance based financing

Facilitator: Jennie van de Weerd (Cordaid)

The question discussed in this session was whether performance based financing (PBF), a current trend in health system strengthening which is also being applied in fragile states, can also contribute to conflict transformation.

The case of **Eastern DRC** (Michel Zabiti, Cordaid) illustrated that implementing performance based financing and strengthening the health system proved challenging and needs a continuous process of adaptation. The two program evaluations conducted concluded that giving responsibilities to

actors in the health system did have a positive impact on statebuilding, good governance and conflict transformation. In addition, it was noted that the absence of services could have been a source of conflict. The **Burundi** case study (Bruno Meessen, ITM Antwerp), was used to review how institutional arrangements of health systems and the (performance based) incentives they set are increasingly recognized as critical to promote or hinder performance in the health sector. An analytical framework was presented to look at complex health system interventions from an institutional perspective. The question is whether PBF is an optimal institutional arrangement in Burundi? The results indicate that it works well, but its contribution to conflict resolution is unclear. In **South Kivu, DRC** (AAP Sud Kivu, Pacifique Mushagalusa) the PBF approach was focused at the institutional level (level of regulators). The intervention helped clarify roles, making the role of government more clear and in keeping actors to their responsibility. In the **Central African Republic** (*Dr. Malam Issa Inoussa and Peter Bob Peerenboom, Cordaid)* an evaluation on the results of PBF in relation to a number of governance elements showed an overall positive contribution of PBF to the governance of the health system. It was debated whether this improved governance also implies that there has been a contribution to conflict transformation. The experience in CAR also showed that the separation of functions lead to a situation where service providers could stand up for their rights. This created conflict but also showed that the autonomy of facilities, that they took responsibility, claimed ownership and had a voice.

5. Pecha Kucha: refreshing ideas on evidence, advocacy, research and practice

Facilitator: Godelieve van Heteren, Rotterdam Global Health Initiative

In the Pecha Kucha presentations[2], presenters agreed that there is a relation between health systems and conflict transformation but that we need to be more precise about what this linkage is and how we want to address this in our interventions. Here as well, more and more questions kept emerging: What exactly are fragile states? Should we take a community/educational strengthening approach? Can we narrow down key terms and make labels more meaningful? What is exactly incorporated in the concept of health system?

5.1 Linking health system research with conflict resolution; the ReBuild experience

Suzanne Fustukian, Queen Margaret University

Suzanne Fustukian presented the findings of ReBuild, a multi-partner, multi-country, 6 year research program focused on health financing and human resources which aims to strengthen pro-poor health systems policy and practice in countries recovering from conflict. She introduced the DFID definition of fragile state as lacking both capacity and willingness, leading to authority failures, service failures and legitimacy failures. The research themes are health financing, incentives, contracting, rural posting, contracting and aid architecture, gender is a cross-cutting issue. Since the research runs from 2011-2017 it is too early to draw conclusions on the link between health system research and conflict resolution, and it was not a specific focus of the research but Suzanne Fustukian noted that this is something she will take back to the team. In discussion with the audience, the importance of the uptake of results was emphasised, and the engagement of policy makers throughout the research process. The new aspect of this study is that a critical mass is being created on the issue of conflict and health. There is enough substance to create a real 'discipline'

[2] Pecha Kucha presentations use a powerpoint format of 20 slides that run for 20 seconds each.

here in an academic sense. The challenges we are faced with raises interesting, important, and valuable issues that we really need to engage in. There is a securitization element to it that we can take advantage of.

5.2 International actors and political determinants of conflict and health

Remco van de Pas, Wemos Foundation

Remco van der Pas placed the discussion in the framework of international relations and social justice. Health and health equity intrinsically relate to the gap between rich and poor. He provided an example of West Papua, where he worked for Médecins du Monde on primary health care and particularly HIV/AIDS services. Besides logistical challenges like staff turn-over and the impact of the conflict there were some positive results, but the impact was low. The reason was that at the same time other factors played a major role; people were being displaced from their land through a forced migration program aimed at mining and plantations. The question in this case is thus whether we should work on formal health services from a health systems approach (through the building blocks), or consider a wider approach that looks more at the social determinants of health? Remco van de Pas argued for a 'right to health' approach which includes health care and underlying determinants of health.

In this light, it is also important to review the role of NGOs. Civil society is part of the 'extended state', power structures and political spheres and can influence the context in which we work. Van de Pas urged the participants to be more critical about who we are and what we represent. He also argued for the re-politicization of NGOs, they should take a political stance based on a human rights framework, and be more rooted in social movements. He noted that the context has an impact on the level of neutrality you can and may need to have as an NGO, but noted that neutrality also blocks us from addressing issues at stake—needs a political stance and links with movements, civil society to look towards social progression. Is it possible to address causes of conflict and address health systems? Who are we, what is our mandate? And what do we represent? Can we do something in our own 'home' societies? Within the health sector we could work on a culture of peace and protect the vulnerable. There are real divides that we are facing; such as the divide between the state (ie. military/police) and population.

> Remco van de Pas: *"It is high time to re-politicise NGOs."*

This idea is not new, the social justice movements already existed in the '80s, but this idea is not well taken up by the current generation. Neutrality can be worse than belligerence; for example in Darfur – neutrality was used by agents to 'keep the status quo' – a more political stance would have been needed. When do you do 'no harm'? In Papua we worked too long in a 'neutral' mode. It should be noted that there is a difference between 'neutrality' vs 'impartiality'.

5.3 Transitional justice, peacebuilding and health

Sylvia Servaes, Working Group on Development and Peace (FriEnt)/Misereor

Sylvia Servaes provided an overview of the different ways in which health and conflict connect. She emphasized that we need to make these links consciously, and that conflict transformation has to come in explicitly. Firstly she discussed health in post-conflict settings; including high mortality and injury, health infrastructure as a locus of violence, health system members as actors of violence, and discriminatory health policies from the past which affect people's health conditions in the present. These factors can contribute to mistrust in people and in institutions.

Secondly she focused on the relation between transitional justice and health. Health is a human right, and can play a role in tribunals. Truth commissions can bring out structural dimensions of violence and psychosocial dimensions of legacy of war. Trauma healing can be a way to provide reparations, and Truth Commissions have recommended health care services for victims of violence. There is also the issue of lustrations, which involves medical tribunals of personnel involved in violence.

Thirdly Sylvia Servaes discussed how health can be a bridge for peacebuilding, since the health sector is considered an ideal 'connector'. She discussed how health sector strengthening can contribute to building trust. The 'do no harm' approach reflects the idea that the health care sector can be a divider as well as a connector, it should not be assumed that health providers are natural connectors and that there is trust. For example, people go to health centres and see who is on call – maybe it is someone from 'the other side' and wait until the shift changes. Flipside is if 'other side' treats you well in an emergency, but this refound trust can be very volatile and may be destroyed again with a subsequent negative experience. There should be an assessment of where there is trust and where it needs to be build. In this respect it is important to consider what the role of the health system was in the pre-conflict and current context. For example, in Rwanda doctors and nurses participated in the genocide and targeted people in their health centers, but this differs per context.

Silvia Serveas:
"First step before conflict transformation: be more conflict and peacebuilding sensitive."

Lastly, some conclusions could be drawn regarding the link between health system strengthening and conflict transformation. Considering that health is a basic right for ALL people, how can we rebuild the health system? In order to do this we need to address the legacy of violence. You cannot run people through 'transitional justice' systems and tribunals without attending to mental health, and the awareness that medical personnel comes from certain parts of society. The main challenge in achieving this is that people and institutions often work in their own silos; it is difficult to get them to connect all the different links. From a peacebuilding point of view we have tried but not succeeded in establishing these links. Perhaps there are new opportunities for this considering the interest in this topic amongst health care providers. Health system strengthening can lead to conflict transformation if it is done in a conflict sensitive manner.

5.4 Health systems evidence and guidance in fragile states

Xavier Bosch-Capblanch, Swiss Tropical and Public Health Institute and Claire Allen, Evidence Aid

Xavier Bosch-Capblanch presented, also on behalf of Claire Allen, on the importance of evidence and guidance in fragile states, and the challenges around this. Essentially this is about using information to make decisions in certain situations on what is a 'better' alternative, for example more cost-effective. Xavier Bosch-Capblanch argued that the best evidence is from systematic reviews. Similarly to the way clinicians have created guidelines based on this evidence, Swiss TPH and Evidence Aid have created a framework to do essentially the same for health systems and in fragile states and are in the process of developing a handbook on this. Making the evidence accessible is not just about formatting findings in a nice way but also about the methods selected. There are a number of challenges in providing health systems guidance. (1) The types of evidence available; not everything is researchable. Research evidence answers questions, while decision makers need advice on how to address problems. (2) The quality of evidence is often of poor; however, this does not mean that it is dismissible or that no recommendations can be formulated. (3) Timeliness of evidence as policy and research agendas are not synchronized; it takes years to produce evidence while decision making windows are short 4) The health systems settings are very country specific

and unpredictable 5) The context, particularly in fragile states, is difficult to capture and beyond the control of research and decision making.

Evidence Aid started in 2010, prior to that it has done needs assessments, conducted a screening of Cochrane reviews and convened a number of conferences on this topic. The research concluded that of the 5074 Cochrane systematic reviews only a few hundred had relevance in emergency settings, an example of a study with priority is a study on damage control surgery for abdominal pain.

Xavier Bosch-Capblanch concluded by summarizing that research evidence is not sufficient to inform decisions but nevertheless important. He also noted that the production of guidance (a body of knowledge based on evidence) needed to inform decisions poses several methodological challenges, which are especially severe when the issue is health systems and the context is a fragile state. EvidenceAid is a step forward in producing research evidence relevant to crisis situations, while further efforts need to be articulated around methodological approaches involving relevant stakeholders.

Afterwards, there was a discussion on the use of systematic reviews. In the social sciences, we use mixed methods, and have different disciplinary perspectives on what is 'evidence'. There may be other ways to address the questions. A distinction was make between doing reviews systematically rather than the formal methods of a systematic review and the Cochrane review.

5.5 Mental health & psychosocial interventions are essential in conflict transformation

Willem van der Put, HealthNet TPO

Conflict affects mental health, for example through post-traumatic stress disorder. HealthNetTPO works on mental health and psychosocial care in a way that is anchored in the health system. It uses a dual approach of (1) mental health including clinical integration in the health system and psycho-social outreach, as well as (2) community systems strengthening, which addresses the consequences of war and violence and social determinants of health. These two streams inform and strengthen each other and each is important. HealthNetTPO has been testing interventions at the level of individual illness, group and society. Willem van der Put provided some examples on this. In Afghanistan for example, establishing women's groups, through the social interactions at village level, helped to decrease early marriage. Experience in Burundi showed that social therapy was more effective to talk about problems in the past, rather than at the individual level.

> Willem van der Put: "*Community system strengthening leads to improved mental health and conflict transformation.*"

Health provides an opportunity to discuss conflict transformation because everyone agrees that it is an important goal. This can only be achieved if people work together and it allows people to refocus on positive rather than negative things. It also puts the locus of control back into communities by building health facilities in the communities even in oppressive times.

Psychosocial support is needed to transform the conflict, considering that behavior change requires good mental health. This broadens the concept of what a health intervention is, and has implications for the required skills of health staff.

Van der Put emphasized the importance of self-reliance and ownership. Funding does not solve the issues, it is key that people take responsibility for their own system, local people need control for example through health cooperatives. The only thing you can do as an outsider is to help people

reflect on their own situation so that they can take action, make decisions, and demand the resources they need.

Discussion

Part of the discussion focused on the analytical framework and defining key concepts; can we narrow down key terms and make labels more meaningful? This could help to create focus and synergy around the issue. (1) The presentations triggered a discussion on what the health system actually is, since people use it differently and look at it from different perspectives. To what extend does it include addressing the social determinants of health? Should we take a community strengthening and/or educational approach? What is the relationship between the health system and the context? Can we create models? Others noted we should not pin ourselves too much on what a health system is since it can be different per context/country. (2) The concept of fragile states was also discussed. It was noted that some states are not fragile in terms of capacity, but have a lack of willingness to focus on public service provision. The boundary between post-conflict state and fragility is also porous, for example the case of Sri Lanka. It was debated whether the label 'fragile', rather than 'unjust', this qualification moves us away from taking a clear political stance. Some argued this implies accepting the situation and a state of conflict, while others noted that conflicts have become more complex and that fragile is a more honest (in terms of what we are able to do) assessment of the situation.

The political dimension of health interventions in fragile states was emphasized. Fragile states are politicized from the outside. At the same time, some organizations work on health system building with a technical mindset and try to avoid politics. However, structural inequalities and the exclusion of certain populations play an important role in fragile states, and contribute to violence. We are all part of a long-running history of war. When you are working in a health system you are asked to take a particular position and take part in the discourse of the time. There are a lot of institutional agendas, we should be looking at others working on the same cause and look beyond our institutional flags and logos, and break out of our narrow institutional approach. It was argued that we should redefine human security to incorporate health in order to attract more attention and funding; fragile states can be sources of disease also such as bird flu epidemics.

6. Final discussion: implications for action

Facilitators: Nicolaus Lorenz, President MMI and Bruno Meessen, Assistant Professor, Unit of Health Financing, Institute for Tropical Medicine Antwerp

The final discussion was introduced by Nicolaus Lorenz and Bruno Meessen. They discussed two key questions with the audience; 'Do you believe that health system strengthening can contribute to conflict transformation?' and 'What are the ways forward'.

Can health system strengthening contribute to conflict transformation?

During the day, a lot of anecdotal or "intuitive" evidence was presented that health system strengthening contributes to conflict transformation, but, Nicolaus argued, we need to build the evidence on this to get a deeper understanding the possible pathways through which this can occur. The discussions during the day for many led to new ideas and insights and also opened up a whole set of new questions. The assessment of the audience was mixed between the believers and the skeptics. It was noted that it is important to be humble, difficult as it may be for medical practitioners, acknowledge the complexity of the situation and realize that there are really no quick

solutions. It is a complex matter that needs sufficient time, and multi-sectoral collaboration, which is also something funding agencies might not like to hear. It was also argued that health actors have a responsibility to engage in conflict transformation when working in a conflict context, since it cannot be left to other actors such as Ministries of Defense that have a very specific political agenda.
The participants mentioned a number of examples that illustrate **under which conditions they believe the health system can contribute to health system strengthening:**

- If we use a community based approach: it is a matter about how we approach health system strengthening. There are examples of health systems interventions and community based health care, e.g. in Darfur in which the situation stabilized and provided the negotiation skills that helped community members to resolve conflicts.
- If we use a multi-sectoral approach and get out of our silos: this is more complex but may yield more than technical health interventions.
- If we reflect on our own role and responsibility as practitioners and organisations within the global system, and think creatively and innovatively about how to solve each problem, rather than being fixated on predefined approaches based on the silo's we have created for ourselves.
- If we remain reflective and aware of the context we work in (do no harm, be conflict sensitive), and our intentions (political agenda's/neutrality) to avoid potential traps.
- If we focus on the how of doing health systems strengthening; so not just the result but the process, the how, when and whom. In this way health system strengthening will be embedded in the context and can find its value and reason in shaping it as a human rights perspective and integrating marginalized communities that may increase/decrease conflict.
- If we use mechanisms such as performance based financing and acknowledge that in itself will naturally not bring peace directly, but that such mechanisms can contribute to intersectoral communications and improved governance.
- If governments and donors can be brought on board with the idea that investing in health in fragile states is a good investment. Fragile states are the place where the interventions are most needed but least implemented. Donors often blame the national governments, while they should judge their own instruments and increase transparency.

It was acknowledged that there are many **limitations** to health system strengthening as an approach to conflict resolution. Some examples and arguments that were provided in response to the above:

- It is not clear whether the interventions we have seen which influence social dynamics at a community level are influencing the conflict also at a larger scale, the evidence base is still limited.
- The health systems as a whole can only have a limited impact; to address conflict transformation the actors that are of key importance are politicians and other leaders with their political agendas.

What are ways forward?

Clarify the objectives: there are normative choices to be made, what do we want to achieve? Is it necessary for health systems strengthening to contribute to conflict transformation, or is it important to see it as a goal on its own? How do we prioritize health and conflict transformation

objectives? Can health interventions be done adequately without being conflict sensitive? This may differ per society and there are certain tradeoffs and political implications. Health system strengthening is a means to get away from vertical approaches, but it should not forget the population and the context by focusing too much on the system.

Clarify key concepts: From an academic perspective it would be useful to strengthen the vocabulary and explain what these words mean. Concepts are important – how do we define fragile states, institutions, health systems, conflict transformation – we do need to be more precise. What is included in the health system? For example it was argued that we should address the wider determinants of health such as poverty since those have a large impact on health. There are other frameworks than the WHO six building blocks that could be used for this.

Collaboration & coordination with other stakeholders: We should act rather than discuss too much, and involve key stakeholders including political agencies within governments who provide funds in this area. We need a joined-up debate with other sectors (i.e. military or peacebuilding actors) and all perspectives taken into account. In many fragile states there is a lack of coordination. There should be a score-card for fragile states that scores donors and practitioners.

Increase visibility and networking: We need to increase visibility of all these topics (fragile states, health systems strengthening, conflict transformation) and we can gather and give continuity to this initiative – such as a working group where we can put in black and white these ideas. There should be more networks and consortia trying to do this. The Health and Fragile States Network[3] was referred to as a current highly relevant, open network in this regard.

Develop a framework and 'measure' conflict transformation: We need to address more the 'cultural divide'. Let's develop a common framework, we need a map to move forward (link, processes and steps) and identify what needs to be done (state building, conflict resolution) – it also needs to help us bring back humility, by saying we work only on a small aspect and that there are more determinants that need to be addressed.

The need to have a closer look at health programmes that address health systems strengthening to evaluate whether they indeed contribute to conflict resolution was widely shared. It would be useful to develop a method and measure to assess conflict transformation and attribution. It was acknowledged that this will be a complicated task considering the many confounding factors.

- Another related research need would be to study the 'impact of intention'; if actors intend to contribute to conflict transformation, how does this affect their choices in how, where, for whom you will choose to do health systems strengthening? This may negatively or positively affect what a health system is supposed to do otherwise. A related aspect of this will be to look at how NGOs are perceived by the local population if they have an intention of contributing to conflict transformation.
- It would also be useful to study interventions in more depth to look at commonalities, differences and what can be learned, the case studies presented showed that much more can be learned in this sense than is obvious at first sight. The causal relationships between the health system and conflict are currently unclear, this needs to be further studied.
- Dynamics; we can look at the future but also look at past experiences, thus the research should be both retrospective and prospective.

[3] To become member of the Health and Fragile States Network and to be part of its mailinglist, simply send an email to healthfragilestates@gmail.com

- Indicators; some are better at capturing vulnerability (i.e. insecurity could be reflected by ANC attendance). An interesting metric could be something that measures people's reflectivity on their own situation and agency; considered major objectives of community strengthening initiatives.

Bruno Meessen provided some concluding remarks regarding the discussion. He emphasized that more research is needed, and this definitely encompasses more and better frameworks. Frameworks may help us to identify issues to address; to highlight normative choices; understand links, processes, and steps. Frameworks will also help us to identify the way forward for operational and policy actors; and, last but not least, they help us realize that our intervention may addresses only one determinant, one link, one outcome. In addition, as Nicolaus mentioned building the evidence base and developing a common framework can help to make interventions conflict-sensitive without compromising the main goal of health system strengthening – the improved provision of health services. He concluded with "Thus, can we kill two birds with one stone? Probably. This expert meeting is only a first step in getting a more conclusive answer to this question."

7. Closure

Henri van Eeghen, Director, Cordaid

Cordaid made a decision one year ago to have at least 70% of our work in fragile contexts, this is both daunting and exciting. We expanded our definition of fragile state to include the community level, and it is good to see reflections of how the community level is being involved in the presentations and discussion today. At Cordaid, we want to contribute to building flourishing communities. We need to look carefully at a systemic approach which is daunting. Donors are asking about impact and single-minded results but in the field, you realize how systemic everything is. The challenge for the academics is to simplify these things. We would like to try to publish the results of today and contribute to creating a body of knowledge on this issue.

We need a deeper understanding of health as an instrument of change. We need more case studies of health in conflict areas, and how interventions affect conflict and the lives of community members. We also need more operational research, looking at dilemma's on 3D, working with military, what our own role as an NGO is. The research that we do needs to be seen as a resource by the practitioners, and to balance the line between being to specific or too general. We need to expand our body of knowledge, including spreading it more geographically. Incorporating the French speaking world is an important challenge in this regard. We would like to strengthen the platform and maybe move it up to a higher level. There are many unresolved questions. We would like to organize an event again next year with MMI members and interested NGOs and academic institutions increase knowledge and sharing like we had today.

> Henri van Eeghen:
> *"Cordaid would like to continue learning and sharing on health system strengthening and conflict transformation, and take this journey with MMI members."*

Annex I: Media

Furthermore, the Expert Meeting on Health System Strengthening and Conflict Transformation was reported in several media;

- Editorial MMI Newsletter October 2012, Jennie van der Weerd, Cordaid
- Blog Bruno Meessen; Health systems strengthening and conflict transformation in fragile states: Catching two birds with one stone? 24 October 2012
- De Volkskrant: 'Eerst resultaat, daarna pas afrekenen', Carlijne Vos, 17-10-2012

Annex II: MEETING PROGRAMME

Health Systems Strengthening and Conflict Transformation in Fragile States

Amsterdam, 11 October 2012

Chair: **Nicolaus Lorenz**
President Medicus Mundi International Network

08.45 – 09.15 **Registration**

09.15 – 9.30 **Opening**
René Grotenhuis, General Director, Cordaid

9.30 – 9.45 **Introduction: Health system strengthening and conflict transformation in fragile states**
Egbert Sondorp, Senior Advisor, Royal Tropical Institute

9.45 – 10.15 **Keynote speaker: how can delivering basic services lead to conflict transformation?**
Rachel Slater, Overseas Development Institute & Research Director
Secure Livelihoods Research Consortium

10.15 – 10.30 *Break*

10.30 – 12.30 **Parallel working groups on country case studies**

- Community and district level interventions
- National health systems
- Performance based financing (language: French)

12.30 – 13.30 **Lunch – Poster session**

13.30 – 14.00 **Report back working groups**

14.00 – 15.45 **Pecha Kucha: refreshing ideas on evidence, advocacy, research and practice**
Facilitator: Godelieve van Heteren, Rotterdam Global Health Initiative

- Linking health system research with conflict resolution – the ReBuild experience
  Suzanne Fustukian, Queen Margaret University
- International actors and political determinants of conflict and health
  Remco van de Pas, Wemos Foundation
- Transitional justice, peacebuilding and health
  Sylvia Servaes, Working Group on Development and Peace (FriEnt)/Misereor
- Health systems evidence and guidance in fragile states
  Xavier Bosch-Capblanch, Swiss Tropical and Public Health Institute and Claire Allen, Evidence Aid
- Mental health interventions and conflict transformation
  Willem van der Put, HealthNetTPO

15.45 – 16.00 *Break*

16.00 – 17.00 **Plenary discussion: implications for action**
Facilitators: Nicolaus Lorenz, President MMI and Bruno Meessen, Assistant Professor, Unit of Health Financing, Institute for Tropical Medicine Antwerp

17.00 – 17.15 **Closure**
Henri van Eeghen, Director, Cordaid

17.15 **Reception**

ANNEX III: CASE STUDIES PRESENTED IN WORKING GROUPS

Health Systems Strengthening and Conflict Transformation in Fragile States

Amsterdam, 11 October 2012

Performance based financing *(in french)*

1. Contribution du programme de financement basé sur la performance au renforcement du système de santé dans un contexte de conflit (RDC)
   AAP Sud Kivu, Pacifique Mushagalusa
2. Applying an institutional economic framework to the analysis of two performance based finance schemes in Burundi
   ITM Antwerp, Bruno Meessen
3. Renforcement de l'autorité de l'état basé sur l'achat de performances dans un contexte de conflit
   Cordaid, Michel Zabiti
4. Le financement basé sur la performance et la bonne gouvernance: Leçons apprises en République Centrafricaine
   Cordaid, Peter Bob Peerenboom and Dr. Malam Issa Inoussa

Community and district level interventions

1. Uruzgan: basic health care and conflict transformation (Afghanistan)
   Cordaid-Kabul, Jain Holsheimer
2. Topping up salaries of civil servants in fragile context - Tajikistan case study
   SwissTPH, Joao Costa
3. Health system strengthening in district Battagram, Pakistan (2008-2011)
   Save the Children, Zaeem Ul Haq
4. Health system strengthening and conflict transformation in fragile states: Memisa's flexible approach to a changing context in Ituri, DRC
   Memisa, Elies van Belle

National health systems

1. The role of better pay and active staff management to deliver and sustain free health care in Sierra Leone
   Charlie Goldsmith Associates, Erin Chu
2. A coordinated township approach to health service delivery – using opportunities to support the health system in Myanmar in the aftermath of Cyclone Nargis
   Merlin, Paul Sender
3. Strengthening the policy implementation gap – federal working relationships in the Nigerian health sector
   Health Partners International, Andrew McKenzie

Documentation including case studies and other contributions: www.bit.ly/mmi-amsterdam2012 (MMI).

Accepted case studies not presented in working groups

The following case studies were selected but the authors were unable to attend the meeting due to a variety of reasons. They are available on www.bit.ly/mmi-amsterdam2012.

1. Analyse de la problematique de l'access aux soins en RDC et la question de la perennite du financement de secteur de la sante
   MDF, Nzotsi Paluku

2. Nation building and community based health service delivery, Timor Leste
   *USAID, Tanya Wells Brown (presented as **poster**)*

3. Building a national HIMS: Investing in Systems, South Sudan
   Liverpool School of Tropical Medicine, Mo Ali & Carmen Camino

4. Strengthening top-down and bottom-up accountability: the view from Aceh, Indonesia
   Broad Branch Associates, Lindsay Morgan

5. "Building Back Better? Health System Reconstruction and Gender Equity*".*
   Val Percival, NPSIA/Carleton University; Tammy Maclean, LSHTM; Esther Richards, REBUILD, LSTM; Sally Theobald, REBUILD, LSTM; Justine Namakula, REBUILD, Makerere University; Sarah Ssali, REBUILD, Makerere University; Francelina Romão, Mozambique Ministry of Health; Joseph Edem-Hotah, REBUILD, College of Medicine and Allied Health Sciences. (*presented as **poster***)

ANNEX IV: PARTICIPANT LIST

Last Name	First Name	Job Title	Organisation
Abdelwadoud	Moaz	MPH student	Royal Tropical Institute
Afolabi	Sadia	Student	Sciences Po
Arrundale	Rachel	Policy and Advocacy Manager	International Medical Corps UK
Atzori	Andrea		DWA Caumm
Bosch-Capblanch	Xavier	Group Leader Systems Support Unit	Swiss THP
Broek	Ankie, v.d	Senior Advisor	Royal Tropical Institute
Brouwer	Emmaline	Project Manager	SHE Collaborates, Maastricht University
Brown	George	ICHD 2012-2013	Royal Tropical Institute
Chu	Erin	Associate	Charlie Goldsmith Associates
Chwarscianek	Dagna	Volunteer	Redemptoris Missio
Costa	Joao	Health Economist	Swiss Tropical and Public Health Institute
Coppers	Katrien		MSF
Das	Utpal	Student 49th ICHD/MPH batch	Royal Tropical Institute
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De Vries	Cristina		Cordaid
Depoortere	Evelyn	Policy support	Institute of Tropical Medicine
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Fadul	Selma	MPH student	Royal Tropical Institute
Furlan	Stefano	Student	Sciences Po
Fustukian	Suzanne	Senior Lecturer	Institute for International Health and Development, Queen Margaret University
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Groothof	Desi		I+solutions
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Horstman	Ronald	Advisor	Public Health Conslutants
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Kivela	Jari	Health Economics, MSc	Qalys Health Economics
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Kok	Peter	public health consultant	kokphc
Lorenz	Nicolaus	President MMI	MM Switzerland
Love	Julie	Programme Officer	Cordaid

Last Name	First Name	Job Title	Organisation
Malanda	Belma	Facilitator - Community of Practice on Health Serv	Institute of Tropical Medicine of Antwerp - HHA Initiative
Mans	Linda	global health advocate	Wemos
McFarlan	Helen		Rebuild
Mckenzie	Andrew	Dr	Health Partners International
Mediano	Carlos	Dr	Medicusmundi spain
Meessen	Bruno	Researcher	Institute of Tropical Medicine
Meesters	Kenny	Consultant	UN OCHA / Tilburg University
Meeus	Wilma	Consultant in International Public Health	Independent
Moran	Nicole	MIH Student	Swiss TPH
Mushagalusha	Pacifique		AAP Sud Kivu
Mwami	Francis	Psychomotor therapist	Emoverder
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Peterhans	Bernadette	Course Coordinator / Project Leader	Swiss Tropical and Public Health Insitute
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Philips	MIT	Health Policy Advisor	MSF
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Seco	Gerard	Analyst and Advocacy Advisor	MSF - OCB
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Tedla	Shushan	Pharmacist	Action Medeor
Teeuwen	Rina		MSF
ter Veen	Annemarie	Senior Advisor	Royal Tropical Institute
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Tummers	Johanneke	Arts	Rode Kruis

Last Name	First Name	Job Title	Organisation
Urwantzoff	Dr. Nina	MD- MPH	MISEREOR e.V.
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van de Pas	Remco	global health advocate	Wemos
van den Berg	Yme	Senior advisor Public Health	Royal Tropical Institute
van der Put	Willem	Director External Affairs	HealthNet TPO
van der Weerd	Jennie	Policy Officer	Cordaid
van der Wijk	Jannes	Trainer Consultant	MDF Afrique Centrale
van Eeghen	Henri	Director	Cordaid
van Heteren	Godelieve		Rotterdam Global Health Initiative
van Mierlo	Bibiane	Technical Advisor	HealthNetTPO
van der Linde	Ada		HealthNetTPO
van der Veen	Remco	Manager	Cordaid
Vos	Karlijne		Volkskrant
Vroeg	Piet	Program Officer	Cordaid
Wiegand	Andreas	Program officer product development and strategic	Ecumenical Pharmaceutical Network
Wulf	Andreas	Medical Project Coordinator	medico international
Zabiti	Michel		Cordaid - DRC
Ickx	Paul	Sr. Principal Technical Advisor	Management Sciences for Health
Marolla	Lorenzo	Student	Sciences Po

Total 90 participants