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Report on QoG/Lancet Policy Day:

Policy Pathways to Sustainable Well-Being and Peace through Investments in Institutional Quality, Health Equity and Gender Equality under Crisis and Conflict.

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With contributions from:

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Report on QoG/Lancet Policy Day: Policy Pathways to Sustainable Well-Being and Peace through Investments in Institutional Quality, Health Equity and Gender Equality under Crisis and Conflict[1]

On November 26th, 2024, under the organizational leadership of Amy Alexander (Assoc. Prof. University of Gothenburg), Sara Causevic (Postdoctoral Fellow, Stockholm University) and Peter Friberg (Prof. University of Gothenburg and Co-Chair of the Lancet Commission), the Quality of Government Institute together with the Lancet Commission on *Peaceful Societies through Health Equity and Gender Equality* (Percival et al. 2023) held a Policy Day that brought together practitioners and academics to build on the work of the Commission under the perspective of "policy pathways to sustainable well-being and peace through investments in institutional quality, health equity and gender equality under crisis and conflict".

As presented by Commissioners Alexander and Causevic in the opening session of the Policy Day, the Lancet Commission was launched to understand the interaction between Sustainable Development Goals 3 on good health and well-being, 5 on gender equality and 16 on Peace, Justice and Institutions. The Commission examined - Can improved health equity and gender equality contribute to more peaceful societies? If so, how? The goals were to establish an empirical foundation for the relationship between health equity, gender equality, and peace, and to contribute to international global policy development by providing practical and actionable guidance and recommendations to communities, civil society groups, states, international institutions, academics and philanthropists. The Commission's report ultimately asks if gender equality, health equity, and peace are mutually reinforcing and how investments in gender equality and health equity lead to peace. In answering those questions, the commission assumed that health systems, gender systems and societal peace are shaped by broader socioeconomic processes, and, as they are shaped, reinforce one another as societies develop overtime. To be more specific, the report argues that poor development in socioeconomic processes results in disempowering health and gender systems that harm the development of human capabilities, exacerbate hardship and inequality, and, ultimately, generate societal conflict and violence. On the flip side, positive development in socioeconomic processes results in empowering health and gender systems that benefit the development of human capabilities, alleviate hardship and inequality, and, ultimately, generate sustainable peace. Finally, the report also noted that whether societal contexts are more violent or more peaceful effects socioeconomic processes and their resultant health and gender systems. Having established this, the report considers how investments in gender equality or health equity potentially transition societies from less harmful to more beneficial cycles. In so doing, the report's research identifies key socioeconomic structures that both impact and are impacted by investments in health and gender systems, highlighting the role of economic and social inequities, governance structures and levels of trust. In addition, the report identifies key global policy actors and the ways that they can prioritize investments in health equity and gender equality in their policy development and targeting in efforts to improve conditions for peace under conflict or crisis.

To interrogate and build on these ideas from the Lancet Commission Report on *Peaceful Societies through Health Equity and Gender Equality* (Percival et al. 2023), the Policy Day brought together practitioners and academics to present based on their expertise under the perspective of "policy pathways to sustainable well-

[1] This report is written based on the synthesis of the notes and summaries of the Policy Day presentations by the Policy Day Organizers and Policy Day Rapporteurs: Amy Alexander, Sara Causevic, Peter Friberg, Moaath Adalaty, Alina Becker, Ioannis Filios (with acknowledgement to receiving financial support for his studies from the Foundation for Education and European Culture (IPEP)), Elli Guldstand, April Holm, Elsa Höök, Sofia Linna, Ronja Rios, Sara Seregni, Abigail Sportza and Emma Svennsson.

being and peace through investments in institutional quality, health equity and gender equality under crisis and conflict". The practitioners consisted of speakers representing three of the actor groups engaged with in the Commission Report: actors representing multilateral organizations, including the World Health Organization and the United Nations, a representative of the national government of Sweden, and civil society actors involved in humanitarian assistance. The academics were recruited based on their research expertise on quality of government, gender equality, health equity and conflict reconciliation.

This report presents the insights generated by the presentations from the Policy Day's practitioners and academics on how we can improve sustainable well-being and peace through investments in institutional quality, health equity and gender equality under crisis and conflict. The report follows the order of presentations in the Policy Day Program and summarizes the key insights from those presentations.

The Policy Day's Opening Session

In addition to the above-described presentation of the Lancet Commission Report, the policy day began with a set of opening session presentations from the World Health Organization Eastern Mediterranean Regional Office (WHO EMRO) and the Swedish Ambassador for Global Health.

The first presentation was by Moa Herrgård from WHO EMRO. Herrgård presented on health emergencies in the region and the ongoing work to address those emergencies. She noted that the design of effective policies in reaction to health emergencies depends on an understanding of the risk of disaster and the cycle through which disasters are potentially managed in a region overtime. On understanding the risk of disaster, Herrgård explained that the risk can be assessed by understanding the hazard to the region in interaction with the region's vulnerability and how proportional this is to the capacity to handle a health emergency in the region. Hazards can manifest in various ways and can overlap. In the Eastern Mediterranean Region, they take the forms of environmental disasters, disease outbreaks and conflicts. Vulnerability can be assessed as the numbers of people needing humanitarian assistance and how those needs potentially vary depending on circumstances that render some more vulnerable than others. Capacity includes public health financing, technology and regulatory bodies that facilitate detecting, risk assessing and monitoring of potential threats to public health. Capacity also includes the level of vital infrastructure, (such as Public Health Emergency Operation Centers), supplies and trained professionals (such as trained emergency managers) in place for the response to health emergences. These various aspects of capacity are listed under the core International Health Regulations (IHR) capacities. In the cycle of disaster management, preparation guided by pre-impact assessment should precede the event. This should be followed by a short-term emergency response and more long-term restoration. This should then lead to recovery, reconstruction and, ultimately, mitigation of a future disaster through capacity building. This should then improve the pre-impact preparation for the next disaster.

The next presentation was by Dr. Arturo Pesigan from WHO EMRO on ongoing work to address health emergencies in the region with a focus on the case of Yemen. Building on Herrgård's presentation, Pesigan demonstrated the variety of potential hazards that emerge from a comprehensive all-hazard assessment of Yemen. For instance, measles outbreak, conflict and cyclones are among the many hazards identified. Pesigan also explained how risk of disaster can be assessed and more effectively managed in the coming year, in this case the example was 2025, through three core strategies. One strategy entails the development of a profile of each identified hazard's likelihood and impact in the coming year to classify which hazards should be given priority in developing mitigation approaches. Following this strategy, conflict and measles were projected as highly likely with high impact and classified as priority hazards. A second strategy entails assessing the risk of an emergency occurring by all identified hazards by month over the calendar year given knowledge of how the hazard occurs seasonally. Based on this strategy, September and October are flagged as critical months in Yemen in 2025 where multiple priority hazards will potentially peak in severity. A third strategy entails assessing the risk of the hazard's impact on the population through information on how district circumstances vary the district's population's exposure to hazard. Districts' capacities to handle

hazard generated health emergencies for their populations are assessed according to achievements in the core International Health Regulations (IHR) capacities.

Dr. Pesigan also described WHO's effort to improve gender equality in Yemen as an additional strategy to improve the organization's ongoing work to address health emergencies. Through the Emergency Human Capital Project (EHCP), this effort has significantly increased the participation of female health workers in trainings on prevention and response to sexual misconduct. The effort has also generated multiple channels for raising grievances related to sexual misconduct and sexual exploitation and abuse. For instance, while just 18% of female health workers in Yemen participated in trainings in 2022, this has increased to 45% by 2024. Moreover, there has been an effort by WHO to improve health services for gender-based violence cases in Yemen.

Finally, Dr. Pesigan concluded with a list of actions that should be prioritized to improve the organization's ongoing work to address health emergencies in Yemen. In order of presentation, these were: 1) Prepare for all-hazard emergencies, including disease surveillance, rapid response, and access to lifesaving services; 2) Strengthen disease surveillance and rapid response mechanisms for timely outbreak detection and containment; 3) ensure access to essential medicines and supplies, including laboratory supplies, and preposition this access in high-risk areas to ensure timely access during emergencies; 4) Strengthen community, mobile and facility-level service delivery, including referral systems, to ensure uninterrupted care during crises; 5) Train and equip healthcare workers with the necessary skills and resources to manage health emergencies effectively; 6) Lead emergency health response as the Health Cluster lead agency, ensuring continuity of services and addressing gaps; 7) Prevent occurrence and spread of epidemic-prone diseases in high-risk areas; 8) Disseminate accurate information to prevent disease spread and foster community participation in emergency responses. To conclude, Pesigan acknowledged that it will be especially challenging to support these prioritized actions in 2025 given the decrease in humanitarian funding to Yemen. On this front, Pesigan noted that there has been 43.5% reduction in intersectoral humanitarian response funding as of September 2024.

The opening session ended with a presentation by Karin Tegmark Wisell, Sweden's Ambassador for Global Health, on "How does the Swedish reform agenda – *Development assistance for a new era - Freedom, empowerment and sustainable growth* - support the work for peaceful societies through health equity and gender equality?" She began her remarks by noting the importance of recognizing global health as a diplomacy tool in foreign policy efforts and emphasizing the importance of ensuring that diplomats are trained to be knowledgeable about global health. She also noted that Sweden has for a long time recognized the importance of global health in foreign policy and diplomacy. She then recognized that we are in times of polycrisis as stated in the Lancet Commission report, noting that many conflict zones overlap with densely populated and economically important areas, which complicate efforts to help and that it is sad to see that the situation has not improved with violent armed conflict on going in many places such as Sudan and Gaza. As a result, she stated that the Lancet Commission report is more relevant than ever. She then turned to highlighting some of the priorities of the Swedish government given the relevance of the Lancet Commission report. She noted that while global opposition to gender equality is on the rise, gender equality is a core priority for Swedish foreign policy. She highlighted that among the seven thematic priorities of the agenda put forward in 2023: *Development assistance for a new era,* "strengthen women and girls' freedom and empowerment" is one along with improved health for the most vulnerable and enhancing humanitarian assistance to save lives. She noted that this includes a commitment to sexual and reproductive health and rights and women's economic empowerment. As the Lancet Commission report suggests, she also noted that these commitments to gender equality strengthen development assistance generally and development assistance directed at global health as they target fundamental inequities that hinder development.

The opening session was followed by four panels that addressed more specific themes on policy pathways to sustainable well-being and peace through investments in institutional quality, health equity and gender equality under crisis and conflict. *Panel 1* included four presentations under the theme, *"Women's Inclusion and Health as a Bridge to Peace".*

Panel 1: Women's Inclusion and Health as a Bridge to Peace

Dr. Valeriya Mechkova from the Department of Political Science at the University of Gothenburg began this set of presentations by presenting insights from her global, longitudinal research on the influence of women's political representation on health-care outcomes (Mechkova and Carlitz 2021; Mechkova, Dahlum and Petracca 2024; Mechkova and Edgell 2024). This research builds on the Lancet Commission report by offering a deeper understanding of how investments in gender equality improve investments in health equity through women's political empowerment. Mechkova began by highlighting the global, longitudinal evidence from a large body of research, including her own, on the impact of increasing women's inclusion in national legislatures. This research demonstrates that, as legislators, women bring new and needed perspectives to the representative agenda that improve investments in health, because women differ in their experiences in social roles and expectations from men, which, in turn, drives their likelihood to place a stronger emphasis on the importance of increasing health equity for societal well-being and progress. This perspective on the importance of health is not only strengthened by the development of women's preferences in isolation, but it is also reinforced through women's ties to women's organizations in civil society and the expectation that, as legislators, women should be especially likely to stand for women's issues. Derived from women's position in social structures due to gender roles and women's unique bodily investment in reproduction, the policy targets of women's organizations and the conceptualization of women's issues tend to focus on increased access to health services and sexual reproductive health and rights. This likely position women legislators as representative stewards of agenda setting and policy development for more health equity. And, indeed, studies show that higher levels of women's presence in national legislatures increase health outcomes vital to health equity, like reduced infant, child and maternal mortality, through more priority to health-care issues in parliamentary behavior and increased health-care budgets. However, Mechkova also explained that women's capacity as legislators to prioritize health is amplified or constrained by variation in their countries' institutional and societal conditions. These observations add additional insight to the Lancet Commission report by pinpointing the variation in broader sociopolitical processes that facilitate or hinder investments in gender equality and health equity across countries and overtime. Mechkova narrowed our attention to three key conditions. One condition is the degree to which states make a genuine commitment to democratic institutionalization. Under a stronger commitment to democratic institutionalization, there is a stronger commitment to inclusive decision-making which likely strengthens women's capacity as legislators to prioritize health. Commitment to inclusive decision-making from the perspective of women's interests is further amplified within democracies with the adoption of some form of quota policy for improving women's presence in national legislatures and when democracies have proportional representation systems. Another condition is the degree to which states combat corruption. Corruption emboldens predominantly male-dominant insider networks to exploit peoples' and societies' need for vital services, like health services, for private, personal gains. This occurs, for instance, through asking for bribes from individuals in exchange for access to health services, through awarding noncompetitive contracts to network insiders who are likely less competent or incompetent in supplying vital medical infrastructure or supplies, and through embezzlement schemes that inflate health budgets relative to the actual delivery of supplies, services to patients, or services to welfare system beneficiaries. Through emboldening these exclusionary networks and these practices, the capacity of women legislators to impact health outcomes through legislating is severely depleted. A final condition is the level of women's participation in civil society. Higher levels of women's civil society participation strengthen the development of societal grievances relevant to women's interests, agenda setting relevant to women's interests and government accountability relative to women's interests. All of this increases women legislators' representational leverage when it comes to women's interests, including their commitment to improving health equity.

Mechkovas presentation was followed by Associate Professor Kristen Kao. Kao presented on gendered perspectives in post-conflict reconciliation in Iraq. Kao began with a list of reasons on why we need to study gendered views of governance and peace processes. This should be pursued because 1) there likely

exists a greater gap in the worldviews of women versus men in most post-conflict settings compared to in WEIRD (Western, Educated, Industrialized, Rich, and Democratic) countries; 2) women experience violent conflict in a very different way than men; 3) current best practices in transitional justice emphasize victim-informed programming and localization of peace building efforts but data are needed to inform these processes; 4) women almost always have less of a voice in transitional justice and post-conflict reconciliation processes; and 5) the question of who are the most legitimate arbiters of that justice is likely to differ greatly for men and women. From here, Kao turned to her research on transitional justice processes in post-conflict Iraq with a particular focus on how studying gendered perspectives in post-conflict reconciliation improves our understanding of the legitimacy of authorities who are involved in local transitional justice processes, which is important for peace outcomes in those settings. Conflict settings like Iraq differ from Western systems of jurisprudence. Given the developing, post-colonial context, these settings are characterized by fragmented sovereignty, where overlapping legal systems of state law, religious law and tribal law work in tandem to solve disputes and crimes. As a result, authorities that can potentially arbitrate local transitional justice processes may be considered more or less legitimate depending on the legal system they represent. Whether these authorities are considered legitimate will impact whether they can rely on a popular "reservoir of support" for their arbitration. Kao's research shows that Iraqi women and Iraqi men differ in which authorities they consider more legitimate arbiters of transitional justice processes. Evidence from surveys designed and fielded by Kao suggests that women are less likely to turn to the state for disputes and more likely to turn to the religious system. Analyzing this further, the choice of the religious system to resolve disputes is driven by the feeling that the religious system is the most likely to be enforced among female respondents, but not among men. Men are more likely to see the state system as enforced.

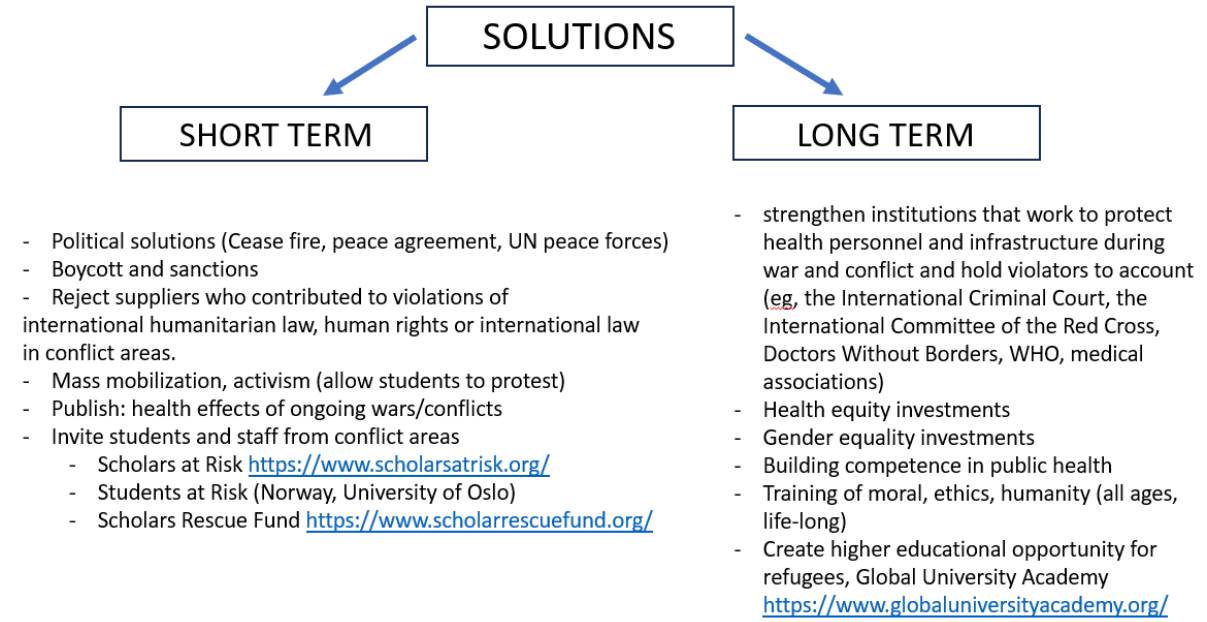
In addition to this evidence, Kao looks at perceptions of just punishment of accused ISIS collaborators as well as prospects for reconciliation with them. This is extremely important at this time in Iraq, as many of the hundreds of thousands IDP camps for those accused of collaboration with IS are under serious threat of being closed. Complementarity between state and non-state transitional justice systems offers a potential solution to slow, inefficient, and often illegitimate top-down justice processes. Such hybrid systems are being adopted in Iraq; international programs are educating tribal leaders in human rights norms and pressuring them to incorporate these norms in their decisions and their sponsorship programs. Furthermore, an array of other local actors is involved in the vetting, clearing, and reintegration of those accused of ISIS collaboration. For instance, sponsorship of IDPs by differing local authorities is a commonly employed solution to reintegrating IDPs deemed not to be a security threat. The issue is that within local communities, reintegration of these individuals is difficult – threats or even physical violence against returnees is common. Kao therefore studies how the tendency for local citizens to reconcile with these IDPs is affected depending on which type of authority supports their reintegration. This research again reveals gender differences; women have a higher propensity to reconcile with IDPs when their reintegration is supported by tribal and religious leaders, compared to men who prefer the state security officials. In addition to finding gender differences depending on the type of authority endorsement, Kao also finds gender differences among Iraqis in how IDPs should be treated to achieve justice – whether they should be treated more lightly with amnesty or more harshly with punishments in varying severity up to capital punishment. Here, Kao finds that Iraqi men prefer a harsher treatment of male IDPs compared to Iraqi women. Further analysis shows that this difference is particularly pronounced among Shia respondents compared to Sunni respondents. Thus, Kao's research demonstrates the importance of studying and incorporating women's perspectives on the legitimacy of authorities in the handling of transitional justice processes and on what means are legitimate for achieving justice in those processes. Evidence from Iraq suggests that women attribute legitimacy to different sources of authority compared to men and that women are more accepting of less punitive punishment of men accused of crimes.

Kao's presentation was followed by Mathilde Boddaert, Technical Officer for the Global Health and Peace Initiative (GHPI) for the WHO. Boddaert presented on WHO's contributions to peace and the Global Health and Peace Initiative. Boddaert began by explaining that the GHPI was launched in November 2019 by Oman and Switzerland, following a multilateral consultation in Geneva attended by more than 50 representatives of 24 countries and partners. The initiative was developed by WHO to better address the

underlying drivers of critical health needs in fragile, conflict-affected and vulnerable settings (FCV) and aims to strengthen the role of WHO and the health sector as contributors to improving the prospects for peace, by strengthening social cohesion, dialogue and resilience to violence. The link of health to peace is all the more important to consider given that 80% of WHO's humanitarian caseload, as well as 70% of disease outbreaks that WHO responds to take place in fragile and conflict-affected settings. This underscores the quote by WHO's Director General, Dr. Tedros Adhanom Ghebreyesus, that "There cannot be health without peace, and there cannot be peace without health." In addition, the GHPI builds on a policy background that recognizes the link between health and peace. For instance, WHO's Constitution states, "the health of all peoples is [also] fundamental to the attainment of peace and security". In addition to conflict, the GHPI considers its role especially relevant in countries where social cohesion, trust, or resilience need to be built or strengthened. Thus, the GHPI is applicable in many different sorts of settings, from situations of active conflict, before or after conflict, in fragile settings with a high degree of social tension, where marginalized groups are present, where access to health services are (perceived to be) inequitable, where distrust is high (between population/authorities/health staff) and where rumors of misinformation undermine public health goals. In short, The GHPI is relevant anywhere social cohesion, resilience and trust need to be built, sustained or strengthened. Various health intervention strategies can be pursued to target and improve different types of peace outcomes, that are to be defined based on each context. For instance, to reduce exclusion and strengthen trust between populations and the authorities, programming can focus on ensuring universal and equitable access to health care, opening dialogue between populations and authorities over health needs and services and improving inclusive and participatory policymaking. To reinforce social cohesion between and within communities, health programs can promote inclusive, participatory health governance at the local level or provide mental health and psychosocial support to support stability and reconciliation. To prevent violence outbreak or violence repetition, and to support reconciliation processes at the community level, health programs can target groups at risk of violence (repetition) and support their socioeconomic (re) integration in society (for instance by training them and engaging them on disease surveillance at community level; or by supporting the reintegration of health personnel from demobilized militias into health systems). To facilitate rapprochement and build confidence between parties to a conflict, some joint training of health personnel across the conflict-line and crossline dialogue and technical cooperation can be done (for example in disease surveillance and response). Etc. Boddaert then described some WHO closed and ongoing projects integrating health and peace. Recently closed projects include one in Cameroon that focused on peacebuilding and violence reduction in communities in the Far-North, through inclusive health and social interventions; one in Burkina Faso that employed an integrated approach to mental health and psychosocial support focused on young people; one in Somalia that focused on improving psychosocial support and mental health care for conflict affected youth in Somalia; and two in Sri Lanka that focused on youth participation and engagement and emotional wellbeing, resilience and community empowerment promotion. Ongoing projects include one in Ginea Bissau focused on strengthening social cohesion through promoting inclusive and effective public health sector governance, management, and administration, one in Haiti focused on promoting social cohesion by strengthening the mental health and well-being of women and girls in Haiti's insecure and politically unstable context, and one in Liberia focused on enhancing social cohesion through rehabilitation and empowerment of marginalized youth.

Boddaert's presentation was followed by Professor Espen Bjertness from the University of Oslo. Bjertness presented on attacks on health systems under conflict. Attack on medical facilities and health professionals during war and conflict is the new reality, and there has been an increase in these violations despite medical personnel and healthcare facilities – hospitals, clinics – and transports such as ambulances are protected by the Geneva Conventions. The protection of medical personnel in armed conflicts is a natural consequence of the protection of the wounded and sick. It goes without saying that it is a fundamental and necessary condition for the sick and injured to receive proper treatment that health personnel must also be protected. This is enshrined in the Geneva Convention of 1949 on the Rights and Duties of Doctors and the Additional Protocols of 1977. Bjertness further referred to the conceptualization and observational work through the WHO's surveillance system for attacks on health care (SSA). This work defines attacks as "acts

or threats of violence or obstruction that interfere with the availability or delivery of curative and preventive health-care services in conflict- or crisis-affected countries" (ICRC 2018, https://www.icrc.org/en/document/new-global-system-monitor-attacks-health-care). Since its launch in 2017, this surveillance system shows that 2022, 2023 and 2024 have seen the most attacks on health systems with increasing consequences for deaths and injuries. Bjertness then analyzed the cases of the ongoing Israel – Hamas war in Gaza and Myanmar post-coup 2021, and concluded that both Israel end Myanmar's military government have committed war crime (Customary IHL - Rule 156. Definition of War Crimes). Bjertness developed a figure that identified short-term and long-term solutions for, at best, achieving sustainable peace in the face of conflict or, at least, protecting and supporting human development in the face of conflict. This figure is adopted from Bjertness' presentation below:



Panel 2: Health system resilience, governance and humanitarian action under fragile contexts

Panel 2 of the program included four presentations under the theme, *"Health system resilience, governance and humanitarian action under fragile contexts"*. Abeer Ahmad, a researcher at the Stockholm International Peace Research Institute (SIPRI) presented first on health system resilience in conflict and fragility. She noted that *conflict* is typically described according to the World Bank definition as: "a situation of acute insecurity driven by the use of deadly force by a group with a political purpose or motivation" and further elaborated on the concept of *fragility* as "a systemic condition with an extremely low level of institutional and governance capacity". According to the World Bank, more than one-third of low and middle-income countries are Fragile and Conflict-affected Settings (FCS), and therefore, face acute shocks and chronic stressors on their health systems, which limits healthcare access in the short term and undermines the sustainability of healthcare services in the long term. Thus, it is vital to understand what impacts resilience in health systems in FCS.

Ahmad defined health system resilience as the capacity of a health system to absorb and adapt to disruptive events in order to maintain the continuity of planned, essential health services, and to reorganise and transform in response to such disruptions to be ready for any future disruptions. Her coauthored review of literature on health system resilience in FCS (Lilja and Ahmad 2023) identified three approaches to resilience in health, 1) organizational resilience, 2) the resilient capacity of healthcare staff, and 3) community resilience. Most literature addressing health system resilience focusses on organizational resilience, e.g., service delivery, leadership, and governance. Organizational resilience ensures sufficient pre-conflict capacity, such as solid infrastructure and a functioning service delivery system, as well as proper disaster

planning to bolster health system readiness and preparedness in the face of disaster. This requires surge capacity through increased medical care capacity during disasters. This is challenging because conflict results in situations where health staff cannot be paid or where their safety cannot be secured. Health staff in FCS often show dedication by volunteering their services on the frontlines without receiving their wages. This compromises staff retention and resilience. The neglect of health staff retention combined with an overemphasis on short-term trauma care in humanitarian aid could hinder progress towards resilient health systems. Finally, there is the community resilience approach through treating communities as active participants rather than passive recipients of health response efforts. Community engagement facilitates collaboration across the core determinants of health system resilience. These core determinants are governance and financing, health workforce, medical products and technologies, public health functions and health service delivery.

Ahmad also explained how investing in a health system to be more resilient, especially before crises arise, can mitigate conflict risk. Health system resilience can mitigate conflict risk through increasing equity and inclusivity in healthcare access, as described in the Lancet Commission Framework, and by improving the continuity of care during crises. This, in turn, can enhance community trust and engagement, reduce group tensions and grievances and reduce structural violence.

Ahmad concluded by emphasizing the need for a less fragmented, more cohesive approach to improving health system resilience across relevant actors: public, private and NGOs. She also noted that more research and evidence is needed on FCS. She also stressed the importance of prioritizing early interventions in health system preparedness rather than waiting for crises such as COVID-19, which severely impacted even high-income countries with far more stable health systems than FCS. Finally, more global funding priority needs to be given to investments in health system resilience, especially when the ongoing conflicts have driven more global funding investment in defense at the expense of health system preparedness and resilience.

The second presenter in panel 2 was Dr. Daniel Carelli, a Postdoctoral Researcher in Environmental Systems Analysis at Chalmers University. Carelli presented on antibiotic resistance, conflict and the challenge of global governance. Carelli emphasized that antibiotics are the greatest medical invention of the last millennium given their widespread, fundamental functions in effectively treating injury and infection. They are vital, for instance, in cancer treatments, hip replacements, organ transplants, Gonorrhea treatment, survival of preterm babies, survival of complicated deliveries, wound infections, urinary tract infections, pneumonia and blood infections. He also presented rather alarming data demonstrating that overtime, from 2000 onward, an increasing proportion of bacteria display resistance to common antibiotics. In addition, he noted that the global burden of antimicrobial resistance is particularly acute in fragile, and conflict affected settings. In fact, Carelli noted that conflict poses the greatest challenge to establishing a sustainable approach to antibiotic use and listed the following key challenges imposed by conflict: 1) resistant bacteria thrive under such conditions; 2) there is an increased use of antibiotics under such conditions; 3) diagnostic opportunities are reduced which increases broad-spectrum use; 4) the potential for data collection based on bacterial monitoring and surveillance is also reduced; 5) conflict also distorts most opportunities for global coalitions and 6) conflict absorbs political focus and priority, shifting focus and priority away from improving sustainable antibiotic use. In the end, Carelli underscored that the fight against antimicrobial resistance faces significant barriers, including insufficient funding, a lack of global advocacy and no unified agenda. With no sanctions for countries failing to act and antimicrobial resistance unlikely to be a political priority, the issue remains neglected despite its potential to kill more people annually than AIDS and malaria combined. Addressing antimicrobial resistance requires moving beyond the simplistic narrative of individual or national responsibility for reducing antibiotic use. This is more than a problem of freeriding. The real challenges are global coordination, overcoming governance disparities, and establishing international authority to drive effective action. Indeed, countries with better governance tend to manage antibiotic use more effectively which highlights the critical role of institutional quality in tackling this crisis.

The third presenter in panel 2 was Annika Sandlund, UNHCR Representative for Nordic and Baltic Countries. Sandlund presented on "Refugee health – from humanitarian action to inclusion". She prepared the following summary of her remarks for this policy day report.

The number of forcible displaced has more than doubled in the past decade, reaching over 123 million people, which is 1.5 % of the world's population. Of these forcible displaced, the majority (71 million) are displaced internally, while about 42 million are refugees, i.e. persons who have crossed an international border because of persecution or war. Notable is that the 5 major refugee crises produce over 70 % of the world's refugees – a clear indication that if we were to invest in peace and peace building, we would be able as an international community to solve many refugee crises – along with a good portion of the internal displacement situations. The 5 countries are Afghanistan, Syria, Ukraine, Venezuela and the two Sudans (South Sudan and Sudan).

The two major causes for displacement remain conflict and climate. According to SIPRI figures over 50 new conflict related crises erupted last year. In terms of climate, climate-related shocks and stresses are also increasingly interacting with drivers of conflict and other causes of displacement (Weathering Risk, 2023, Weathering Risk | Climate change is a risk to peace. Evidence-based responses will help weather the storm.). UNHCR's recently released report highlights that over 220 million people have been displaced due to climate in the past decade, meaning over 60,000 people a day have been forced to move. The majority of these people remain internally displaced, i.e. they are displaced within their own country. The report can be found here (No Escape: On the frontlines of climate change, conflict and forced displacement | UNHCR). Climate also worsens the situation for those already displaced, as 3 out of 4 forcibly displaced people live in countries with high-to-extreme exposure to climate-related hazards. The number of countries experiencing severe climate chocks is expected to rise from 3 to 65 by 2040.

However, in terms of response, the challenge is not the new conflicts and the emergency response, something that the humanitarian community is prepared for - but the fact that old crises / conflicts never end. It is because displacement situations last longer and solutions are more difficult to find that we need more sustainable response.

Since the Global Compact on Refugees, a new framework agreed by the UN member states in 2018, UNHCR is more actively than before engaging development actors and the private sector in the context of sustainable responses. This is also true in the field of health, where in addition to funds, the private sector companies, such as Nova-Nordisk one of the world's largest pharmaceutical companies, are also contributing expertise.

Long term sustainable responses are reached through inclusion in strengthened national and local systems, enhancing responsibility-sharing and financing, establishing supportive policy and regulatory frameworks, and strengthening national leadership and ownership and substantive community engagement.

The public health inclusion approach and engagement with development actors upholds the universal health coverage (UHC) principles and aligns with UNHCR's vision of saving lives, promoting rights, finding and safeguarding solutions and building self-reliance for refugees and hosting communities. This is also in line with UNHCR's Global Public Health Strategy (2021-2025) as well as the Global Compact on Refugees and its operationalization in public health.

In various contexts, national systems need to be strengthened with appropriate capacities and quality, ensuring they can adequately serve both refugees and host communities. Today, we have a set-up whereby many countries hosting 100,000 if not millions of refugees rely on humanitarian aid and parallel service delivery in terms of health. The health clinics established by the humanitarians are often also accessed by the locals – but if the response is to be sustainable this needs to be turned around so that refugees access the clinics that are established – and strengthened through development action and /or private sector investments - for the locals.

This is also true for mental health responses. Around 22% of adults in conflict settings have mental health disorders. This is much more than in non-conflict settings. Reasons for the increased prevalence of mental health conditions include adverse experiences in country of origin, on the way and in refugee settings and lack of supportive social systems. Many refugee hosting countries do not have a functional mental health system to integrate refugees into, while the needs are often extremely high. Therefore, UNHCR uses a twin track approach: (1) support direct service provision through partners and (2) working towards integration through strengthening national services.

There are considerable costs to be met both in the immediate and long-term. These costs (many of which are recurrent) must be met whether this be by the state, the household, or another actor. In the short to medium term, we are therefore looking at a transition from UNHCR-led to government-led services, noting that this may result in an increase of overall costs (even if in the short term) since segregated services often do not meet national standards.

A recent World Bank-UNHCR study found that the estimated annual global cost to provide health services to refugees through national systems is approximately US$11 billion per year. Notably, the cost in low-income countries is much lower, at around US$239 million. Prioritizing support to these low-income countries could advance a significant part of the global refugee inclusion agenda. Moreover, investments to build health system capacity would benefit host communities as well, enhancing healthcare access and supporting better care for everyone (The Global Cost Of Refugee Inclusion in Host Countries' Health Systems | UNHCR). For example, Chad is host to some 1.5m refugees. In 2023 the World Bank announced $340 million in new financing to help Chad address multiple challenges, including $90 million specifically for the massive influx of refugees from neighboring countries. The Refugees and Host Communities Support Project (PARCA) aims to improve access to health services for both refugees and local communities. This includes emergency cash transfers and facilitating access to education and health services. These efforts are part of a broader strategy to enhance social services and promote long-term development in Chad.

From the perspective of refugee hosting countries, the fear is that the more direct aid that humanitarians provide based on need, will dwindle and will not be replaced by development aid that reaches the often non-prioritized areas where many refugees live. This concern is understandable as humanitarian and development aid work on different principles and with different aims.

It is in everyone's interest to ensure health interventions and access to health that reaches everyone in a community. As health practitioners you will intuitively understand this as neither disease or viruses differentiate based on legal status (look at what happens if vaccination campaigns only reach a part of the population).

The final presentation in panel 2 was by Ulrika Modéer, Secretary General of the Swedish Red Cross. Modéer presented on the organization's developing work in humanitarian assistance. According to Modéer, the Red Cross is the world's largest humanitarian network with a large network of volunteers. The organization works in crisis and conflict, with climate change and its subsequent humanitarian crises. This is a need for a stronger focus on mental health in humanitarian assistance. On this front, the Red Cross has clinics for people needing psycho-social support, especially due to trauma from conflict areas, or in conflict and crisis situations. The organization focuses on ensuring universal health coverage and attempts to achieve this by being present where they are needed most typically and strengthening the resilience of communities and community-based health by targeting local health clinics. The Red Cross also works toward this aim by supporting innovative approaches to community building, such as through social media and other platforms, to share experiences of mental illness and struggles that many feel that they are not able to share in person.

Panel 3: Policy pathways to institutional quality through the engagement of civil society and citizens under fragile contexts

The program then continued with four presentations under *Panel 3* with the theme, *"Policy pathways to institutional quality through the engagement of civil society and citizens under fragile contexts"*. This set of presentations began with Professor Monika Bauhr from Gothenburg University. Bauhr presented based on her research on social bargaining (Bauhr, Carlitz and Kovacikova 2024), sexual corruption and access to public services. Bauhr began by presenting on the disadvantages citizens' face in street level interactions with service providers in their efforts to gain access to public services. She noted that street level bureaucrats should act impartially and professionally in delivering public services while still adapting to citizens' different needs. Thus, giving providers discretion should allow them to adapt to citizens' different needs and, in turn, effectively provide the relevant services. However, relying solely on their discretionary provision could result in service providers benefiting some individuals at the expense of those who are more in need if some citizens have a greater potential to bargain for social services relative to others. In this case, Bauhr argues that we need a better understanding of how citizens bargain for social services, which bargaining strategy is most effective and what advantages some citizens over others in their potential to bargain. This will give us more transparency on which citizens may be advantaged over other citizens in bargaining for social services and support the development of policies aimed at reducing the impact of inequality in the potential to bargain on the likelihood to get access. When it comes to bargaining, Bauhr notes that citizens engage in either social bargaining or economic bargaining for access to public services. Under social bargaining, citizens use social networks and knowledge to persuade service providers to meet their needs. In so doing, citizens can leverage ethnic and partisan ties as well as access to information about rights and duties to gain effective access to services. Under economic bargaining, citizens use short-term economic transactions, like informal payments and bribes to influence service providers. By analyzing survey data from 34 African countries, Bauhr and her co-authors examine the effectiveness of social relative to economic bargaining and what advantages some citizens over others in their potential to bargain. The study finds that economic bargaining is not effective; citizens that pay bribes are less likely to gain effective access to public services. Bribery is oftentimes extortive and demanded by public service providers that are either not able or willing to effectively deliver public services. However, social bargaining capacity is more likely to lead to effective access to public services; citizens with access to information and that share partisanship ties with the service provider gain effective access.

Bauhr then turned to presenting her work on sexual corruption (https://www.bsg.ox.ac.uk/research/publications/chandler-papers-sexual-corruption) as an additional form of corruption "currency" that is implicated in bargaining for social services but is a form of corruption that is notoriously difficult to define and measure. It is vital to understand this given that failure to combat corruption is sometimes traced to a lack of understanding of the differences between different forms of corruption. Bauhr explained that sexual corruption is a form of corruption that involves sexual favors or benefits. Through research focused on Brazil and Nigeria, she has found that this form of corruption is particularly challenging for the following reasons. This tends to fall between legal cracks as it is often miss classified as sexual harassment, victims are often assumed to be complicit in the act, and there are problems with reporting the crime due to fear of reprisal by the perpetrator or their loyal aides, fear of not being believed, lack of trust in the system to protect and defend victims, acceptance of the acts as being the norm, or fear of stigmatization. As a result, the legal risk for perpetrators is reduced. Bauhr also finds that in Brazil and Nigeria there appears to be a consensus among policymakers that it is not in the public's interest to punish those who provide or offer sexual activity as part of a dynamic of corrupt exchange, which negatively effects the development of anticorruption policy. Thus, Bauhr suggests that it is important to build broader coalitions of support and interest in the issue of sexual corruption by framing sexual corruption as an attempt to close down open opportunities for corruption, and not only as a response to feminist concerns about gender rights.

Panel 3 continued with a presentation by Professor Marcia Grimes from the University of Gothenburg. Grimes presented on civil society and bottom-up accountability. In particular, she focused on whether bottom-up accountability is a potential short route to better health outcomes.

Grimes noted that public services are weak or absent in many parts of the world. In the past 20 years, there has been an increasing salience of the idea of bottom-up accountability as a short route of accountability. Under this approach, citizens are empowered through forming coalitions and having more direct inclusion the management of services by directly holding providers accountable. This short route may be preferable to the longer route of citizen demand and accountability funneling through the state given that voters do not necessarily elect politicians that serve their public service needs and politicians do not always aim to improve service provisions. Indeed, in highly corrupt settings where the state is likely to be less effective, citizen's involvement for accountability is particularly necessary. However, in practice, where corruption is higher, the desire to supply accountability and thus the actual supply of accountability is paradoxically lower. This generates a context of a low accountability trap where the lack of top-down and bottom-up accountability are viciously reinforcing.

One evidence assessed approach to improving bottom-up accountability is through generating social accountability. Under this approach, generating shared knowledge about local providers and participation in community activities directly related to monitoring the performance of the local health potentially generates internal efficacy (Lieberman and Zhou, 2021), fosters a sense of responsibility for monitoring service providers (Pandey, Goyal and Sundararaman, 2009), helps overcome free-riding problems and enables citizens to identify concrete actions they can take to improve services—all of which may be critical for generating bottom-up pressure by citizens. A recent study (Raffler, Posner and Parkerson 2019) evaluated the effectiveness of this with research on citizens access to social accountability mechanisms across 187 health centers and their associated catchment areas in 16 districts in Uganda. In some areas, citizens received information about patient rights and responsibilities, utilization patterns, and health outcomes, organized meetings between members of the community and health center staff and worked with health center staff and community members to develop action plans. The study then assessed how this impacted accountability of service provision through individual-level perceptions and health center-level outcomes. Ideally, the outcome would have been an improvement of service provisions by overcoming free-riding problems and enabling citizens to identify concrete actions to generate bottom-up pressure. In practice, however, the effects were quite discouraging. The bottom-up interventions did not substantially improve the situation. Only treatment quality and patient satisfaction improved somewhat.

Studies have also looked at participatory budgeting and public policy management councils as additional interventions to improve social accountability and, in turn, bottom-up accountability. Participatory budgeting in local government shows somewhat more encouraging evidence. This improved budget allocations to health and sanitation and decreased infant mortality in a study conducted in Brazil (Gonçalves 2014). Public policy management councils have been shown to reduce infant mortality, especially in municipalities with higher levels of administrative capacity. However, this was observed mostly in low-corruption municipalities; if municipalities were already corrupt it did not make a difference whether citizens participated (Touchton et al. 2017).

Social accountability initiatives may show some promise, but they can be challenging to develop due to demands that they place on citizens. The require citizens to have time and willingness to invest in the initiatives, to risk being socially sanctioned if the initiative challenges norms or powerholders, to have confidence in governmental response, coordination and mobilization capacity, policy knowledge and technical skills, and prioritize collective outcomes over individual-level interests once engaged

Grimes then turned to the question of whether a stronger civil society reduces corruption by focusing on a case of civil society activism and health sector corruption in Ukraine. In 2015, the NGO "100% Life" compared prices paid by the Ministry of Health for HIV/AIDS medicine with global process and found that such medication was more expensive in Ukraine than in other countries. Following the ousting of president Yanokovych and subsequent reforms, a second NGO (the Anti-Corruption Action Center) found

that companies staged bidding wars and were not actually competing, resulting in prices remaining as high as before. Afterwards, a commission of international actors (Crown Agents of the UK, UNDP, and UNICEF) assumed authority and managed the procurement of HIV/AIDS medication. This led to a reduction in prices of up to 40%, matching the international standard. Ultimately, the authority was returned to the Ministry of Health in 2021. This is a good example of how civil society can make a meaningful difference; however, it is important to note that the involvement of international actors was necessary to achieve this change.

Grimes then discussed evidence from global country-level studies (Grimes 2013; Lee 2007; Themudo 2013; 2014) and noted that researchers established a link between civil society strength and corruption, but only where conditions are favorable for civil societal accountability. These conditions are press freedom, government transparency, and political competition.

To conclude, Grimes noted the following. Bottom-up accountability depends on the (institutional) context. If we look at the whole global sample, results vary greatly between contexts. Institutions affect citizens' ability and willingness to exercise accountability, what they expect of government, how they engage. People will not transform the entire system, rather they will adapt to an environment if it's very corrupt. The policy implications of this are that audit, responsiveness and pressure from above lead to better outcomes and pressure from below has a better effect when pressure from above is present. In a corrupt setting, people are likely to adapt to corruptness, but if one can create an institution to exert pressure from the top and encourage pressure from the bottom, the situation improves substantially.

The third presenter in panel 3 was Dr. Annekatrin Deglow from Uppsala University. Deglow presented on violent elections and citizens' commitment to democracy based on co-authored research on Nigeria and India (Deglow and Fjelde 2024 A and B). She noted that the motivation for this research was the fact that democracy (as a form of governance) is under pressure. Deglow elaborated that we are living in an age of autocratization. For a long time, the global trend in regime development pointed towards an increase of democratization. Currently, however, the number of countries shifting from democracy to more authoritarian forms of government is larger than the number of countries where democracy becomes stronger. Indeed, according to V-Dem, around 70% of the world's population is living in autocracies in 2024. An implication of this is growing violations of democratic rights and electoral integrity. Thus, it is important for us to study whether and when citizens stand up for democracy.

Deglow also noted that democracies die slowly. There are few sudden takeovers; rather, we can observe a gradual shift towards autocracy. It takes time for political leaders and elites to undermine democratic rights and freedoms. The role of citizen support for such transgressions is important to understand democratic trajectories. It could give us insight into how to make democracies more resilient to this kind of "slow death".

On this front, Deglow emphasized that we must recognize that many citizens trade democracy for other preferences. Existing research indicates that when asked to choose between democratic principles and other political/(socio-)economic benefits, most citizens seem to prefer the latter. Studies observe support and voting for politicians that violate democratic principles if they provide other policy benefits, in particular, when they are co-partisans. Evidence on this phenomenon comes mostly from established democracies that have been democratic for many decades. For instance, this is observed in work on the US. There are few studies, however, on recent democracies or those countries that fluctuate between democracy and autocracy. This is problematic because the democratic and political context in these countries is so volatile and therefore particularly vulnerable.

According to V-Dem, the vast majority of elections in weak democracies since 1990 have been affected by intimidations or violence. Citizens vote in contexts where violence and coercion are used to influence elections. This includes the destruction of electoral infrastructure, the intimidation of voters, and violent attacks on political candidates, carried out by non-state armed actors and/or governments to influence the

electoral process. For, example: In India, the Modi-led regime has repeatedly shut down the internet, restricting citizens' rights to inform themselves prior to the elections.

Governments legitimate this by using insecurity as a pre-text to dismantle democratic rights. For citizens, this results in a tradeoff between democracy and (perceived) security.

Deglow explained that her and Fjelde's research looks more deeply into this challenge to citizens' commitment to democracy under violent elections with data from post-election surveys in India and Nigeria that took place after the 2019 Presidential/General elections. In those surveys, respondents were randomly presented with two hypothetical scenarios of different forms of election violence. In one scenario, there was a violent incident during the elections. In the other scenario, there was no violence. After being presented the scenarios, all participants were asked to which extent they agreed with a set of statements which essentially implied that the government undermined democratic principles. Participants were, for instance, asked:

"To prevent violent elections, the government should be allowed to…

- … ban journalists
- … move polling stations
- … use violence against protesters".

Deglow and her co-author's goal was to determine if being exposed to violence affected participants' willingness to trade democracy for security by observing if those exposed to violence agreed that the government should be allowed to ban journalists, move polling stations or use violence against protesters. She noted that they found that the extent to which people are willing to trade off democracy for electoral security depends on their socio-political identities, in particular, whether or not they belong to the government constituencies. On this front, being exposed to a violent scenario or not had no impact on government constituencies but did have an impact on non-government constituencies. In Nigeria, respondents were less likely to trade off democracy if they supported the opposition party/candidate. In India, respondents were less likely to trade off democracy if they belonged to a politically marginalized group. However, respondents were more likely to trade off democracy in a context marked by state coercion and insurgent threats if they belonged to a particularly marginalized group.

Overall, the studies suggest that violent elections seem to matter for citizens' commitment to democracy. The results suggest that groups outside of government constituencies may be a force for democratization because they were more likely to stand up for democracy when exposed to election violence. This, however, did not happen in contexts marked by insurgent threats. Government constituencies may be more willing to tolerate violations of democratic rights since they were *not* more likely to stand up for democracy when exposed to election violence.

The final presenter in panel 3 was Professor Victor Lapuente from the University of Gothenburg. Lapuente presented on trust, polarization, populism and COVID-19 deaths across European regions (Charron et al. 2023). He began by quoting Louis Pasteur that "Science knows no country, because knowledge belongs to humanity, and is the torch that illuminates the world". And noted that, yet, the Covid-19 pandemic killed more people in some countries than others and asked why. In the explanations that came out of research on this, initially, academic research and literature focused on regime type as a central explanation. On average it was observed that there were smaller death rates among non-democracies (compared to democracies). Some non-democracies, for instance, China, were initially praised for handling the pandemic quite well. Over time, however, trust in government emerged as the major dividing line between good and bad handling of the pandemic. Evidence showed that having good/effective governance institutions seemed to matter more than other factors, such as regime type or even the state of the health care system. Infection rates were smallest in electoral democracies where a high trust in government is present and highest in non-democracies where trust in government is low. Indeed, research looking more deeply into

this across EU regions in 2020 showed that the lower the level of social and/or institutional trust, the higher the excess mortality in the region and that the higher the level of populism/anti-experts politics in a region, the higher the excess mortality in the region. These results suggest that polarization that generates social divisions results in uncooperative societies that hinder effective management of pandemics. Populist sentiments fuel polarization and, in turn, weaken social and/or institutional trust. The uncooperative society that emerges under this context is inimical to health system resilience under crises. Generating trust and overcoming polarization are thus essential if we are going to succeed in fighting pandemics, global health threats and other collective challenges.

Panel 4: Humanitarian assistance and development cooperation in fragile contexts

The final panel of the Policy Day program was *Panel 4* which focused on the theme, *"Humanitarian assistance and development cooperation in fragile contexts"*. The panel had three presenters. The first presenter was Anna Svensson, the Senior Public Health Advisor for the Swedish Red Cross. Svensson presented on humanitarian assistance before, under and after crisis. She began by noting that the *International Federation of Red Cross and Red Crescent Societies* (IFRC) is the world's largest humanitarian network. It is an international membership organization that unites 191 Red Cross and Red Crescent Societies and supports them through a global secretariat. The IFRC acts before, during and after disasters and health emergencies to meet the needs and improve the lives of vulnerable people. The work is guided by seven fundamental principles. The first is *humanity* with the aim to prevent and alleviate suffering, protect life and health. The second is *impartiality*. Under this principle, there is a focus on non-discrimination such that decisions are made on a needs only basis and there is no differentiation in the supply of humanitarian assistance based on who is in need. Anyone in need under the crisis is eligible. The third principle is *neutrality* which prohibits the organization taking sides in any conflict or dispute. The fourth principle is *independence*, while collaboration is possible the organization is independent in its decision-making. The fifth principle is *voluntary*; it is optional to give, and it is optional to receive assistance. The sixth principle is *unity*; one national society per country/territory is open for all. And the seventh principle is *universality*; the organization operates as a world-wide network where all national societies are equal.

Because the organization is neutral, impartial and independent, the organization can reach those who need it when others cannot, providing humanitarian assistance, protecting lives, upholding rights, and relieving the suffering of people whose lives have been torn apart. There is an emphasis on local action and strengthening communities through humanitarian assistance.

~~B~~efore the crises, there is a focus on strengthening local capacity and different programs in different counties, giving example of community-based health in Sweden. This work also targets crisis planning based on evidence-based programming frameworks that are tailored to the local needs of each country. The work is based on volunteers that are locals, involving communities and identifying vulnerable groups. There is also a focus on offering mental health assistance and psychosocial support. Under this focus, the organization follows a framework that generates a protective environment by targeting basic psychosocial support through specialized medical health care (from promotion of positive mental health and psychological well-being to prevention of further psychological distress and mental health conditions, to treatment for mental health conditions) and supporting the capacity needed to provide that assistance as it changes from more basic to more specialized.

When a crisis or conflict occurs, volunteers collaborate with the community to provide assistance based on needs. This can include sharing information, managing logistics, distributing supplies, and providing water, food, shelter, first aid, medical assistance and psychological support.

The second presenter was Dr. Saidkasim Sakhipov from the United Nations Population Fund's Country Office in Moldova. Sakhipov presented on "Building a Foundation: Protecting the Vulnerable When It Matters Most". The country office that he works in was created when there was an influx of Ukrainian

refugees as a result of the war between Russia and Ukraine. Moldova is one of the largest recipients per capita of Ukrainian refugees. With a population of 2.6 million, it is one of Europe's poorest nations, struggling with its own crises and weak health and social protection systems even before the war. 95% of refugees now live in communities, with more joining as Refugee Accommodation Centers close. UNFPA's approach is restoring or strengthening the existing Sexual Reproductive Health and Gender Based Violence systems to accommodate the influx of refugees and alleviate the social tensions. With majority of refugees in Moldova being women, girls, and older persons, they face unprecedented risks of gender-based violence, and there's a significant demand for reproductive health services among women, based on numerous assessments (UNFPA SRH Assessment, GBV Safety Audit, et al). The Republic of Moldova, a landlocked country between Ukraine and Romania, is considered to be one of the poorest countries in Europe. The health system of the Republic of Moldova is organized according to the principles of universal access to basic health services, with mandatory health insurance for other health services and equity and solidarity in health care financing. However, over 10% of the population lacks health insurance coverage. The influx of refugees has placed significant pressure on the healthcare system. In response to the health vulnerabilities of the refugee population the following concrete investments in health services were made:

1) 12 modernized perinatal centers were constructed servicing both newborns and mothers between 2022-2024 with the support of UNFPA and other partners.

2) This included 20 obstetrical/gynecological operating rooms and 36 birth rooms.

3) Blood transfusion units were strengthened for efficient management of obstetric emergencies. This included specialized chairs for blood collection, blood storage equipment, rapid plasma thawing devices and other devices needed by blood banks, such as shakers and platelet incubators.

4) The pre-hospital emergency medical assistance service for the management of obstetric emergencies was strengthened. Strengthening this is essential for the effective management of obstetric emergencies - ensuring rapid and safe intervention in cases of obstetric complications, preventing maternal and neonatal mortality through quality emergency care. To do this, ambulances were invested in to improve emergency access to the prenatal centers.

5) The equipping of 200 gynecological examination units/offices within the primary healthcare centers with standardized gynecological equipment is in progress - which will contribute to strengthening the national health system in the provision of essential maternal and neonatal health services. This initiative ensures that pregnant women and mothers with newborns, including refugee women, have access to quality prenatal and postnatal care.

The results of these investments are that women across the country, including refugee women from Ukraine who have found refuge in Moldova, have access to the highest quality birth care according to international standards – with every birth being carried out safely.

The final presenters on panel 3 were Assoc. Prof. Anna Persson and Hayden Buker from the Quality of Government Institute at Gothenburg University. They presented on the Institute's expert evaluation of the Swedish Development Cooperation Agency's efforts to reduce corruption in partner countries (Evidence-Based Anti-Corruption? Evaluation of Sida's Efforts to Reduce Corruption in Partner Countries). The presenters began by noting that there is a clear connection between corruption and health outcomes across countries. Corruption is a major obstacle to desired outcomes of health-related development efforts. How does corruption manifest in health? Corruption in the health sector negatively affects access, quality, equity, efficiency, and efficacy of health care services. Manifestations include bribery, absenteeism, embezzlement, and extortion. Drivers of corruption in health include vulnerability to exploitation since there is so much at stake as health a matter of life and death, the large resources that health services demand that can be exploited, problems with monitoring, transparency and accountability in the service provision process due to problems with information asymmetries, complexity, and the large number of actors involved. They continued by noting that there is also a clear connection between corruption and conflict. Corruption stands as an obstacle to desired outcomes of conflict related development efforts. Conflict exacerbates corruption.

Corruption not only follows conflict but is also one of the root causes of conflict. On the one hand, corruption fuels conflict by: diminishing the effectiveness of national institutions, undermining the rule of law, generating popular grievances, providing financing for armed conflict, and worsening poverty. On the other hand, conflict fuels corruption by creating societal distrust, weakened institutions and wartime economies. They then turned to their evaluation of the Swedish Development Cooperation Agency's efforts to reduce corruption in partner countries. Under this focus they began by describing Sida's work with corruption as a development obstacle. This dates back to the early 2000s. Since 2016, Sida has taken up the mission of countering corruption as a development obstacle in partner countries with renewed vigor. The staff is instructed to integrate anti-corruption into all aspects of Sida's operations. Corruption is considered a social practice and a systemic phenomenon. Thus, it is best handled through indirect, context-specific and preventive measures as well as by systematically integrating anti-corruption into all efforts. Sida's efforts to reduce corruption in partner countries was also evaluated by the QoG team through a survey of Program Officers. 72% said that corruption is the first largest or second largest obstacle to development, whereas conflict was identified by 26%. 86% indicate a strong understanding of the corruption context. 88% have a continuous dialogue about how anti-corruption can be integrated into all projects. However, 62% indicate a lack of a clear understanding of the theories of change in anti-corruption projects and half have never used the Anti-Corruption Help Desk (U4 ACHD) or Democracy and Human Rights Help Desk. The results also indicated a serious underutilization of Sida's internal infrastructure that is supposed to support Program Officers in developing their anti-corruption efforts. The efforts of Sida were also evaluated through three case studies of Kenya, Georgia and Serbia. These studies looked at whether Program Officers and partners in partner countries adhere to Sida policy, outlining its anti-corruption approach, and if their efforts sensitive to the context. Program Officers and partners in Kenya and Georgia exhibited very excellent knowledge of corruption in the country context. They could identify established power dynamics, could map specific institutions clearly onto which are most trusted/legitimate, which were considered by the public to be least trustworthy, and had a keen eye on how the socio-political context was developing. This understanding of the local conditions seemed guide the selection of projects to fund by Sida. However, the evaluation also suggested that there was a limited understanding of theories of change in project documents. Here, there is a major implementation gap that hinders Sida's potential to reduce corruption in its partner countries. Mainly, Sida Program Officers seem to exhibit a strong reluctance to embrace the idea of explicitly stating a project's theory of anti-corruption change. Stemming largely from these results, the report concludes with some recommendations. First, related largely to government directives, the evaluation team suggested ensuring that anti-corruption remains a priority area. This will indicate to Program Officers that this is something that needs to be worked with in every contribution in more ways than a simple checklist of obligations. Second, the evaluation team recommended support for continuous evaluation of specific forms of corruption that occur locally, because at the end of the day, we need to know what does and does not work and why and knowing what does not work is as important as knowing what does. Third, the evaluation team recommended stronger integration of the current knowledge base about corruption in policy documents so that these insights can more easily disseminate to the work on the ground. Fourth, the evaluation team recommended strengthening Sida's internal infrastructure that is responsible for disseminating this information. Finally, evaluation team recommended that maintaining continuity of Programme Officers would also help with this. Programme Officers tend to have relatively short stints in partner countries. Thus, by the time that they are effectively acquainted with the context and their projects, they are already on their way out, leaving very little time to get into the nitty and gritty of their anti-corruption work.

References

Bauhr, Monika, Ruth Carlitz, and Lucia Kovacikova. "Beyond buildings: Social bargaining and effective access to public services." Public Organization Review 24, no. 1 (2024): 389-406.

Charron, Nicholas, Victor Lapuente, and A. N. D. R. É. S. RODRÍGUEZ-POSE. "Uncooperative society, uncooperative politics or both? Trust, polarization, populism and COVID-19 deaths across European regions." *European Journal of Political Research* 62, no. 3 (2023): 781-805.

Deglow, Annekatrin, and Hanne Fjelde. "Violent Elections and Citizens' Support for Democratic Constraints on the Executive: Evidence from Nigeria." Comparative Political Studies 57, no. 4 (2024A): 613-643.

Deglow, Annekatrin, and Hanne Fjelde. "Militarized elections and citizens' support for democratic rights: evidence from India." *Democratization* (2024B): 1-23.

Gonçalves, Sónia. "The effects of participatory budgeting on municipal expenditures and infant mortality in Brazil." *World development* 53 (2014): 94-110.

Grimes, Marcia. "The contingencies of societal accountability: Examining the link between civil society and good government." *Studies in comparative international development* 48 (2013): 380-402.

Lee, C. 2007. Labor Unions and Good Governance: A Cross-National, Comparative Analysis. American Sociological Review. 72 :585–609.

Lieberman, Evan, and Yang-Yang Zhou. "Self-efficacy and citizen engagement in development: experimental evidence from Tanzania." *Journal of Experimental Political Science* 9, no. 1 (2022): 46-63.

Lilja and Ahmad A.S. 'Health system resilience and peacebuilding in fragile and conflict-affected settings. Current Opinion in Environmental Sustainability (2023).

Mechkova, Valeriya, and Ruth Carlitz. "Gendered accountability: when and why do women's policy priorities get implemented?." European Political Science Review 13, no. 1 (2021): 3-21.

Mechkova, Valeriya, Sirianne Dahlum, and Constanza Sanhueza Petrarca. "Women's political representation, good governance and human development." Governance 37, no. 1 (2024): 19-38.

Mechkova, Valeriya, and Amanda B. Edgell. "Substantive representation, women's health, and regime type." Comparative Political Studies 57, no. 14 (2024): 2449-2481.

Pandey, Priyanka, Sangeeta Goyal, and Venkatesh Sundararaman. "Community participation in public schools: impact of information campaigns in three Indian states." *Education economics* 17, no. 3 (2009): 355-375.

Percival, Valerie, Oskar T. Thoms, Ben Oppenheim, Dane Rowlands, Carolyn Chisadza, Sara Fewer, Gavin Yamey et al. "The Lancet Commission on peaceful societies through health equity and gender equality." The Lancet 402, no. 10413 (2023): 1661-1722.

Raffler, Pia, Daniel N. Posner, and Doug Parkerson. "The weakness of bottom-up accountability: experimental evidence from the Ugandan health sector." *Los Angeles: Innovations for Poverty Action* (2019).

Themudo, Nuno S. "Government size, nonprofit sector strength, and corruption: a cross-national examination." *The American Review of Public Administration* 44, no. 3 (2014): 309-323.

Themudo, Nuno S. "Reassessing the impact of civil society: nonprofit sector, press freedom, and corruption." *Governance* 26, no. 1 (2013): 63-89.

Touchton, Michael, Natasha Borges Sugiyama, and Brian Wampler. "Democracy at work: Moving beyond elections to improve well-being." American Political Science Review 111, no. 1 (2017): 68-82.