The role of non-state actors in health systems resilience: using and developing their capacities

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ReBUILD FOR RESILIENCE

Key Messages

1. Non-state actors play an increased and important role in service provision and as connectors between health systems and communities in fragile and shock-prone settings, when the state is weaker, less trusted and, in some cases, absent or contested. They are key components in resilient health systems.
2. Public policies often under-acknowledge their roles. Policies to support their contributions need to start from acknowledgement, acceptance and a willingness to maximise their positive role, while mitigating risks, such as duplication of effort and lack of coordination with policy priorities.
3. Non-state actors are varied in make-up and are context-dependent, so awareness of their roles, positions, capacities and limitations is key. Policymakers should ensure they start from a good understanding of organisations, their relationships, and local power and political dynamics, using participatory tools like power mapping.
4. Local leaders, including traditional and informal leaders representing different constituencies, are a key resource for engaging communities, including in crises. Structures for working with them and keeping them informed on an ongoing basis are critical.
5. Informal providers constitute diverse networks, often with wide reach which can help to expand service coverage. While they present regulatory challenges, building collaborative relationships with them to provide training and deliver community mobilisation, distribution of goods and information sharing can provide important dividends.
6. For trained but unlicensed health staff, addressing legal barriers to employment is important (e.g. for refugee health staff in Lebanon), while practical support for internally-displaced staff, such as in Myanmar, can help maintain their contribution and skills.
7. The private for-profit sector can make substantial contributions to management of crises in many settings. This is aided by having clear regulatory structures, coordination and engagement platforms and partnership frameworks which recognise the capacities and complementarities of different actors and sectors. Coordination mechanisms need good intelligence as patterns of usage and capacities (e.g. staffing) can change rapidly during shocks.
8. Local NGOs and CSOs have demonstrated resilience capacities and great reach to remote communities and areas, including during shocks, but are also vulnerable to funding cycles and their dependence on external finance. Platforms to ensure mapping of community actors and to support development of their capacities, collaboration and long-term funding can be helpful, but require sensitivity in contested areas.

Background

During and after shocks and crises, health and wider public systems come under immense pressure in the response, recovery, and reconstruction phases, as well as in preparing for future shocks. Resilience in these contexts often requires non-state actors to take on significant roles, beyond those needed in more stable contexts.

Non-state actors take many forms, including community leaders, informal healthcare providers, the private commercial sector, local non-governmental organisations (NGOs) and civil society organisations (CSOs). They play very different roles and bring diverse strengths to areas of need. However, the ways in which they are supported to engage during shocks and crises, and to work together (or not), will be key to their resilience.

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In this brief, we draw lessons from ReBUILD for Resilience research sites in Lebanon, Myanmar, Nepal, and Sierra Leone, and from wider thematic research. We provide lessons on how to enhance the roles and resilience capacities of domestic non-state actors to support equitable healthcare delivery in fragile and shock-prone settings. In doing so, we build on previous ReBUILD work.

Community leaders

In all four partner countries, community leaders play a significant role in connecting communities to formal systems; engaging them, supporting community resilience capacities and influencing health behaviours and local decision making.

ReBUILD brought together community leaders in **Sierra Leone** to raise health awareness and act on health concerns in the community. Traditional leaders representing different constituencies have taken ownership of collaborative fora where community health issues are discussed and acted on, with minimal reliance on the strained health system. Their contributions highlight the critical need for health systems to learn from and integrate the strengths of these leaders to promote equitable healthcare within communities.

Individual uncoordinated health-related initiatives were being undertaken in the ReBUILD learning site in Majdal Anjar municipality, **Lebanon**. As part of efforts to establish a municipal health committee and so improve health service coordination, community members, including religious leaders, were engaged, along with local NGOs and INGOs. Careful facilitation and close mentoring built trust and balanced power dynamics within the committee, creating open communication and enhancing the health committee's ability to serve the whole community's healthcare needs through numerous coordinated initiatives.

Traditional and political (state) roles may be combined by non-state actors, as was the case in **Myanmar,** where traditional village leaders took on a political roles. After the military coup of 2021 and the breakdown in central control, the role of local actors, including village and religious leaders, was magnified, particularly in areas far from government army camps. In response, communities mobilised and found innovative solutions, including deploying volunteers, such as auxiliary midwives and community health workers, to provide essential services during the pandemic. The experience highlights the importance of acknowledging the role of local leaders during crises and engaging them in preparatory training and communications.

In Lumbini province, **Nepal,** we saw the potential of collective action across local state and non-state actors during shocks. Local municipality officials, who have been responsible for basic health service delivery since federalisation in the country, formed Rapid Response Teams to coordinate efforts with community leaders and other sectoral actors during COVID-19.

A mothers' group, Lumbini province, Nepal.

Informal providers

Informal healthcare providers play a role in all partner settings, although their backgrounds and services vary considerably. In **Lebanon,** Syrian health professionals, who are not registered to work in the Lebanese health system, work informally. The resultant lack of legal protection, as well as stigma and discrimination from the host community, present numerous challenges. ReBUILD facilitated support groups to empower and improve the working conditions of women working in the informal sector.

In **Sierra Leone,** the informal sector is very diverse, including traditional healers, herbalists, religious and spiritual leaders, traditional birth attendants (TBAs), and drug peddlers. Some are seen by the public as being valued parts of the health system, while others, like drug peddlers, are shunned by authorities as untrained and unregulated. Knowledge of their work by the authorities and effective tools to influence and regulate them are lacking in practice for all of these providers.

Myanmar also has a diverse informal provider sector, including TBAs, religious healers, and small drug shops which are found across the country. The current crisis in the country has prompted skilled health workers to move to border areas where they work informally with financial and technical support from the diaspora.

In **Nepal,** traditional healers are part of the local community and play an active role in the informal healthcare system. This is especially the case in the Terai areas, where traditional healers diagnose, inject, prescribe, and provide care for communities, using skills learned on the job. They operate within the HERD International research site in Lumbini province but also cross the border into India. They are enabled by the absence of a strong primary care system and policies to control their activities, as well as strong, trusting relationships within their communities, religious values, access, and mobility.

In all of our contexts we see that policies should be tailored to specific groups and challenges, but must include building the local primary healthcare system alongside fostering collaborative relationships with informal providers, using their strengths while mitigating the risks inherent in their practices. The informal sector might be trained and used for community mobilisation and the distribution of goods and information. For example, in Kachin and Karin States, **Myanmar,** there are many skilled civil disobedience movement staff who fled to the border areas for security reasons and are now coordinating to provide training and medical care.

For trained but unlicensed health staff, addressing legal barriers to employment is important, e.g. in Lebanon, where Syrian health staff who have been displaced are not able to practice. Practical support for internally displaced staff, such as in Myanmar, can help maintain their contribution and skills (e.g. through ongoing training and provision of equipment).

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Private commercial sector

The private for-profit sector is substantial in all four settings, but knowledge of how best to govern it remains very limited. In **Myanmar,** qualified private nurses and doctors offer services across the country, from villages to urban areas, with relatively low-cost care at village level. They are more skilled than informal practitioners and were able to continue offering care during crises. In urban areas, they run small clinics in townships and work in bigger private hospitals, alongside private pharmacies. Their role is large but not captured in national or local health information datasets and regulatory controls on them are weak, leading to irrational prescribing and easy access to antibiotics for patients, increasing risks of antimicrobial resistance. However, with better governance oversight by national and local authorities, the private for-profit sector could make an important

contribution in crisis responses. This was demonstrated in the response to COVID-19, where private labs and equipment were used. However, after the coup, stability and trust between non-state actors and the new government declined, damaging this cooperation.

Use of the private sector (including foreign-run provider chains) increased after the coup due to distrust in government facilities and falling staffing rates. However, this was only affordable for richer households, with poorer families forced to continue using public facilities. Public hospitals have faced high usage while losing staff to the civil disobedience movement.

In **Lebanon,** the private for-profit sector (mainly dispensaries and hospitals) is widespread but costly. With the economic and other crises, the private sector has been relatively better able to retain staff (compared to the public sector), and prices have risen. This in turn has boosted use of pharmacies, which are more affordable and provide a large range of over-the-counter medicines, raising the need for clear and enforced directives in this area.

In contrast, in lower income countries, such as **Sierra Leone,** the private commercial sector tends to be focused in urban areas, where their services can be afforded, and the public and private not-for-profit sectors (see below) have been more dominant in providing services in rural areas and in responding to crises.

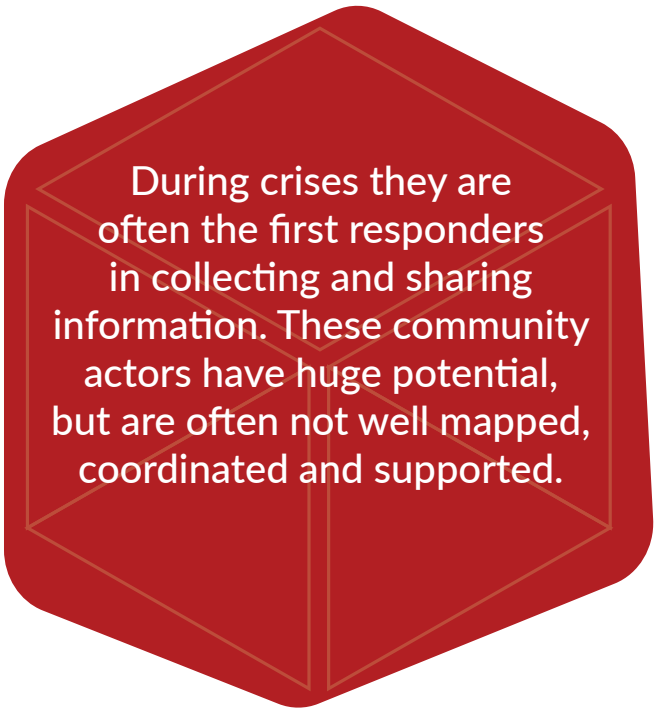
In many settings, such as **Nepal,** there are tensions between public and private healthcare sectors, with mutual distrust creating barriers to cooperation and partnerships, particularly during crises. Such phenomenon was evident during the early stage of COVID-19. The government resisted bringing the private sector on board, with the mindset that they would be making a profit, which was a loss of opportunity for the country. As the pandemic unfolded, it became clear that the government lacked resources to tackle the challenge and gradually the private sector was brought in to support critical areas where it had strengths (e.g. testing and rapid procurement). A partnership framework for cooperation in crises based on mutual strengths would have helped in preparation for the pandemic. Beyond crises, Nepal's health systems landscape reflects broader challenges in public and private partnership and collaboration. Private healthcare providers play a significant role in healthcare, yet are largely uncaptured and unregulated, operating with limited information and service linkages with public health systems at all levels of government.

Moyamba District Stakeholder Group and the ReBUILD for Resilience team in Sierra Leone.

Non-governmental organisations (NGOs) and civil society organisations (CSOs)

The local NGO sector is very varied across the four settings, with some well-established NGOs and CSOs with deep local roots providing important sources of healthcare during crises, while in other settings, NGOs have sprung up opportunistically in response to international funding (e.g. during Ebola in **Sierra Leone**) only to wither when that support diminished.

NGOs often complement public service delivery roles, including in remote areas, and can also demand accountability and amplify community voices. However, dependence on short-term funding is a common challenge, and NGOs often work in siloes, not integrated into national plans, and instead primarily accountable to funders, which may be external. Ensuring effective platforms for coordination and data sharing are priorities for enhancing their ability to contribute to health systems resilience.



Federalisation in countries like **Nepal** has created more space for NGOs to operate, with NGOs also taking on mandated roles for activities like social audits (carried out annually with communities, the health facility management committees and municipalities to hold stakeholders to account) and community awareness-raising. They are also potentially benefiting from international funder localisation agendas, which increase resources for local NGOs. Some organisations are part of the state-mandated community health system, blurring state/non-state boundaries (such as the Health Mothers Groups, which are supported by Female Community Health Volunteers and coordinated by community leaders). During crises they are often the first responders in collecting and sharing information. These community actors have huge potential, but are often not well mapped, coordinated and supported.

Local NGOs remain financially dependent on external finance, though they do receive some government support, which is limited in scale. Some are funded from global health initiatives, such as the Global Fund for AIDS, Tb and Malaria, but these tend to be larger NGOs, which can manage the requirements and risks of these contracts.

In **Myanmar,** NGOs, including ethnic health organisations, have been critical to continued healthcare delivery during periods of contestation and conflict, as is now the case again. Non-state actors have shown resilience capacities, such as flexibility and adaptability in organising service delivery, supply chains, funding, communication and monitoring systems, as well as health worker management, grounded in their experiences during previous crises. They have received support from INGOs and external funders, but many have managed to continue working for the community even when disconnected from these sources during crises. Building their capacity and strengthening local level governance to include them is therefore essential to resilience, though this is challenging due to their small size.

In **Lebanon,** local NGOs have been established opportunistically to take advantage of external finance during periods of attention, but many become inactive when that funding dwindles, creating cycles of boom and bust. This is also evidenced by health centres and dispensaries set up with overseas funds, but without any local controls or mapping to local needs. Many organisations are religious and political, catering to particular constituencies and with powerful links in the community, but not serving the community as a whole. Local coordination of their establishment and focus areas would help to ensure that they are making better use of funds and focusing on unmet needs in an equitable and sustainable manner.

Protracted emergency and disputed government contexts

In settings where state legitimacy is contested and government control only extends to some areas of the country, the whole state/non-state distinction becomes much less clear, as was the case in **Syria** during the civil war. In protracted crises, NGOs and INGOs can come to play a 'public' role, providing services at low or no cost and focusing on essential and preventive healthcare, while the private sector may focus on curative care for those able to pay, filling gaps, e.g. in relation to laboratory services. Long-term challenges include maintaining an appropriate staff mix and training, as well as regulation of quality in the private sector and affordability for poorer households.

The contracting of NGOs to provide health services over a long period in **Afghanistan** illustrates the importance of these actors in providing essential services and ensuring resilience during crises, and the importance of understanding how purchasing arrangements affect their capacities and sustainability. ReBUILD briefs on health systems across borders and on health systems strengthening discuss these themes in more depth.

A female community health volunteer training a women's group on nutrition using resources developed by HERD International, Nepal.

References

This brief is based on Witter, S., Khalil, J., Than, K., Idriss, A., Moussallem, M., Kamara, H., Baral, S. (2025) The role of non-state actors in health system resilience: using and developing their capacities. Under revision for *Social Science and Medicine, Health Systems* (special edition).

Health education being provided by non-states actors in Myanmar during the COVID-19 pandemic.

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Cover image: Syrian, close-to-community health workers in Lebanon