UNDERSTANDING RESILIENCE, SELF-RELIANCE, AND INCREASING COUNTRY VOICE/DECOLONIZING GLOBAL HEALTH:

A Clash of Perspectives in Global Health.

MOMENTUM Country and Global Leadership

MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

This report is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) under the terms of the Cooperative Agreement #7200AA20CA00002, led by Jhpiego and partners. The contents are the responsibility of MOMENTUM Country and Global Leadership and do not necessarily reflect the views of USAID or the United States Government.

Cover photo: Kate Holt, Jhpiego/MCSP

Suggested Citation

Shawar, Yusra Ribhi; Rachel Neill; Michael Kunnuji; Malvikha Manoj; and Jeremy Shiffman; 2022. *Understanding Resilience, Self-Reliance, and Increasing Country Voice/Decolonizing Global Health: A Clash of Perspectives in Global Health*. Washington, DC: USAID MOMENTUM.

.

TABLE OF CONTENTS

Introduction **3**

Methods **3**

Data 4

Findings: Understanding the Three Concepts: Resilience, Self-Reliance, and Increasing Country Voice/Decolonizing Global Health **7**

Reformist vs. Transformational Perspectives Across the Three Concepts 7

Resilience 8

Self-Reliance 15

Increasing Country Voice and Decolonizing Global Health 21

Discussion **27**

Factors Shaping Differences in How Concepts Are Used and Understood 27

Limitations 28

Key Take-Aways and Implications 28

Strategic Considerations 30

Conclusion **31**

Annexes **32**

Annex 1. Search Strategy 32

Annex 2. Inclusion and Exclusion Criteria 35

Annex 3. Literature Included in the Study 37

Annex 4. Data Extraction Form 38

Annex 5. Interviewee Geographical Location and Organizational Roles and Affiliations 40

References **41**

LIST OF TABLES

Table 1. Key informant organizational affiliations **5**

Table 2. Summary of key informant geographical location and organizational affiliations **6**

Table 3. Summary of main views on health system resilience among transformational and reformist perspectives **9**

Table 4. Self-reliance definitions from USAID **16**

Table 6. Summary of main views on self-reliance among transformative and reformist perspectives **17**

Table 7. Summary of differences on increasing country voice/decolonizing global health among reformist and transformative perspectives **24**

INTRODUCTION

"Self-reliance," "resilience," and "increasing country voice" (sometimes called decolonizing global health) are widely used concepts in global health.[1–4] However, the terms are used in diverse ways in global health and among actors involved in MOMENTUM—a U.S. Agency for International Development (USAID) sponsored program seeking to accelerate reductions in maternal, newborn, and child mortality and morbidity in high-burden countries. This report analyzes 1) how these concepts are understood within global health and specifically among MOMENTUM actors and closely aligned implementing partner organizations, with due attention to their relationship to the relatively recent decolonizing global health discourse; 2) why differences in understanding exist; and 3) implications for practice for global health and the MOMENTUM program.

USAID funded this paper through the MOMENTUM mechanism because these concepts are central to the MOMENTUM suite of awards, appearing in organizational and strategy documents. However, there is uncertainty about how they are understood and applied across projects and actors from different geographies, positions, and agencies (i.e., implementing partners, governments, and donors). Debates on and use of these concepts and their applications have been constrained by a lack of "conceptual maturity"[5]—insufficient clarity on what these terms mean—resulting in limited operationalization in research and practice.

The lack of common understanding of these three concepts is in part a result of differences between two perspectives constituting two ends of a spectrum in global health—reformist and transformational. These perspectives—present to varying degrees among key actors in global health—differ on how the problem is defined, which solutions should be advanced, and how progress should be measured. Actors hold perspectives across the reformist-transformational spectrum. Those embracing a reformist perspective advance incremental solutions, working within existing global and local health systems to effect change; those holding a transformational perspective are more revolutionary in nature, seeking to overhaul systems and power relations in global health.

We examine the concepts of self-reliance, resilience, and increasing country voice in turn, exploring reformist and transformational perspectives on how each concept is understood and implied solutions and the way it should be measured. A clear articulation of how these concepts are understood and operationalized and their underlying aims, as well as the main points of divergence among involved actors, are essential for informing practice. We conclude by considering the factors that explain differences in how the concepts are used, as well as implications for practice in global health, especially for the MOMENTUM project and new USAID programs. The analysis is intended to spark discussions among actors engaged in MOMENTUM about how these concepts are understood and employed in advancing project goals.

METHODS

A meta-ethnographic approach, which is a well-established methodological approach to conduct qualitative synthesis reviews that are both interpretive and critical in nature,[6] was employed for document and interview review, synthesis, and analysis. Meta-ethnography is appropriate for interpretive reviews that aim to examine multiple perspectives, build a deeper understanding of a phenomenon, and develop a comparative synthesis of existing qualitative scholarship.[7] The methodology aims to be interpretative, not aggregative, and is considered appropriate for examining multiple accounts or case studies.[7] Seven phases of meta-ethnography, developed by Noblit and Hare,[7] were utilized to guide the review. The eMERGe reporting guidelines for meta-ethnography were also consulted.[8]

DATA

We triangulated multiple forms of literature and key informant interviews with leaders within the MOMENTUM network, those in other prominent global health organizations, and those at the forefront of shaping understanding of each concept.

An initial systematic and comprehensive literature search was undertaken to "be exhaustive in the search for relevant accounts."[7] Index articles were purposefully selected that utilized the key concepts for the review: decolonization of global health, resilience, and self-reliance. Three, interrelated search concepts were developed and executed on October 6, 2020. Annex 1 includes the search terms for the review.

We retrieved 4,694 articles from the peer-reviewed literature and uploaded into RefWorks for review, identifying 3,364 articles concerning self-reliance, 769 linked to resilience, 531 related to decolonization, and 102 articles that concerned more than one concept. A team of three researchers conducted a title and abstract review in RefWorks, with one researcher reviewing each title and abstract. Articles were moved into one of three folders: included in the review, for discussion, and excluded. Annex 2 outlines the criteria used to select the articles. In line with guidance for meta- ethnography, criteria were developed iteratively as literature was reviewed and the scope and objectives of the review were subsequently narrowed. Annex 3 provides a table for the articles remaining after the title and abstract review.

Following the systematic search, a second search for relevant grey literature was conducted. Grey literature was located via Google, utilizing the search concepts and terms used in the systematic search. Grey literature developed by USAID and its partners was prioritized due to the aims of the review. Additional peer-review literature was also identified using snowballing approaches from the reference list of articles, including relevant publications after 2000.

In addition, 27 semi-structured key informant interviews (Table 1) were conducted with leaders within the MOMENTUM suite of awards (including those involved in MOMENTUM Country and Global Leadership, MOMENTUM Knowledge Accelerator, MOMENTUM Integrated Health Resilience, among other projects); leaders in other key global health organizations; and those at the forefront of shaping respective concept discourses. We identified these individuals through the organizational chart of the MOMENTUM consortium, our literature review, and by asking interviewees whom they considered to be most centrally involved in applying the three concepts in their work or advancing conceptualization and/or measurement of the concepts. We also were purposeful in selecting participants residing and working in Ghana, India, Tanzania, and Indonesia—both from outside and inside the MOMENTUM consortium—given the geographic focus of MOMENTUM; these countries were identified by USAID as being furthest along in terms of health systems resilience and the Journey to Self-Reliance. Using a purposive rather than sampling selection strategy, our aim was to reach theoretical saturation[9]—the point at which all major themes have been identified and additional interviews are unlikely to reveal new information.

The key informant interviews occurred via zoom between February 2, 2021, and April 29, 2021. Each interview lasted about one hour and was recorded and transcribed with permission from the key informants. The study protocol was cleared through the Institutional Review Board of Johns Hopkins University (Baltimore, MD, USA), which granted the study exempt status, as it was deemed to pose minimal risk to informants. All interview transcriptions and notes were de-identified and secured in password protected documents to ensure informant confidentiality. Each interviewee was typically asked about one or at most two concepts of their choice, given their preference and background (i.e., those directing an initiative focused on a particular concept were asked about that concept). Drawing on emergent themes from the literature review and extraction, each interviewee was asked about the origins of the concept(s) in global health

discourse and their evolution over time; how they defined and understood the concept(s) as well as any challenges to and/or critiques of their dominant understandings they observed in global health; and any implications they believed the dominant understandings had on practice and policy and how power is distributed in global health. We did not aim to resolve disagreements among those interviewed or provide recommendations. Rather, we investigated the way in which global health actors understood the concept(s) with the aim of generating productive discussion among the actors, and specifically the MOMENTUM suite of awards for improved strategy and decision-making.

TABLE 1. KEY INFORMANT ORGANIZATIONAL AFFILIATIONS

Organizations	
Bill & Melinda Gates Foundation	JSI
Gavi, the Vaccine Alliance	Ministry of Health, Community Development, Gender, Elderly, and Children, Tanzania
Ghana Health Service	Operation Smile
GOAL Global	Population Reference Bureau
Harvard University	Save the Children
IMA World Health	University of Cape Coast
Independent Contractor, Pakistan	University of Cape Town
Jhpiego Ghana	University of Sydney
Jhpiego India	USAID
Jhpiego Indonesia	World Health Organization (WHO)
Jhpiego Tanzania	World Bank
The Jumbam Family Foundation	

DATA EXTRACTION AND ANALYSIS

We triangulated among data sources, including documents and key informant interviews. A data extraction form was developed in Microsoft Excel to review and analyze the literature that was collected. Concepts on the extraction form (Annex 4) corresponded to a series of sub-questions developed from the overall research questions and objectives (summarized below), which were drawn from the power and framing literature.[10–13] For each concept, one researcher extracted relevant information from each included article and inputted it into the Excel document. These data were then synthesized in a Word document for each concept. This document summarized:

1. The definitions utilized—how is the term defined or understood?
2. The origins and evolution of the concept in global health—who champions the term's use and advancement (and who does not), and how did the term's use come about and evolve over time?
3. The nature of the problem—what is the root of the problem that the term seeks to address; who or what is to blame for the status quo?
4. The way in which the term was operationalized—what approaches or strategies should be employed to address the problem?

5. Measurement—how should progress in addressing the problem be assessed?
6. Implications in terms of practice, policy, and power distribution—what implications do the term's use and advancement in global health have on actor relations and the way in which funding is allocated and policy and/or programming is carried out?

Additional sub-codes were added under these primary codes for each of the concepts. The data from the interviews were coded using the same codes in a separate document. Table 2 summarizes the geographical location and organizational role of informants, as well as their affiliation with MOMENTUM (if applicable); Annex 5 provides further information about each informant and the data from the interviews are cited accordingly throughout this report.

Members of the research team came together to discuss emergent themes across the terms. Through this and subsequent team meetings, the team collectively identified a clear spectrum of beliefs, with two distinct perspectives, which we termed reformist and transformational given their orientation to the way in which the nature of the problem, its solutions, and measurement approach were described. We discussed broad principles underlying each perspective, which facilitated our coding of the data. Specifically, those who hold a reformist perspective conceptualize the problem as predominantly down-stream, the solutions proposed largely work within the constraints of the current system, and the measurement approach tends to be more universal and quantitative oriented. Those who hold a transformational perspective describe the problem as predominantly upstream, the solutions proposed fundamentally demand a new system, and measurement approach tends to be more dependent on the particular context.

TABLE 2. SUMMARY OF KEY INFORMANT GEOGRAPHICAL LOCATION AND ORGANIZATIONAL AFFILIATIONS

Key Informant Characteristics Summary		
Geographical Location	High-income country (HIC)	17
	Low- or middle-income country (LMIC)	10
Organization Type	Academic	7*
	Donor	4
	Government	3*
	Implementing Partner	12
	Intergovernmental Organization	3
MOMENTUM Suite of Awards	AlignMNH Global Steering Committee	1
	MOMENTUM Country and Global Leadership	7
	MOMENTUM Integrated Health Resilience	4
	MOMENTUM Knowledge Accelerator	1
	MOMENTUM AOR	3

*Several key informants identified their primary identity to be both government and academic

FINDINGS: UNDERSTANDING THE THREE CONCEPTS: RESILIENCE, SELF-RELIANCE, AND INCREASING COUNTRY VOICE/DECOLONIZING GLOBAL HEALTH

REFORMIST VS. TRANSFORMATIONAL PERSPECTIVES ACROSS THE THREE CONCEPTS

The lack of common understanding of each of these three concepts is in part a result of differences between the two perspectives that we identified, which we term *reformist* and *transformational*. The two perspectives are not binary and can be understood as a spectrum of beliefs.

The reformist and transformational perspectives differ on how the problem is defined, which solutions are advanced, and how progress is measured. Those holding a perspective that is on the reformist end of the spectrum view the problem as largely a matter of inadequate infrastructure, capacity, and/or representation and embody an incremental approach in how they approach the solution; they seek to make changes within the political and power constraints of the existing global and national health system and tend to propose solutions that are more technocratic in nature. Accordingly, those with a reformist perspective tend to propose indicators for measurement that are largely universally applicable, technically focused, and reflective of the incremental nature of the solutions proposed.

In contrast, those holding a perspective that is on the transformational end of the spectrum view the problem as largely systemic and upstream and reflect a revolutionary approach in their proposed solutions; they seek to tackle political and power dynamics head on, overhaul the existing national and global health systems, and are more likely to propose solutions that are political in nature, directly addressing past and current power imbalances. Accordingly, those with a transformational perspective tend to advance indicators for measurement that are political in nature and viewed as highly contextual. There is often not a clear assessment approach advanced given the nature of the solutions proposed.

There is variance among individuals and organizations in terms of their embrace and awareness of reformist and transformational perspectives. Even within the same organization, there are divergent perspectives among individuals. Moreover, there are instances where we detected both perspectives in the same individual. For example, sometimes individuals articulate a transformational perspective in their understanding of the nature of the problem, but then advance solutions and/or measures that are squarely reformist in nature. Other times, the same individual may advance different perspectives, depending on the topic at hand.

Nevertheless, the reformist perspective across the three concepts is reflective of the current dominant global health discourse. It largely manifests in reports, strategies, and research produced by organizations within MOMENTUM and other major global health organizations. It is also represented by a majority of practitioners working within these agencies, including at USAID, and among implementing partners in high-, low-, and middle-income countries, as well as academics. In contrast, those holding a transformational perspective are more likely to be uncomfortable with the status quo, highly critical of the dominant global health discourse. Within the MOMENTUM consortium, it is advanced by a relatively smaller but growing number of individuals. The transformational perspective is more likely to be advanced by national governments and country nongovernmental organization (NGO) staff in the case of self-reliance, and academics and activists from high-income countries (but often with LMIC backgrounds) in the case of resilience and decolonizing global health.

Each concept is presented in turn, including a brief overview, and traces the origins, evolution, and use of the concept in global health before drilling down on reformist and transformational perspective differences with respect to problem definition, solution definition, and measurement. Subsequent to that, we explain how differences around how concept usage and understanding are shaped by power dynamics, parallel discourses, and technical disagreements and the implications of these findings for MOMENTUM.

RESILIENCE

ORIGINS, EVOLUTION, AND USE OF CONCEPT IN GLOBAL HEALTH

The concept of resilience originates in the physical sciences, where it was understood to be a physical system's ability to return to its original form after a disruption.[14] This early conceptualization of resilience, termed *engineering resilience,* was based on a "machine" view of systems and is understood as a system's ability to bounce back from a disturbance. Beginning in the 1970s, ecologists used it to refer to an ecosystem's ability to "absorb shocks while maintaining function."[15] Later use of resilience broadened to include human ecosystems and began to be increasingly applied in the social sciences; conceptualizations of resilience accordingly began to embrace the complex adaptive nature of systems. Within complex adaptive systems theory, resilience is understood as the system's capacity to responsively learn and adapt, while maintaining its core structure and function during times of disorder.[16] The term ultimately began to be employed in an array of other disciplines, including psychology (Interview number [I] 4), urban planning, disaster management (I4, I9, I11), economics, food security (I6, I9, I11) and engineering.[17–19]

The emergence and mainstream use of "resilience" and specifically "health system resilience" in the global health literature drew on understandings from these fields and was largely catalyzed by the 2014–15 West Africa Ebola epidemic in combination with the 2008 global economic crisis, Zika outbreak, and increasing attention to global climate change. Some respondents, however, note discussions of resilience taking place during the early years of the AIDS epidemic (I4).[20,21] Especially after 2014, health systems resilience frequently began appearing in global health policies and research forums. For example, "resilient health systems" was the theme of the 2015 World Health Assembly, it is mentioned in the 2016–2030 Sustainable Development Goals, and there was a sharp rise in published papers on the subject in global health.

The Rockefeller Foundation, in particular, was critical in bringing the concept to the fore given their "resilient cities" work.[22] The concept became increasingly central to development policies of multiple United Nations agencies and bilateral organizations,[23] including the World Bank, WHO, UK Department for International Development, and USAID.[24] While the validation of the concept by the WHO as an objective in its health systems strengthening and research portfolio was a significant milestone, the concept was largely absent in the formal resolutions shared by WHO's governing bodies, indicating lack of consensus about its use among country delegations.[25]

A number of global health agencies consider resilience to be a crucial element of health system performance and strengthening,[26,27] highlighting the concept's advantages in focusing on community priorities and ownership, integrating systems thinking, and developing capacities of populations and strengthening health systems by anticipating shocks to them. Those critical of the discourse, however, are concerned that it maintains the status quo, with social and political factors that underlie health system dysfunction being largely overlooked.

Analysis of literature and key informant interviews highlighted a spectrum of beliefs along the two distinct perspectives—reformist and transformational—which represent the debate on resilience, as illustrated in

Table 3. The reformist perspective is reflective of the current dominant resilience discourse in global health and largely advanced in the strategies of prominent global health agencies.

The transformational perspective is critical of the dominant resilience discourse in global health, which is sometimes reflected in resistance to use of the word altogether, and is largely held by some academics and embraced by fewer individuals in global health agencies, including those in MOMENTUM.

TABLE 3. SUMMARY OF MAIN VIEWS ON HEALTH SYSTEM RESILIENCE AMONG TRANSFORMATIONAL AND REFORMIST PERSPECTIVES

	Reformist	Transformational
Problem Definition	• Problem: Inadequate self-reliance and/or health security capacity • Predominant shock: Acute and haphazard (infectious disease outbreaks) shocks	• Problem: Structural crises weakening system • Predominant shock: Chronic shocks and caused by actor choices
Solution Definition	• Technocratic/formulaic • Hardware elements prioritized (such as infrastructure and finances) • Outcome: Stabilize health system (i.e., maintain, absorb, bounce back) • Plan for catastrophe continuously • Engage “whole of society” with community/individual focus	• Political • Software elements prioritized (such as power relations, leadership capacity, and norms) • Outcome: Transform underpinnings of health system • Plan for catastrophe is not paramount (stymies bold vision) • Engage actors so onus of burden not placed on least powerful
Measurement	• Technocratic elements • Often focused on one or a couple of health system building blocks	• Political elements • Often focused on linkages between all health system building blocks

PROBLEM DEFINITION DIFFERENCES

The essence of resilience is understood differently by those holding perspectives along the reformist and transformational spectrum, including what they see to be the root problem and the predominant nature of the “shock” that inflicts health systems.

Those holding a reformist perspective tend to see inadequate self-reliance and/or health security as a root problem. Ultimately concerned with increasing country self-reliance, the pursuit of resilience is viewed as a means to increase government capacity, funding, and commitment (I2). Within USAID, resilience is presented as a critical component of and means to achieve its “Journey to Self-Reliance” approach by strengthening processes of supply and demand and the context within country health systems to indirectly increase government capacity and commitment.[28] From this perspective, “self- reliant countries are resilient,” capable of “planning, managing, adapting, and financing their continued development, even as challenges arise.”[29] An implementing partner reflected on how self-reliance and resilience were often conflated among MOMENTUM organizations with the latter presented as a critical aspect of helping countries achieve the former:

“I’ve seen far too many documents coming out of USAID, and some of the implementing partners, where they start off talking about self-reliance and then, in the next sentence, they’re using resilience in lieu of that, and I don’t think that they’re the same thing... The U.S. is considered to be self-reliant, but is its health system resilient? I can’t say exactly where this is coming from” (I4).

Largely reflected in USAID and MOMENTUM implementing partner documents, those holding a reformist perspective see resilience as a means to ensure that LMICs are able to withstand and adapt to shocks, which may impact populations elsewhere.[29] From this view, a fundamental problem that resilience mitigates is inadequate global health security: "the activities required, both proactive and reactive, to minimize the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries.”[30] Specifically, the concern is that the increasing frequency of infectious disease outbreaks and other shocks and stressors within LMICs are likely to impact the U.S. population, making it “paramount that USAID act to assist countries in developing health resilience to minimize future healthcare risks.”[29] Accordingly, a resilience focus, which fosters stable and effective public health and health care delivery, strengthens global health security implementation. In the same way, global health security significantly contributes to health resilience by establishing standards, training, laboratories, and surveillance.[29] A respondent from a closely adjacent MOMENTUM organization reflected on how this understanding of resilience underscored a primarily self-interested desire to protect the North, seeing improvement of health in LMICs as a means to an end rather than an end in itself:

“After Ebola, everything was around resilience and preparedness and the IHR [International Health Regulations] and this and that, but basically…was is it not self-motivated, self-interest? It is not because 10,000 people died or 15,000 people died because of the Ebola outbreak…. [It is because] you don't want these cases to come across the ocean...” (I7).

Those embracing a reformist perspective—while acknowledging a range of possible shocks — tend to frame resilience as predominately a response to acute shocks to the system; these occurrences are sudden and transient in nature.[22,31,32] In systematic and scoping reviews of empirical literature, a majority of the papers that examined the resilience of health systems embodied the reformist perspective, focusing on acute and often catastrophic shocks to the system.[33,34] These include disease outbreaks[,35,36] insecurity,[37] and natural and man-made disasters.[38,39] While the empirical literature from other sectors has embraced the notion of resilience to both acute and chronic shocks, the dominant understanding in the health sector and those within MOMENTUM is largely focused on the former—a likely result of the resilience discourse in global health gaining momentum after the 2014–2016 Ebola outbreak.[33] This emphasis is also reflected in USAID’s *Global Health Resilience BluePrint,* which emphasizes the agency’s experience in preventing, preparing for, responding to, and recovering from a range of infectious disease outbreaks, including the global HIV epidemic, the Ebola outbreak in West Africa, and the current COVID-19 pandemic, all of which have “provided lessons to inform health resilience efforts.”[29]

In contrast, those holding a transformational perspective are highly critical of linking resilience with self-reliance and global health security; rather, they see structural conditions, such as historical colonial legacies, as well as current trade, tax, health insurance, and aid structures, contributing to overarching health system dysfunction and inequity as a key problem.[40] Resilience is thus a means to address structural crises weakening the system, deeply embedded health inequalities, and the deliberate choices that shape the often inadequate health system responses to structural crises and health inequalities.[37,41,42]

Therefore, the shocks that those with a transformational perspective tend to emphasize are chronic, slower-burning, and play out over a far longer time-span. These include challenges that LMICs' health systems regularly experience, which result from human error, dynamic political environments, dysfunctional and unclear policies, limited funding, inadequate human resource capacity, and high levels of disease.[33,43–45] In addition, those holding a transformational view emphasize that shocks and disturbances often arise out of *intentional* choices made by international, national, and local actors, resulting in deliberate and inadvertent consequences. These include donor conditionalities and trade agreements at the global level; election promises, government reforms, and regulatory changes at the national level; and changes to citizen voice mechanisms and organizational instability at the local level.[46]

SOLUTION DEFINITION DIFFERENCES

These differing problem definitions shape the divergent ways in which those with these perspectives see the solutions. At a fundamental level, actors with these perspectives differ on 1) the nature of the solution (technocratic vs. political); 2) the prioritization of resilience building blocks (hardware vs. software); 3) the ultimate outcome of resilience (stabilization vs. transformation); 4) the value of continuous anticipation of catastrophe (critical vs. distracting); and 5) who is responsible for ensuring health system resilience (all of society vs. the most powerful, such as those who have the most resources and/or are in a position of decision-making).

Those with a reformist perspective tend to focus on technical solutions, most of which lie within health or closely adjacent sectors; including emphasizing community mobilization, disease surveillance, integration or collaboration of sectors, partners, and services.[29] Accordingly, those with a reformist perspective are more likely to prioritize hardware resilience building blocks—a bias more broadly reflected in the field of global health.[47] Hardware elements include finances, infrastructure, and governance understood as organizational structures and legislation (i.e., hospitals, standards, and surveillance systems).[48] With respect to the ultimate goal, those with a strongly reformist view tend to stress health system stability, often emphasizing maintenance, control, recovery, and/or "bouncing back" to be the key resilience outcome.[1,2,49–52] Several respondents described resilience as the health system's ability to "bounce back" rather than collapse in the face of shocks (I4, I6, I7, I19). This understanding was reflected by several respondents, including an implementing partner involved in MOMENTUM and another working in a prominent intergovernmental organization:

> *"Resilience from a systems perspective...is the ability to weather or bounce back from shocks or stressors, rather than collapse" (I4).*

> *"My definition would be that you are back where you were before the emergency started. The more quickly you can do it, the more resilient you were" (I7).*

Furthermore, those holding a reformist perspective value the continuous anticipation of crisis. They see crises as permanent; actors thus have to be permanently prepared for the worst. The focus is on anticipating how, where, and when crises will happen (i.e., preparation) and what sorts of responses are pragmatic and acceptable in those extreme circumstances. A respondent working in an intergovernmental organization explained the rationale for strengthening preparedness in countries as it relates to advancing resilience:

> *"You know a flood is going to happen; so be prepared so that once it happens, you have the structures to respond to it and be back at where you were before the flood as quickly as possible" (I7).*

Finally, those with a reformist perspective are more inclined to see the importance of engaging all relevant stakeholders, especially communities and individuals, in creating health system resilience. USAID, for example, advances a "whole of society" approach in building resilience by building partnerships across public, private, and nongovernmental sectors. The approach places particular emphasis on empowering communities to have agency in the process. One implementing partner involved in MOMENTUM underscored a community's agency in building resilience:

> *"Resilience transports us back to the community.... Resilience is only built when communities own their health and they are able to…set aside resources and able to access health facilities, clean and safe delivery, family planning methods, [and] immunization. [They] are able to demand it and find ways and be creative [to secure it]" (I13).*

A LMIC government representative underscored an individual's agency in a resilience approach:

> *"Resilience is the ability of bouncing back after having the worst of scenarios, like an experience that puts you down so hard and all of a sudden, even with the pain and suffering, you dust yourself and stand up" (I19).*

In contrast, those with a transformational perspective see that any approach to resilience necessitates long-term commitments to finding socio-economic and political solutions that tackle: the roots of structural violence, the challenges posed by leaders of weak states that maintain power by controlling interactions between their country and the rest of the world, and other reasons underlying why populations are at risk in the first place.[43] They tend to underscore "the dangers of using 'resilience' as part of a de-politicised and technocratic discourse."[40] This concern was reflected by a respondent working in an intergovernmental organization:

> *"The challenge, of course, and this is one of the concerns I have about it [resilience], is that it becomes sort of a resilience checklist" (I11).*

Those with a transformational perspective critique the reformist framing of resilience for being overly formulaic and not adequately considering the political economy that is ultimately needed to build more inclusive and robust health systems.[53] Furthermore, they advance that the reformist framing tends to mask the agency of actors within the health systems,[41] viewing involved actors as neutral players without political interests.[44] This obscures the socio-economic and political factors that lead to inadequate responses to shocks, with the strategies and solutions advanced often divorced from meaningful assessment of the political economy and power dynamics that produced the health system crises in the first place.[1,25,40,43,44] For example, some are critical of the international and national response to the 2020 port blast in Beirut, Lebanon, that left 190 people dead, 6,000 seriously injured, and 300,000 homeless, which did not adequately consider the decades of state neglect and rent-seeking political decisions that directly led to the blast in the first place.[54] Some even see powerful actors advancing the resilience discourse as a political strategy to attain "good enough governance" or "second best solutions" for health—sidestepping any meaningful action on addressing the structural crises weakening health systems.[25]

Those holding a transformational perspective tend to stress the importance of software elements—"the ideas and interests, values and norms, and affinities and power that guide actions and underpin the relationships among system actors and elements."[55] These include leadership capacity, power relations, values, relationships, and organizational culture.[44] While acknowledging the importance of hardware elements (i.e., resources and infrastructure), a transformational perspective emphasizes software elements,[45]

and a commitment to address a range of interconnected issues that often extend beyond the health sector, as especially critical. These include, for example, a LMICs' dependent position in the world economy, the "brain drain" of medical professionals because of externally promoted austerity measures, and policies that uphold user fees for medical services and medicines.[43]

Furthermore, those with transformational views question if maintenance or "bouncing back" to a health system's baseline functioning prior to shock is the right goal; for them, a robust and equitable health system should be the goal instead. Those who hold this view argue that advancing a "bounce back" goal ignores existing challenges and deficiencies of the system and assumes that the system was in an "adequate" state prior to the shock or even existed to begin with.[56] Rather, the resilience outcome should focus on achieving equitable health service distribution and/or outcomes. From a transformational perspective, a goal of health system stability is likely to perpetuate pre-existing vulnerabilities that may underlie stable but poorly performing health system indicators.[57] This perspective finds operationalization of "bouncing back" to effectively translate to "coping," which paradoxically contributes to system fragility.[41] For example, Lee et al.[58] demonstrate this point through their analysis of the routine immunization supply chain in Bihar, India, and conclude that doing away with coping measures and its cultural acceptance is critical to resolving broader and deeper system-related dysfunction. One MOMENTUM implementing partner stressed this point:

> *"If you are not [building back better], you're just surviving and that's not what we want. We don't want people to be able to go through shocks or various strong stresses and still be alive. That's not considered resilience" (12).*

In addition, those holding a transformational perspective tend to be critical of the reformist perspective's constant focus on anticipating a crisis, which is dominant in the current resilience discourse. They argue that this is likely to stymy the capacity or willingness to have a bold vision (i.e., employing rights-based approaches to health care or achieving universal health coverage). Furthermore, continuous anticipation of catastrophe distracts attention from deeply embedded health inequities, the choices that shape health system responses, and the "hard grind" of responding to chronic stresses that do not manifest as acute shocks.[59,60] Those with a transformational perspective see resilience, in practice, preparing "good subjects for war: surviving all the structural insecurities in life and just 'bouncing back' from all the difficulties they will face."[61] In consequence, the status quo is maintained,[40,62,63] with populations remaining insecure, incapable of mobilizing against the oppressive structures, and ruling classes that maintain structural violence and inequity, and unable to imagine alternative possibilities.[64]

Finally, those holding a transformational view tend to be critical of the dominant "whole of society" approach—cautious that it is often framed and translated in practice as coping, with the more powerful putting undue burden on the poor and disadvantaged, expecting them to "draw on their internal strengths and resources" to make up for health system weaknesses.[42] Operationalization of resilience in this way masks the fact that resources are far from equally shared among states and within communities.[61] Furthermore, they are critical of the "whole of society" approach given that it is likely to reinforce the existing interconnected actors and structures that underpin dysfunctional health systems.[42] Rather than overhauling the system (i.e., changing the loci of power and fostering new governance structures and relations in local health systems and global health governance), those advancing a reformist resilience perspective risk emboldening existing dynamics, structures, and actors[42]—all of which are likely part of the underlying problem in advancing the health and equity of populations.

MEASUREMENT DIFFERENCES

Those advancing reformist and transformational perspectives differ in their approach to measuring resilience. In practice, those with a distinctly reformist perspective adopt a more technical approach (i.e., measuring emergency preparedness, infrastructure or health care resilience, and health service utilization). Such measures typically reflect the risk management and organizational continuity plans that are developed. These are often aimed at isolated events that are transient and have clear boundaries, which are in line with reformist understanding of the problem being largely a result of acute shocks. Such approaches are distinctly influenced by the fields of disaster management and emergency preparedness, medical sciences, and public health sciences,[65] which respectively employ: checklists that assess facility and organizational resilience;[66–71] evaluations focused on “health care resilience” and “resilience engineering,” with their analyses concerned with work processes and avoidance of medical errors to maintain functionality of services;[72–76] and quantitative measures that examine the ability of a health system to statistically maintain function or achieve health system targets, despite short-term crises.[23,66,77–80] The latter studies typically focus on service delivery, making use of service utilization indicators to assess resilience before, during, and after a crisis.

In contrast, studies from the public health sciences that adopt a largely transformational perspective are more likely be qualitative[65] and are influenced by ideas of “everyday resilience” and addressing the contributions of social connectedness and leadership on health system resilience.[81–85] Those embracing a transformational perspective are critical of dominant resilience measurements given that they rarely account for structural conditions that influence health system functioning (i.e., aid structures, histories of colonialism), and all health system building blocks (i.e., instead, typically focusing on one or some building blocks, rather than the interlinkages of all).[65] Accordingly, those with a transformational perspective are more likely to anchor health systems resilience assessments in governance, which would enable consideration of both explicit and implicit power dynamics, as well as the competing interests and goals of actors influencing various domains and levels of the health system.[41]

Moreover, those with a transformational view are more likely to highlight the need to focus assessments on who or what benefits from proposed resilience adaptations. Without such consideration, measuring resilience is more likely to be conflated with assessments of improvements in health and equity. In this framing, achieving resilience essentially risks becoming just as, if not more, important than whether adaptation and resilience results in better health outcomes. This view underscores that adaptation or corrections of institutional design, in an effort to achieve resilience, may not always be good. They point to the risk of “over-optimization”— the idea that a system’s response to a known shock can go too far, such that it leaves the system more vulnerable (as compared to before) to an unanticipated shock. Thus, responses in the name of resilience can undermine high-quality or equitable systems and lead to vulnerability,[41,42] especially when prescriptive adaptation strategies for resilience are pursued without taking into context health system values, principles, and goals.[56]

SELF-RELIANCE

ORIGINS, EVOLUTION, AND USE OF CONCEPT IN GLOBAL HEALTH

Self-reliance's origins within mainstream international development discourse comes from postcolonial development theory, which was largely developed from and championed by the Global South. This concept has been re-framed by actors in HICs, while maintaining its original attraction and purpose to LMICs.

Between the 1920s and 1980s, self-reliance was defined and utilized predominantly by southern actors, intellectuals, and heads of state with support from development scholars. Self-reliance was championed at the national level through development strategies and at the global level with a focus on independence and equality on the world stage.[86–90] For example, the 1978 Alma Ata declaration considered self-reliance as a component of comprehensive primary health care systems, with an emphasis on community and bottom-up solutions to improving health equity.[86] Between the 1990s and 2010s, usage of self-reliance shifted. While LMIC actors continued to utilize the concept, advancement of self-reliance discourse was increasingly led by international donors and was aligned with broader discourses of sustainability and country ownership. This was exemplified in high-level discourse such as the 2005 Paris Aid Declaration.

Most recently, understanding of the concept is largely shaped by USAID's Journey to Self- Reliance initiative. The use of self-reliance began to arise from the domestic political context of the Trump Administration and a desire to continue foreign assistance during an executive hiring freeze, internal reviews, and a limited budgetary environment.[91,92] This view has been expressed by others, with acknowledgement to then-USAID Administrator Mark Green for crafting the Journey of Self-Reliance as effective branding, arguing that, "Green's emphasis on transitions and building self-reliance has found a convenient middle ground between the Trump administration's 'America First' agenda—which looks warily at spending American dollars outside of narrowly defined American interests—and development experts' calls for greater 'country ownership' of development efforts."[93] USAID also received praise from the Modernizing Foreign Assistance Network, which highlighted the Journey to Self- Reliance's renewed emphasis on effectiveness and metrics.[94]

With the election of President Joe R. Biden and the confirmation of the new USAID Administrator, Samantha Power, it appears that the initiative may undergo another terminology shift towards sustainability, with a focus on interconnectedness over individualism.[95] Interview participants had already connected the terms sustainability and self-reliance (I2, I4, I11).

Nonetheless, present-day definitions of self-reliance are wide-ranging, including those reflected in USAID documents (Table 4). Many of these strategy documents remain on the USAID website and in the annual program statement of MOMENTUM, while others have been archived or re-branded following the shifting of USAID strategy under Administrator Powers[1].

---

[1] The original website for the Journey to Self-Reliance has been archived (see https://2017-2020.usaid.gov/selfreliance). The country roadmap portal has been re-braded as the "USAID Country Roadmap Portal" without the Journey to Self-Reliance terminology (see: https://roadmaps.usaid.gov/)

TABLE 4. SELF-RELIANCE DEFINITIONS FROM USAID

Example definition	Themes/focus
"Fostering self-reliance means building in-country capacity for leadership, coordination, and partnership, and requires working with ministries and the public sector alongside private-sector and non-governmental actors." (pg. 4) (U.S. Agency for International Development, 2019b)	• How USAID works with partners • Country capacity
In financing self-reliance, USAID is "changing the way it does business to better-support our partner countries' ability to finance their own development journeys … provide an approach to help countries overcome systemic constraints to mobilizing and managing financial resources and transforming those investments into sustainable development outcomes … to improve countries' ability to finance their own social and economic development." (U.S. Agency for International Development, 2019a: pg. 1)	• USAID strategy emphasized • Country capacity • Private sector
"A country's capacity to plan, finance, and implement solutions to local development challenges, as well as the commitment to see these through effectively, inclusively, and with accountability." (U.S. Agency for International Development, 2019c: pg. 1)	• Country capacity • Country commitment • Sustainability

Furthermore, differences in the way self-reliance is understood is reflected by related or adjacent terminology that is utilized by various actors. For example, donors and implementing partners often refer to "country ownership" (for example, see: Igoe [93] and Jobson et al. [96]). Similarly, "locally sustained" or "sustainability", used by donors and global organizations (for example, see: Jobson et al.[96] and Palen et al.[97]), is positioned against the similar concept of "self-sufficient" or "community led" used by LMIC actors (for example, see: Banerji[86] and Medhanie[98]).

Differences in language used both in interviews and gray literature appear to reflect the positionality of various actors, both literally (physical position between countries providing and receiving assistance) and metaphorically (underlying power and practice dynamics across these groups). Several interview participants remarked that self-reliance could be used interchangeably with, or was closely connected to, sustainability (I2, I4, I17, I20). As one respondent reflected:

> *"It's now being called self-reliance. We used to call it, decades ago when I started off in the sector, as self-sufficiency, right? And then the OECD came in, they started using the word sustainability. And now we're talking self-reliance. All the same things. And it's the whole idea of getting rid of dependency" (I23).*

The varying understanding of self-reliance is reflective of differences between those with transformational and reformist perspectives, as illustrated in Table 6. Historically, LMIC actors' use of self-reliance reflected a transformational view. A reformist perspective of the concept was introduced by international donors around the 1990s, which eventually evolved into the current understanding of self-reliance—reflected in USAID's Journey to Self-Reliance and the dominant global health discourse. Present-day, major donor institutions (including USAID) and global NGO actors are the primary adherents to a reformist perspective. In contrast, national governments and country NGO staff were more likely to articulate a transformational perspective, which is now reflected in some of the current critiques of the Journey to Self-Reliance. However, respondents complicate this narrative with individual views varying widely within stakeholder groups. For example, a

minority of global NGO actors shared criticisms of self-reliance aligned with transformative viewpoints despite their organization's reformist tendencies.

TABLE 6. SUMMARY OF MAIN VIEWS ON SELF-RELIANCE AMONG TRANSFORMATIVE AND REFORMIST PERSPECTIVES

	Reformist	Transformational
Problem Definition	Emphasis on national system • Points to low domestic spending, lack of capacity, dependence on external resources	Emphasis on global system • Points to structural inequalities, trade, and power imbalances
Solution Generation	Emphasizes working within the existing system, including: • Country ownership in project design and implementation • Localization of funding, sub-awards • Domestic resource mobilization • Private-sector engagement • Commitment from country actors • All stakeholders—donors, partners, governments, communities—have a role	Emphasizes an overhaul of the existing system and uprooting of entrenched power dynamics, including: • Redefining terms of trade (historical) • Country strategies focusing on national leadership (today) • National governments (or communities) are fully in the lead
Measure-ment Approaches	Measurement is a key component, which is defined globally and nationally. • Journey to Self-Reliance measurement approaches—indicators, roadmaps—are standardized • Normative implications for Journey to Self-Reliance agenda imbedded within the metrics—e.g., trade freedom, democracy	No explicit approach; countries may define their own measurement metrics for country plans.

PROBLEM DEFINITION DIFFERENCES

The reformist perspective aligns with USAID's Journey to Self-Reliance approach. Linguistically, the strategy implies a linear and universalist journey towards ending foreign assistance.[99] The implicit problem, therefore, is that countries require, or are perceived to require, capacity building in order to reach this. Many respondents articulated a problem definition that aligned with the reformist perspective (I4, I8, I18, I11, I10). For example:

> *"I think, my understanding of self-reliance…means you no longer need a donor. I mean, that's the way they [donors] understand it, because…at some point the support should end like you can't keep on supporting a group of communities or a country forever on the same thing" (I13).*

Another respondent related the concept to countries "driving the train," that external assistance can still provide support but countries are in control of their development trajectories (I11). When asked about the meaning of self-reliance, participants related it to adjacent terms and concepts, including sustainability, funding local organizations, graduation, and country ownership (I1, I2, I4, I17, I20, I13).

In contrast, those with a transformational perspective see the problems underlying self-reliance to be generally focused on 1) liberal, capitalist models of development; 2) structural inequities in the world economic and political system; and 3) the resulting, unequal power dynamics manifested in the "first world" and the "third world" (to use the language of the time).[88,100–102] Based on a review of historical literature, problem definition was owned and led by academics and national leaders in post- colonial countries, with additions from development scholars and adherents to the New Economic World Order[2] initiated in 1974.[87,90,102] Interview respondents from LMICs also connected the concept of self-reliance to their national governments, tying together the historical context of the transformational perspective and present-day understanding (I8, I9, I18, I19). For example:

> *"But we have had the terminology self-reliance ever since we had our independence. The founding father of nation, the late President Mwalimu Nyerere, had worked hard to instill the spirit of self-reliance in the people though in the Republic of Tanzania" (I19).*

SOLUTION DEFINITION DIFFERENCES

A differing understanding of the problems underpinning self-reliance have led to different solutions across those holding reformist and transformational perspectives. For those with a reformist view, solutions are largely framed and driven by donor agencies. Per the Paris Declaration, improving aid effectiveness is taken as a shared responsibility of donors and partner governments, with an emphasis on capacity building through country planning processes and increasing domestic resources towards jointly defined development priorities.[103] USAID's Journey to Self-Reliance upholds many of these solutions, particularly domestic financing and country capacity.

If dependence on external financing is understood to be a problem, then domestic financing is the natural solution. USAID's 2019 Acting on the Call report indicates that increased domestic resource mobilization is a key component of self-reliance.[104] Critics of self-reliance have argued that self-reliance is a code for the end of foreign aid. USAID has pushed back on these criticisms, articulating that, "transition is not meant to imply graduation, or a sudden exit. Rather, it is meant to imply maintaining high-quality, trusting relationships with partners on the ground that leverage the country's advanced ability to lead its own development journey."[105] However, USAID's framing to the U.S. Congress has placed an emphasis on an end to foreign assistance. A 2020 House Report outlines, "The ability of a country to finance its own development is central to USAID's overall strategic pivot to the Journey to Self-Reliance." [106] A contradiction is that USAID is simultaneously arguing that self-reliance does not entail an end to foreign assistance, while at the same time focusing their domestic strategy and messaging explicitly on the ending of foreign aid. In other words, USAID's own framing of the problem is different when speaking to its two main audiences—U.S. domestic political constituencies and the aid and development community. However, many participants also shared viewpoints that aligned with transitions (I2, I13, I11, I20, I3):

> *"There's a connotation when you start talking about self-reliance or sustainability, that it's like, code for a project ending and services not being provided in a finite amount of time" (I20).*

---

[2] The New Economic World Order, also called the New International Economic Order, was initiated formally in 1974. Primarily a governance reform, it aspired to transform the structure of the global economy to be more equitable and favorable to developing countries in the spirit of full decolonization.

A related critique is that self-reliance and its positioning of an “endpoint” focuses international assistance inward at a time when global solidarity and cooperation is required to reach large-scale, universal development goals such as achieving the Sustainable Development Goals.[107,108] This argument juxtaposes self-reliance with interdependence and global equity.[107,108] A respondent raised this concern: “What does it mean to be self-reliant in an increasingly globalized world, in a globalized economy? How can you really be truly self-reliant in a globalized world?” (I4).

The proposed solution within the reformist frame is the building of country-level capacity through external technical assistance and programming. USAID’s 2020 bulletin on transforming USAID’s programs confirms this, emphasizing prioritization of programs that, “strengthen in-country capacity and facilitate locally-led development.” [106] However, those in the transformational camp question the ability of external actors, whether USAID directly or USAID-supported partners, to build capacity in LMICs. Gelase Mutahaba, Tanzanian academic, argued that the terms and incentives of aid perpetuate continuation of donor control, even when recipients’ capacity has been strengthened, and that there is a tendency of bypassing the control of the recipient’s unpredictable environment in order to facilitate implementation, which thereby undermines self-reliance.[109] A final critique from those holding a transformational view is that capacity building of local organizations is largely directed towards replicating bureaucratic processes necessary for USAID project management at the country level. It’s argued that this is not self-reliance, but rather a shifting of bureaucratic skills specific to USAID contracts from U.S.-based organizations to LMIC-based organizations.[110]

Finally, capacity building efforts also had reformist critiques, with respondents echoing the practical challenge of implementation (I1, I2, I7, I9, I10). Many respondents expressed that engagement with country governments was critical but alluded to the challenge that this engagement took significant time and slowed down the ability to develop workplans and project activities (I1, I2, I3). And while there was unanimous agreement that local partnerships were critical, many expressed challenges, including a lack of technical partners in particular technical areas (I2), and structural challenges such as corruption or low pay leading to a per diem culture, which international NGOs have little ability to change or overcome (I1, I2, I9 I11).

Specific solutions to improve self-reliance emerged from interviews and highlight the dominance of the reformist paradigm across interview participants. Examples of solutions include:

- **Improving country consultations at the start of projects or even at the proposal phase**. Participants shared this had improved over their careers in development, although others highlighted this could be done more systematically on USAID projects and was driven in part by the enabling of project structures (I1, I23). Others highlighted that while national governments have more voice, there is less room for bureaucratic level actors, frontline providers, or community-level actors to co-shape project design (I2, I22).
- **Following country leadership**. Participants highlighted that self-reliance is really about country ownership and improving partnerships to follow the country’s planning and priorities. Several highlighted that many MOMENTUM countries had increased capacity, with less need for outside assistance. Many particularly felt that countries had the right technical skills and planning capacity but lacked needed domestic resources or governance reforms (I2, I9, I12). However, others identified specific technical areas (e.g., newborn health) where this was not the case. Country-level participants also highlighted the importance of national leaders directing planning and agenda-setting efforts.
- **Working through local organizations**: Several participants stressed that local partner investment must be made holistically to achieve sustainability. This included a long-term view towards engagement and phased transitions (I1, I11, I20). It also means staffing local country offices with national staff, not an international workforce (I17).

- **Graduating from assistance**: Although participants stressed that graduation should be gradual, and long-term, many also spoke directly about graduation as an end goal of self-reliance. For example:

> *"At the beginning we're okay, we will give you this much money to do ABC but, at the end of three years, we want to see that you are allocating this amount of money to do those activities. And so, the idea is as our funding model kind of drops off, their domestic resources and their advocacy kind of increases. So, they 'graduate out' when they're able to cover their own costs for that area." (I2).*

In contrast, the historical use of self-reliance, aligning with a transformational perspective, led to solutions that were fundamentally emancipatory in nature. At the national level, this was reflected in a call for community-led development approaches and self-reliance of individuals (particularly rural communities) from dependency on government support.[86,89,102,111] At the international level, this focused on changing the terms of economic markets, trade, and finance in an effort to re-balance global economic and political power dynamics in the postcolonial era.[90,102,112] This "solution" was driven by LMIC governments and academics, with some support from academics in HICs who supported the economic orthodoxy of the time. As Johan Galtung,[87] a Norwegian sociologist, wrote in 1976:

> *"Self-reliance is a dynamic movement from the periphery, at all levels—individual, local, national, regional. It is not something, done for the periphery; basically, it is something done by the periphery" (page 208).*

In other words, the responsibility for generating and implementing solutions rested squarely with LMIC actors, whether national governments or local communities.

MEASUREMENT DIFFERENCES

Differing problem definitions and solutions have led to varied measurement approaches for self- reliance. In the reformist view and specific to USAID's Journey to Self-Reliance, 17 metrics have been developed to assess a country's self-reliance. Some indicators, such as citizen capacity or capacity of the economy, represent "progress" outcomes related to development, while others, such as open and accountable governance and economic policy, represent more normative policy choices at a national level. This measurement approach represents both a universalist approach to self-reliance and implies an "endpoint" when metric performance indicates that self-reliance has been accomplished.

In contrast, there was historically no defined measurement approach across countries identified during the course of this study. Self-reliance was driven mainly by country actors and thus codified in high-level policy documents and planning strategies (for a cross-country example see The Report of the South Commission)[111] and for analysis of country strategies, see Baru[99] and Lal[88]). A lack of measurement focus has continued to the present day among transformers.

INCREASING COUNTRY VOICE AND DECOLONIZING GLOBAL HEALTH

ORIGINS, EVOLUTION, AND USE OF CONCEPT IN GLOBAL HEALTH

"Increasing country voice" and "decolonizing global health" have distinct origins and meanings and are employed by different actors. The former is largely employed by and reflective of the reformist perspective; the latter is embraced by those with a transformational perspective. Increasing country voice, which has its origins in the development sector and making aid more effective, is concerned with the problem of under-represented or suppressed LMIC voices in global health. Decolonizing global health is a more recently emergent discourse, although attempts had been made since the 1970s, to challenge the colonial system of managing health in postcolonial and settler-colonialism contexts.[113–116] In such contexts, decolonization means transforming the local health system, which typically reflects colonialism's unequal access to services, insensitivity to cultural and ethnic healthcare preferences, dependence on international aid, and indigenous people's dissatisfaction with services.[114–116]

Decolonizing global health draws ideas from leaders, such as Kwame Nkrumah, Julius Nyere (also a champion of self-reliance), Thomas Sankara [102,117–121], and writers, including Frantz Fanon, Ngugi Wa Thiong'o, Chinua Achebe, Albert Memmi, Wole Soyinka, Ashis Nandy, and Aimé Césaire, [122–127] who fought for African or Indian independence and sovereignty. The ideas advanced by such individuals inspired and shaped historical movements that sought to dismantle colonial empires and liberate countries from western control.

Accordingly, decolonizing global health sees the problem of inadequate LMIC voices to be a symptom of a deeper problem—the coloniality of global health. Both concepts seek to address the problem of power imbalance in global health. As this section shows, the most recent decolonizing global health movement has its origin in the demand for increased country voice in the curriculum in South Africa. As a movement, however, decolonizing global health offers a radically different diagnosis of the problem of global health and strategies to address the problem from those offered by attempts to increase country voice.

INCREASING COUNTRY VOICE

Increasing country voice in global health has its origin in a broader development context of making aid more effective. In an attempt to make aid more effective, leaders of countries and multilateral and bilateral development institutions committed to taking actions to reform the delivery and management of aid provided to LMICs, in what came to be known as the Paris Declaration on Aid Effectiveness, which several key informants pointed to as the origins of "increasing country voice":

> *"There's a connection to the Paris Declaration, country ownership, and everything…" (I21).*
>
> *"I think that was maybe a political moment when we sort of started listening more or thinking more about how to get countries to really driving the agenda" (I7).*

Key components of the declaration include commitment to country ownership of development initiatives by strengthening countries' development strategies; aligning aid with countries' priorities, systems, and procedures; respecting partner countries' leadership; and strengthening local capacities for exercising leadership.[128] The idea of increasing country voice guides many global health activities, including serving as a core component of the MOMENTUM approach. This approach underscores local leadership, emphasizing the expertise, leadership capability, and capacity of LMIC actors whose "voices have been under-represented."[129] It builds partnerships with local actors, identifies technical assistance needs, and strengthens local capacity

for improved health systems' sustainability in LMICs. The approach seeks to elevate country voices that ordinarily would have been under-represented or suppressed in identifying priority areas in global health initiatives, in designing solutions to problems, and in driving the implementation of programs.

In 2010, USAID undertook a major reform agenda with three main areas of focus. One of the USAID Forward reform focus areas is to promote sustainable development through high-impact partnerships and local solutions. With this reform, USAID missions use, strengthen, and partner with local actors, including governments, civil society organizations, and local private-sector actors.[130] This way, it ensures increased country voice in its activities.

Oxfam America, Save the Children, and the Overseas Development Institute developed a Local Engagement Assessment Framework (LEAF) for assessing country ownership of development initiatives, an indicator of increased country voice. The LEAF tool was referenced as a major source of measurement indicators for elevating country voice (I21). Country ownership is measured in the priority phase of development initiatives on engagement with national and subnational governments in identifying problems and consultation in the designing of objectives and project activities. During the implementation phase, ownership is measured by partnership in the implementation of actions, obtaining feedback and accountability, and by consultation in monitoring and evaluation. The LEAF assessment also considers whether local governments are responsible for managing the project resources and contribute resources to the project as indicators of ownership.[131]

DECOLONIZING GLOBAL HEALTH

In contrast, the term "decolonize" was used in the public health context in countries with settler-colonialism.[115] In such contexts, the local health system is seen by advocates of decolonization as a vestige of historical coloniality. It is characterized by unequal access to services, insensitivity to cultural and ethnic difference, dependence on international aid that come with "ties and conditions," and general lack of satisfaction with services by the people, with indigenous people being on the receiving end.[114–116,132]

The "decolonize global health" discourse was also largely influenced by decolonization movements outside of the global health field. The discourse draws ideas and strength largely from the writings of thinkers such as Fanon[133] and Rodney,[134] as well as other activists and writers in LMICs.[102,117–121] The movement in higher education, and a particular student protest that took place in South Africa's University of Cape Town in March 2015, proved particularly influential for the discourses' recent emergence within global health. Dubbed the Rhodes Must Fall protest, students demanded, among other things, a more inclusive education system, a decolonized curriculum, and the removal of the Cecil Rhodes statue from the University of Cape Town campus, which was seen as symbolizing oppression and racism and a continuation of the colonial legacy.[135,136] Protesters succeeded in having the statue brought down on April 9, 2015. This protest, as well as a subsequent protest that it inspired in Oxford,[135] galvanized a number of student-led conferences and meetings in HIC universities dedicated specifically to decolonizing global health. The Duke University Decolonizing Global Health Working Group, formed in 2018, references the Rhodes Must Fall movement in the "in solidarity" section of its website.[137] Students at Duke and other universities thus began to demand greater awareness of global health's roots in oppressive systems and the decolonization of global health curriculum.[4]

The discourse around "decolonizing global health" subsequently grew, with a rapid acceleration of articles, which addressed and called attention to the issue, in several prominent health journals, including *BMJ Global Health* and *Lancet;* editorials, commentaries, and original articles were published calling for the decolonization of global health by individuals from various backgrounds.[4,138–141] Those calling for decolonization of global health highlight the entrenched power asymmetry between high and LMICs to be a

core concern in global health governance, agenda setting, medical and public health training, research, and practice. They see the field inheriting the “cultural baggage” of its predecessors (tropical/colonial medicine and international health),[142] with colonial powers still dominating the restricted space of global health policy and decision-making.[143] They raise concern that the current discourse in global health views LMICs as just recipients of philanthropy without ideas and novelty and with limited capacity for leadership.[143]

COVID-19 has further propelled the decolonize global health movement by demystifying the health systems of HICs and revealing that such countries may need aid as much as, if not more than, LMICs.[144] The scramble for supplies by HICs brought questions of equity to the fore and unmasked the degree of coloniality in global health.[142,145] Furthermore, the racist disposition of medical professionals in HICs was highlighted when two French doctors discussed experimenting drug efficacy in Africa.[146–148]

The two discourses—increasing country voice and decolonizing global health—reflect reformist and transformational perspectives respectively. The differences between the two perspectives are summarized in Table 7. The increasing country voice discourse seeks incremental change to the absence of inclusiveness in global health governance and suppressed LMIC voice in global health agenda setting. It has been the dominant discourse in global health, reflected in the approach of HIC global health actors and major multilateral and bilateral institutions working in the global health space, including USAID and MOMENTUM implementing partners. In contrast, the decolonizing global health discourse reflects a transformational perspective, which aims to achieve a wholesale transformation of global health practices. The discourse has largely remained confined to university conferences and peer-reviewed journals, largely eluding many non-academic actors, including government officials, local service providers, and national- and global-level implementing partners. Advocates for global health decolonization are typically LMIC actors (researchers and activists) in HIC institutions or those trained in HIC institutions. However, implementing partners and donors from HICs have increasingly grown aware of it over the last year as it has become part of informal discussions in some global health organizations, with some embracing or being sympathetic to this discourse.[149]

TABLE 7. SUMMARY OF DIFFERENCES ON INCREASING COUNTRY VOICE/DECOLONIZING GLOBAL HEALTH AMONG REFORMIST AND TRANSFORMATIVE PERSPECTIVES

	Reformist perspective (increasing country voice)	Transformational perspective (decolonizing global health)
Problem	• Inadequate infrastructure/capacity in LMICs • Non-inclusive global health governance and suppressed LMIC voices in global health agenda setting	• Systemic problem of hierarchization of humanity and health systems • Exploitative neoliberalism
Solution	• Partnering with local actors to strengthen local capacity • Better representation • Shift decision-making locus to LMIC offices but still within the donor/implementing partner's domain	• Rectify power asymmetry in health research and health care • Decolonize global health curriculum • Local investment in health programs
Measurement	• Decision-making in LMIC offices Representation at major agenda-setting meetings • Co-creation of solutions (and representation at co-creation workshops) • Local ownership of public health programs (measured by knowledge of extant health programs) • Local leadership in program planning and implementation (decision-making power) • Use of local resources for health programs – experts, government budgets	• Racial composition of global health institutions • Global health curriculum that is historical, acknowledging the colonial legacy of global health • Local funding of health programs • Diversity in boards of global health institutions • LMIC slots in global health institutions • Equity and inclusion • Local funding of health programs

PROBLEM DEFINITION DIFFERENCES

Those with reformist and transformative perspectives differ in defining the problem. Those holding a reformist perspective see the non-inclusive nature of global health governance, which excludes LMIC actors and suppresses LMIC voices in global health agenda setting, as the problem. Generally, reformist actions aimed at making U.S. aid more effective in helping recipient countries overcome their problems prioritize "country ownership of the priorities and resources for, and implementation of, development."[150] Implicitly, the lack of country ownership of the process of determining problems and priorities and lack of country ownership of the implementation of programs to address the problems are challenges to development work involving the provision of funding for programs in LMICs. This applies to global health practice. Recipient countries do not own development programs because they do not have a voice in determining the priorities and solutions. The 2010 USAID Forward agenda and the LEAF also stress this idea.[130,131]

In contrast, those with a transformative perspective emphasize the suppressed voices of LMIC actors as the problem of coloniality of global health. Bertram et al.[151] explain that decolonizing global health is tackling the "power structures in global health that favor those who have traditionally held decision-making roles due to their gender, nationality, physical location, ability to fund, type of organizations they lead, or any other

reason." From a transformative perspective, representation alone is an unhelpful goal because tokenism, rather than representation, is what is effectively achieved. As one respondent noted, one or a few people invited to join the discourse may not truly represent the country, and is more likely to reflect the voice of the most privileged in LMICs:

> *"I don't think that having one person is representative of the country… but again, we checked the box, right?" (I10).*

Rather, those with a transformational perspective describe the deeper problem to be racialized hierarchization of humanity and health systems and exploitative neoliberalism.

RACIALIZED HIERARCHIZATION OF HUMANITY

In describing the former problem, Affun-Adegbulu and Adegbulu[138] call for decolonization of global (public) health to "take place at the epistemic and ontological levels," which requires "redefining what is and what it means to be human and reimagining humanity in the pluriverse." To address this, there needs to be acknowledgement that there are many ways of being and doing, unlearning the universality of being and actively engaging with pluriversalities. Nemutandani et al.[152] argue that attempts to integrate traditional health into the health system has been largely one-sided, with conditions and terms solely determined by biomedical professionals. Abimbola and Pai[139] posit that global health is decolonized if it is inclusive, just, diverse, and without a hint of colonialist supremacy in its practice.

EXPLOITATIVE NEOLIBERALISM

Those with a transformational perspective also frame the problem as exploitative neoliberalism. Akugizibwe[146] explains that contemporary global health operates a model that treats LMICs as recipients of philanthropy when in reality the system works in favor of HICs. He argues that global health has been used as an exploitative tool, which needs to be examined through the lens of the broader socio-economic contexts in which it is deployed. The economic co-dependency that characterizes global health is a major problem. Akugizibwe[146] explains that donors provide more than one-fifth of health spending in 20 sub-Saharan African countries, and over 40 percent in nine. While this is often marketed as a one-way flow of charity, it in reality indicates a complex power dynamic that also yields benefits for the donor: improving its relations with the recipient country, while establishing an incentive for that country to align its policies with donor interests. This negatively affects country autonomy, ownership, and voice. Dependency in the form of debt to international institutions can also diminish governments' autonomy for making decisions and compel governments to make broad reforms that can negatively impact health care. For example, the Mexico City policy, which prevents foreign organizations receiving U.S. global health aid from providing information, referrals, or services for legal abortion, even with their own money, has resulted in a lack of policy continuity and negative health care outcomes.[153] Framing global health coloniality this way suggests that local health systems autonomy is at odds with vested interests of some donor countries in safeguarding pharmaceutical industry profits and goes against a global system built around disease-specific biomedical commodities.

SOLUTION DEFINITION DIFFERENCES

Based on these differences in problem definition, proffered solutions differ. Those with a reformist perspective hold the view that better LMIC representation in global health agenda-setting forums and shifting decision-making locus to LMIC offices will lead to increased country voice, as reflected by one respondent:

“Elevating country voices means more [LMIC]representation in different global fora, more research where they [those from LMICs] are primary authors, more interaction with them, [and] they are in leadership positions where they can state their own opinion” (I5).

The LEAF presents a summary of the solutions to the problem of suppressed LMIC voices. The framework prioritizes consultations with national and subnational governments and other local actors in agenda setting. In addition, it recommends partnerships and consultations in the implementation of policies and programs. Reformers also recommend increased use of local resources (which may be in kind) in addressing local problems. Often, this requires partnering with national and subnational governments and civil society organizations.

In contrast, those with a transformational perspective see solutions in creating a health care system where all peoples are treated with dignity, biomedicine and other medicines are of equal status, health research is devoid of racist undercurrents, global health curriculum is not ahistorical and it strives to undo its past ills. Abimbola and Pai[139] describe successful decolonization of global health to be the removal all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level. One respondent with a transformational-leaning view suggests that attempting to make the health system serve the people without a wholesale change to the system is futile:

“[There is] an expectation that people fit into that [health] system, when that system was never created for them. So, the people are struggling because they have to come into the so-called westernized colonized system. But it’s not a healthy system in itself. Then how do we dismantle that because it isn't serving the people?” (I25).

MEASUREMENT DIFFERENCES

The measurement of increased country voice and decolonizing global health has also been diverse; however, there are some measures in common. For those embracing reformist views, attention has been on co-creation of public health solutions; the sub-populations of a country represented at a typical co-creation workshop is then considered a measure of increased country voice (I10, I14).[131] At the global level, representation of countries in international working groups is used as a measure of increased country voice (I5, I10, I14, I27). Another measure of increased country voice is local actors’ (especially government officials) knowledge about ongoing health programs (I24). Knowing about programs is an indication of ownership and not knowing about programs suggests that they may have been imposed by external actors (I16). Reformers further suggest that local leadership and their holding of decision- making positions in program planning and implementation is a measure of increased country voice (I15, I16). They also posit that use of local resources—experts and national/subnational government funding for programs (I11)[150] and the proportion of external funding that goes directly to local institutions (I1, I22)—are measures of increased country voice.

Those embracing the transformational perspective, on the other hand, suggest that the co- existence of biomedicine and alternative medicines within a health system is a measure of decolonization. At the global level, decolonization will be measured by the absence of racial and supremacist ideas in global health governance and initiatives. While key measures may also include diversity, equity, and inclusion in the boards of global health initiatives and key institutions such as Gavi, the Vaccine Alliance, the transformational perspective does not advance clear indicators for determining progress.

DISCUSSION

Across the three concepts, reformist and transformational perspectives were detected among actors and organizations in both HIC and LMIC settings. Those holding perspectives on the reformist end of the spectrum are more incremental in nature, working within the limitations of current systems. Their views are largely reflective of the current dominant discourse in global health, demonstrated in the way the most powerful and dominant global health actors understand and employ these terms. In contrast, those holding perspectives on the transformational end of the spectrum largely challenge and/or critique the current dominant discourse. This perspective is more likely to be articulated by LMIC national governments and country NGO staff, drawing from historical perspectives of their country contexts, in the case of self-reliance. In the case of resilience and increasing country voice/decolonizing global health, a transformational perspective is more likely to be articulated by academics and activists from HICs (but often with LMIC backgrounds).

FACTORS SHAPING DIFFERENCES IN HOW CONCEPTS ARE USED AND UNDERSTOOD

Our analysis points to three key reasons for differences around how the three concepts are used and understood. These concern parallel discourses, technical and normative disagreements, and/or power dynamics.

PARALLEL DISCOURSES

One reason for the split in how those who hold these views understand each of these concepts is the siloed way in which discussions about them have taken place. With respect to resilience and increasing country voice/decolonizing global health, this split is manifest in the different platforms where engagement has taken place in. The reformist discourse largely takes place among HIC development actors and local partners in government and civil society organizations in agency meetings and organizational strategy documents. In contrast, the transformational discourse is largely sustained within peer-reviewed journals, blogs, and efforts on the ground among academics, activists, and service providers. The disconnect between HIC actors who are originally from LMICs and those residing in LMICs is also explained by parallel discourses. The former often articulate ideas about these concepts through peer-reviewed publications, which are often inaccessible to counterparts residing in LMICs. Such silos prevent those with different lived experiences and knowledge from sharing and discussing their ideas and perspectives on how they perceive the problem and what they think are the best solutions. Finally, the siloed way in which these perspectives have unfolded has also been shaped by the fact that different understandings of these concepts emerged in different time periods. For example, discourse around self-reliance and decolonization has historically been more transformational in nature, with a dominant reformist thrust emerging in the 1990s and especially in the development of the new USAID strategy under the Trump administration (with respect to self-reliance) and the 2000s (with respect to discourse around increasing country voice). Key informants from HICs saw the origin of these concepts to be largely from HIC-based global health agencies. In contrast, many LMIC actors drew from historical national legacies with the concept, highlighting what Mathew Kavanagh at Georgetown University called “a remarkable lack of historical understanding” on the part of HIC-based global health agencies.[108]

TECHNICAL AND NORMATIVE DISAGREEMENTS

Another factor shaping reformist and transformational perspective differences are technical and normative disagreements. Technical disagreements are largely disciplinary in nature, shaping perspectives on what is seen as the problem and its solutions. For example, political science or anthropology training is more likely to

socialize individuals to view problems and solutions with greater attention to underlying power dynamics and imbalances; while medical or implementation science training is more likely to emphasize technocratic considerations and the universal nature of quantitative measurement. We see this reflected clearly in the resilience discourse, where there is a bias for hardware elements and imperative to quantify results in the dominant reformist resilience discourse in global health (where medical professionals dominate), especially as compared to its understanding in other fields. Similarly, there are normative disagreements shaping the two perspectives. At a fundamental level this is represented in differences around the extent to which the two perspectives believe global health is inherently good and that it can be improved with modifications. Many of those who hold a transformational perspective are skeptical of this; a reformist perspective is more likely to see this to be largely true.

POWER DYNAMICS

Finally, positionality and power dynamics shape differences in reformist and transformational perspectives. In other words, the power or influence one holds (or lacks) may influence the perspectives they adopt. Those benefiting from current global and national health system configurations and who generally hold the most power over policy and program creation are more likely to advance reformist perspectives. Reformist perspectives are also more likely to be advanced by individuals who feel constrained by the interests of the organizations they work in. For example, dominant reformist views within the MOMENTUM consortium may largely be explained by the fiscal power that the U.S. Congress—an entity that seeks to maintain their power and influence in global affairs—holds over USAID, and ultimately the consortium. This accordingly shapes what language those in the consortium chose and how the problem is framed and understood, as well as what solutions are advanced. In contrast, those with little comparative power and who have little to gain from the status quo are more likely to advance transformational perspectives.

LIMITATIONS

This analysis has several limitations. For one, the analysis has limited generalizability given that most of the key informants are affiliated with the MOMENTUM project and none of the interviews were conducted with members of marginalized populations benefiting from development programs, non-traditional partners, advocacy groups, or civil society. Examining the perspectives of these groups is crucial, but beyond the scope of this study, which focused on the perspectives of those associated with the MOMENTUM suite of awards, as well as academics and leaders representing key implementing partners, governments, and donors in global health. Furthermore, we conducted only 27 interviews, which is an insufficient number to make strong generalizations about the extent to which certain perspectives are represented by certain actors (i.e., those working in USAID, those residing/working in a LMIC). Also, we did not review non-English literature, which may have excluded key perspectives.

KEY TAKE-AWAYS AND IMPLICATIONS

Despite the growing dominance of these concepts in global health, there is little consensus over their understandings, origins, and use. Some of this ambiguity is caused by differences in how they are conceptualized, by whom, and from what positionality. This research highlights the presence of diverse views and understanding about the three main concepts within MOMENTUM staff, within partner governments, and among adjacent institutions across the reformist-transformational spectrum. The MOMENTUM consortium is largely grounded in a reformist perspective. The reformist perspective dominates in terms of policy, organizational structure, and funding strategies. For example, with respect to policy, the consortium is active in supporting linkages among communities and public and private sectors; with respect to

organizational structure, there is increasing efforts for decentralization of decision-making to country offices; and in terms of funding, there are more resources dedicated to local organizations through sub-awards. These solutions are reformist in nature given that they address the problems within the constraints of the system, rather than seeking to fundamentally overhaul it.

However, there is not complete consensus on reformist views among those in the MOMENTUM consortium. To the contrary, the analysis indicates a clear variance in the embrace and awareness of the transformational perspective among actors within MOMENTUM. There are some individuals acutely aware and supportive of transformational perspectives; however, there are also a large number of individuals working in the consortium that are unaware or skeptical of the transformational perspective. Furthermore, individuals may themselves adopt transformational-reformist tendencies in different ways along these spectrums, depending on who they are engaging with, their positionality, the problem at hand, and the root causes they identify. These perspectives do not represent a clear dichotomy, and individuals and organizations may even move along the spectrum at different points of time and for various reasons.

Therefore, it is especially critical to create clarity on what MOMENTUM (and other major global health organizations – especially donors with purse strings attached) means when it uses various terms and understand how others may interpret them. This is important given how discourse shapes the creation and implementation of programs, as well as funding allocations and engagement with local partners and entities. The difference is not just linguistic; the language that is utilized has much broader implications for how problems are framed, what solutions are advanced, how they are enacted, who is involved, and how actors in the process are perceived. For example, a reformist-leaning understanding of resilience leads to greater emphasis on continually preparing for an acute catastrophe; accordingly, the mechanisms put in place to advance this resilience approach—i.e., an emphasis on hardware elements (infrastructure and resources), development of emergency country plans, and engagement with all, especially individuals at the community level—is very different from a transformational resilience approach.

Those with a strongly transformational understanding, in contrast, find that those with a strictly reformist view of resilience minimize “everyday” and “slower-burning” catastrophes and place undue burden on the most vulnerable—individuals within communities—rather than the most powerful—political elites—who have the most resources and are responsible for readdressing collective challenges.

This ambiguity, which directly influences funding decisions and implementation processes on the ground, is further compounded when words get replaced with overlapping yet different meanings because of changing leadership and priorities. For example, self-reliance was preceded by terms like sustainability and country ownership and is now succeeded again by sustainable development.

Understanding and incorporation of perspectives along the reformist-transformational spectrum is critical given the influence that these discourses have on the acceptability and uptake of intervention, as well the consortium’s effectiveness in producing objectives and ultimate impact. An agency with a reformist understanding of the problem and its solutions is likely to face greater difficulty securing buy-in and engagement with partners and stakeholders holding a transformational perspective. This ambiguity not only leads to confusion and misalignment, but also risks being perceived as tone deaf.

The findings of this report, therefore, highlight a key implication for practice: the need to create processes and mechanisms that may enable MOMENTUM—a reformist-leaning consortium of actors—to reasonably incorporate and practically accommodate more transformational-leaning desires and actions. However, it is critical to be realistic about how existing structures, incentives, and interests within the broader global health system influence what perspectives are acceptable and what actions are therefore possible to carry out.

MOMENTUM is embedded in a power structure that is reformist in nature. It is constrained in its goals and actions given the boundaries Congress and USAID sets for it. Moreover, in-country interlocutors—typically at the top of in-country hierarchies, who work closely with HIC donors and partners and are largely socialized into their framing of problems and solutions, also reinforce the reformist structure, given that many desire foreign aid continuity to maintain their positions and the programs they work on. The consortium can't fundamentally adopt a transformational thrust without a complete overhaul of the system, which would require the most powerful to completely surrender their control. While this is unlikely, it nevertheless is possible to consider, accommodate, and even incorporate some of the desires of a transformational perspective. Differences across the reformist-transformational spectrum need not be seen as a binary with little scope for reconciliation: psychologically safe spaces and platforms can give way to productive discussions to identify areas for collaboration, as well as to transcend siloed programming. MOMENTUM can hold space for both perspectives to work collaboratively; these need not be seen as an either-or.

Furthermore, there are multiple opportunities that currently exist to garner better understanding, reflection, and engagement on the use and underlying meanings of these concepts from a transformational perspective. For example, COVID-19 presents a disruption in the pre-conceived understanding that resilience is a prerequisite to self-reliance, given the way that HICs faltered in their initial response to the pandemic as compared to LMICs. USAID's transition from the Journey to Self- Reliance to sustainable development presents another opportunity to create clarity at the country level around a common goal and how MOMENTUM can support country actors who may define a different vision of sustainability than USAID and its partners**.** Finally, the decolonizing global health movement is gaining traction beyond the academic discourse and slowly making its way, even if informally, into global health funders and implementing organizations via working groups, brown bag discussions, and circulation of viewpoints written on the subject in academic and non-academic forums. These pressures and perspective shifts, largely occurring outside the consortium, can at the very least create greater awareness of transformational principles and, overtime, be pivotal in creating small normative shifts within the agency.

STRATEGIC CONSIDERATIONS

We highlight two strategic considerations for MOMENTUM in incorporating more transformational perspectives in its work.

- **Create participatory processes for deliberation and discussion.** First, MOMENTUM can be intentional in creating forums for engagement and deliberation of various perspectives to come together in defining these concepts. These can take place via leading internal and external visioning and co-creation sessions, which involve diverse actors with varying experiences, training, and positions.

  These sessions could bridge the current siloed way that communication of these concepts has taken place. For example, in academia vs. development agencies; among agencies and development partners in HICs vs. service providers and implementing partners in LMICs; and among those originally from LMICs but residing in HICs vs. those residing and working in LMICs. This active consideration of other perspectives, and especially those that are radically different than what is reflected in their strategies and implementation, will undoubtedly allow MOMENTUM to continuously evolve and further strengthen its program design and implementation. According to key informants, a similar process is currently conducted for proposal conception and implementation (i.e., co-creation workshops). It is just as critical to engage in collaboration for defining the very concepts that anchor and guide program design and implementation processes.

- **Create a formal working stream dedicated to exploring principles on the reformist-transformational spectrum for practice.** Second, the MOMENTUM consortium may consider building on the discussions produced through these forums to create a dedicated project stream that would seek to broaden discourse on less dominant perspectives. Accordingly, such a project stream could explore implications of principles across the reformist-transformational perspective for practice, through staff education, as well as grant funding and technical capacity to implement projects that centrally incorporate transformational solutions. There is precedent for the creation of such an entity. In 2009, the Nordic Trust Fund was established in the World Bank, which historically has been resistant to rights-based approaches, as an internal "knowledge and learning initiative" to assist bank staff to better understand how human rights relate to their work and goals.[154,155] The Nordic Trust Fund also provides World Bank teams, through a grant program, the financial and technical support to examine the role of human rights in their work.

  While a similar mechanism in MOMENTUM would need not lobby for official USAID or partner policy changes (a requirement the World Bank imposed on the Nordic Trust Fund), the establishment of such an entity may serve as important catalyst in expanding understanding and operationalization of various views, and especially those that have traditionally not been dominant in current organizational and strategy documents, within MOMENTUM.

  We offer several ideas that this work stream could engage in. For one, the work stream could spearhead efforts to gather and review transformationalist indicators, which can be applied across all MOMENTUM projects as a means to broaden awareness of this perspective and create accountability, even if informal. Second, the group could play a consultative role as new activities are conceptualized, in the same way that gender specialists are currently consulted to ensure that all projects integrate a more gender transformative approach. Finally, the work stream could showcase activities and approaches that engage in transformational principles, such as those that explicitly 1) build in a focus on domestic resource mobilization, 2) exhibit strong national governments leadership in articulating the priorities and/or implementing a program, and 3) conduct a political economy analysis that identifies, among other variables, the power dynamics within the country and among specific populations.

CONCLUSION

MOMENTUM has an opportunity to champion calls for considering diverse views and acknowledging both reformist and transformational perspectives. Taking such steps will enable MOMENTUM to better advance their programs and policies associated with these and other emergent concepts in global health—a crucial step to ensuring the best maternal, newborn, and child health, family planning and reproductive health outcomes.

ANNEXES

ANNEX 1. SEARCH STRATEGY

ALL results retrieved: 7,024

Duplicates removed: 2,332

References Added Manually: 2

Remaining Articles Retrieved: 4,694

Resilience Concept Articles: 769

Self-Reliance Concept Articles: 3,364

Decolonization Concept Articles: 531

Tried and Removed terms: LMIC country names/regions also, "world health", "worldwide health", "capacity building", "self-capacity", independence, "donor independence", institutionalization, graduation, "strategic transition", "developing population", "developing populations", "developing economy", "developing economies", "less developed economy", "less developed economies", "underdeveloped economies", "middle income economy", "middle income economies", "low income economy", "low income economies", "lower income economies", "low gdp", "low gnp", "low gross domestic", "low gross national", "lower gdp", "lower gross domestic", "emerging economies", "emerging nation", "emerging nations", "underdeveloped population", "underdeveloped populations", "middle income population", "middle income populations", "underserved population", "deprived population", "deprived populations", "underserved populations", "under served population", "under served populations", "poor population", "poor populations", "poorer population", "poorer populations", "low income population", "low income populations", "lower income population", "lower income populations"

PUBMED

Date Last Searched: 10/06/2020

ALL Results Retrieved: 2,677

Resilience Results Retrieved: 628

Self-Reliance Results Retrieved: 1,697

Decolonizing Results Retrieved: 313

Filters: 2000 – 2020

("Concept formation"[majr] OR ((resilient*[tiab] OR resilienc*[tiab] OR shock[tiab] OR shocks[tiab] OR coping[tiab] OR adaptation[tiab] OR adaptive[tiab] OR adaptations[tiab] OR responsiveness[tiab]) AND ("health system*"[tiab])) OR "self reliance"[tiab] OR "Self reliant"[tiab] OR autonomy[tiab] OR Decoloni*[tiab] OR "white supremac*"[tiab] OR colonialism[tiab] OR "power imbalanc*"[tiab] OR authorship*[ti])

AND

("Global Health"[Majr] OR "global health"[tiab] OR "international health"[tiab] OR "developing countries"[mh] OR "developing country"[tiab] OR "developing countries"[tiab] OR "developing nation"[tiab] OR "developing nations"[tiab] OR "developing world"[tiab] OR "less developed country"[tiab] OR "less developed countries"[tiab] OR "less developed nation"[tiab] OR "less developed nations"[tiab] OR "less developed world"[tiab] OR "lesser developed countries"[tiab] OR "lesser developed nations"[tiab] OR "under developed country"[tiab] OR "under developed countries"[tiab] OR "under developed nations"[tiab] OR "under developed world"[tiab] OR "underdeveloped country"[tiab] OR "underdeveloped countries"[tiab] OR "underdeveloped nation"[tiab] OR "underdeveloped nations"[tiab] OR "underdeveloped world"[tiab] OR "middle income country"[tiab] OR "middle income countries"[tiab] OR "middle income nation"[tiab] OR "middle income nations"[tiab] OR "low

income country"[tiab] OR "low income countries"[tiab] OR "low income nation"[tiab] OR "low income nations"[tiab] OR "lower income country"[tiab] OR "lower income countries"[tiab] OR "lower income nations"[tiab] OR "underserved countries"[tiab] OR "underserved nations"[tiab] OR "deprived countries"[tiab] OR "poor country"[tiab] OR "poor countries"[tiab] OR "poor nation"[tiab] OR "poor nations"[tiab] OR "poor world"[tiab] OR "poorer countries"[tiab] OR "poorer nations"[tiab] OR "lmic"[tiab] OR "lmics"[tiab] OR "third world"[tiab] OR "lami country"[tiab] OR "lami countries"[tiab] OR "transitional country"[tiab] OR "transitional countries"[tiab] OR "global north"[tiab] OR "global south"[tiab] OR "government"[mh] OR govern*[tiab])

EMBASE

Date Last Searched: 10/06/2020

ALL Results Retrieved: 2,344

Resilience Results Retrieved: 150

Self-Reliance Results Retrieved: 1,889

Decolonizing Results Retrieved: 271

Filters: 2000 – 2020

'concept formation'/exp/mj OR ((resilient* OR resilienc* OR shock OR shocks OR coping OR adaptation OR adaptive OR adaptations OR responsiveness) NEAR/3 ("health system*")):ti,ab OR "self reliance":ti,ab OR "Self reliant":ti,ab OR autonomy:ti,ab OR Decoloni*:ti,ab OR "white supremac*":ti,ab OR colonialism:ti,ab OR "power imbalanc*":ti,ab OR authorship*:ti

AND

'global health'/exp/mj OR "global health":ti,ab OR "international health":ti,ab OR 'developing country'/exp/mj OR "developing country":ti,ab OR "developing countries":ti,ab OR "developing nation":ti,ab OR "developing nations":ti,ab OR "developing world":ti,ab OR "less developed country":ti,ab OR "less developed countries":ti,ab OR "less developed nation":ti,ab OR "less developed nations":ti,ab OR "less developed world":ti,ab OR "lesser developed countries":ti,ab OR "lesser developed nations":ti,ab OR "under developed country":ti,ab OR "under developed countries":ti,ab OR "under developed nations":ti,ab OR "under developed world":ti,ab OR "underdeveloped country":ti,ab OR "underdeveloped countries":ti,ab OR "underdeveloped nation":ti,ab OR "underdeveloped nations":ti,ab OR "underdeveloped world":ti,ab OR "middle income country":ti,ab OR "middle income countries":ti,ab OR "middle income nation":ti,ab OR "middle income nations":ti,ab OR "low income country":ti,ab OR "low income countries":ti,ab OR "low income nation":ti,ab OR "low income nations":ti,ab OR "lower income country":ti,ab OR "lower income countries":ti,ab OR "lower income nations":ti,ab OR "underserved countries":ti,ab OR "underserved nations":ti,ab OR "deprived countries":ti,ab OR "poor country":ti,ab OR "poor countries":ti,ab OR "poor nation":ti,ab OR "poor nations":ti,ab OR "poor world":ti,ab OR "poorer countries":ti,ab OR "poorer nations":ti,ab OR "lmic":ti,ab OR "lmics":ti,ab OR "third world":ti,ab OR "lami country":ti,ab OR "lami countries":ti,ab OR "transitional country":ti,ab OR "transitional countries":ti,ab OR "global north":ti,ab OR "global south":ti,ab OR 'government'/exp OR govern*:ti,ab

OVID GLOBAL HEALTH

Date Last Searched: 10/06/2020 **ALL Results Retrieved:** 2003 **Resilience Results Retrieved:** 182

Self-Reliance Results Retrieved: 1,579 **Decolonizing Results Retrieved:** 239 **Filters:** 2000 – 2020

1. ((resilient* or resilienc* or shock or shocks or coping or adaptation or adaptive or adaptations or responsiveness) adj3 "health system*").ab. or ((resilient* or resilienc* or shock or shocks or coping or adaptation or adaptive or adaptations or responsiveness) adj3 "health system*").ti.
2. ("self reliance" or "Self reliant" or autonomy).ab. or ("self reliance" or "Self reliant" or autonomy).ti.
3. (Decoloni* or "white supremac*" or colonialism or "power imbalanc*").ab. or (Decoloni* or "white supremac*" or colonialism or "power imbalanc*").ti.
4. authorship*.ti.
5. 3 OR 4

6.

("global health" or "international health" or "developing country" or "developing countries" or "developing nation" or "developing nations" or "developing world" or "less developed country" or "less developed countries" or "less developed nation" or "less developed nations" or "less developed world" or "lesser developed countries" or "lesser developed nations" or "under developed country" or "under developed countries" or "under developed nations" or "under developed world" or "underdeveloped country" or "underdeveloped countries" or "underdeveloped nation" or "underdeveloped nations" or "underdeveloped world" or "middle income country" or "middle income countries" or "middle income nation" or "middle income nations" or "low income country" or "low income countries" or "low income nation" or "low income nations" or "lower income country" or "lower income countries" or "lower income nations" or "underserved countries" or "underserved nations" or "deprived countries" or "poor country" or "poor countries" or "poor nation" or "poor nations" or "poor world" or "poorer countries" or "poorer nations" or "lmic" or "lmics" or "third world" or "lami country" or "lami countries" or "transitional country" or "transitional countries" or "global north" or "global south" or govern*).ti. or ("global health" or "international health" or "developing country" or "developing countries" or "developing nation" or "developing nations" or "developing world" or "less developed country" or "less developed countries" or "less developed nation" or "less developed nations" or "less developed world" or "lesser developed countries" or "lesser developed nations" or "under developed country" or "under developed countries" or "under developed nations" or "under developed world" or "underdeveloped country" or "underdeveloped countries" or "underdeveloped nation" or "underdeveloped nations" or "underdeveloped world" or "middle income country" or "middle income countries" or "middle income nation" or "middle income nations" or "low income country" or "low income countries" or "low income nation" or "low income nations" or "lower income country" or "lower income countries" or "lower income nations" or "underserved countries" or "underserved nations" or "deprived countries" or "poor country" or "poor countries" or "poor nation" or "poor nations" or "poor world" or "poorer countries" or "poorer nations" or "lmic" or "lmics" or "third world" or "lami country" or "lami countries" or "transitional country" or "transitional countries" or "global north" or "global south" or govern*).ab.

7. government/
8. Developing Countries/
9. 6 OR 7 OR 8
10. 1 AND 9
11. limit 10 to yr="2000 - 2020"
12. 2 AND 9
13. limit 12 to yr="2000-2020"
14. 5 AND 9
15. limit 14 to yr="2000 - 2020"
16. 1 OR 2 OR 5
17. 9 AND 16
18. limit 17 to yr="2000 – 2020

ANNEX 2. INCLUSION AND EXCLUSION CRITERIA

Concept	*Include*	*For discussion*	*Exclude*
Concept-wide	• Articles should address power/framing per the theoretical anchor articles (Duval and Koon)– should explicitly refer to the concepts. i.e., describe its origins, measurement, etc. • Should be information rich per our evolving research questions	• Articles that refer to the concept in the article. The concept is not the main unit of analysis, but the article has substantive discussion or use of it in the article (helps us with framing aspect).	• Articles that are outside global health; articles not referring to LMICs • Articles that are country specific outside momentum countries (TBC)
Self-reliance	• Articles that specifically focus on or discuss country-led/self-reliance concepts	• Articles focused on analyzing reforms/policies/programs, with a focus on or recommendations related to elevating country voices/country-led approaches • Articles that focus on self-reliance at 'lower' levels of government that also relate to donor/international programming or global health policy recommendations	• Articles using self-reliance in terms of individuals in society, not at the country or systems level • Articles focusing measuring responsiveness of the health system to patient preferences • Articles in high-income countries
Resilience	• Articles that explicitly discuss and/or measure resilience in the context of national health systems, especially in the context of LMICs/ unstable countries and/or global health/development. • Ideally, focuses on the term conceptually (how it emerged, how it is understood, critiques, etc.) OR an in-depth discussion of how concept manifests/measured within one or more LMIC national contexts	• Articles that discuss and/or measure closely related terms (i.e., health systems responsiveness or preparedness) • Articles that discuss resilience only in the context of other related developments (i.e., pandemics/shocks or universal health coverage) • Those that examine resilience tangentially in the context of a country case study • Articles that discuss the concept in HIC contexts only	• Articles that only focus on resilience of populations (including health care workers) or subnational entities (i.e., particular clinics/community initiatives) without explicit discussion of the term in relation to national health system • Articles outside of the health sector (i.e., related to climate change) • Articles that focus on responsiveness/resilience only with respect to individual behavior/quality of care

Concept	Include	For discussion	Exclude
Decolonization/ Elevating country voice	• Articles explicitly about decolonization of/ elevating country voices within global health	• Article explicitly uses an anti-racist or decolonizing approach in its approach or explicitly engages with this concept in the recommendations section • Article refers to concepts related to 'elevating country voices' and relates that back to power/systemic structures (whether colonial or otherwise) • The article is about authorship representation, with a specific focus on LMIC/geographic analysis of authors	• Article mentions colonialism (e.g. as a structural determinant, root cause, historical legacy) but does not engage in anti-colonialist thought • Article is outside the health sector • Article focuses on indigenous persons and/or applies a decolonizing approach in high-income countries only (e.g. USA, Australia, Canada) • Article focuses on power relations between medical volunteers/student volunteers/medical volunteering trips not health systems programs/policies/technical assistance • Article is not on the topic of decolonization/raising country voices

ANNEX 3. LITERATURE INCLUDED IN THE STUDY

Concept			
	25	38	3,454
	45	51	669
	21	58	423

ANNEX 4. DATA EXTRACTION FORM

Extracted data	Description of the data needs to be extracted
Study characteristics	
Author	Last name of first author
Year	Article publication year
Title	Title of the article
Article Type	• Peer review - original research • Peer review - literature review • Peer review - commentary, editorial, perspective • Gray - blog • Gray - organizational report • Gray - organization materials • Other
Author Background	• LMIC academic • HIC academic • HIC first author + LMIC collaborators • LMIC implementing partner/practitioner • HIC implementing partner/practitioner • LMIC author in HIC organization • US Government • Other
Definition	
Objective	
Interpretive	
Further details on definition	
Framing	
Origins	
External positioning	
Measurement	

Extracted data	Description of the data needs to be extracted
Power	
Usage	
Implications for autonomy	
Additional themes	
New themes	
Reviewer notes	
Applicability to other concepts	

ANNEX 5. INTERVIEWEE GEOGRAPHICAL LOCATION AND ORGANIZATIONAL ROLES AND AFFILIATIONS

Interview Number	Geographical Location	Organization Role/Affiliation
I1	LMIC	Implementing Partner
I2	LMIC	Implementing Partner
I3	LMIC	Implementing Partner
I4	HIC	Implementing Partner
I5	HIC	Implementing Partner
I6	HIC	Implementing Partner
I7	HIC	Intergovernmental Organization
I8	LMIC	Implementing Partner
I9	HIC	Implementing Partner
I10	HIC	Donor
I11	HIC	Intergovernmental Organization
I12	HIC	Implementing Partner
I13	HIC	Implementing Partner
I14	HIC	Donor
I15	LMIC	Academic
I16	LMIC	Government/Academic
I17	HIC	Implementing Partner
I18	LMIC	Government/Academic
I19	LMIC	Government
I20	HIC	NGO
I21	HIC	Intergovernmental Organization
I22	HIC	Donor
I23	LMIC	Academic
I24	HIC	Academic
I25	LMIC	Academic
I26	HIC	Academic
I27	HIC	Donor

REFERENCES

1. Kruk ME, Ling EJ, Bitton A, *et al.* Building resilient health systems: a proposal for a resilience index. *BMJ* 2017; **357**: j2323.
2. Hanefeld J, Mayhew S, Legido-Quigley H, *et al.* Towards an understanding of resilience: responding to health systems shocks. *Health Policy Plan* 2018; **33**: 1144.
3. Muangchana C, Thanormwat Y, Kongsiang A. Workshops advocating ASEAN Vaccine Security and Self-Reliance (AVSSR): A regional initiative. *Vaccine* 2019; **37**: 2034–41.
4. Büyüm AM, Kenney C, Koris A, Mkumba L, Raveendran Y. Decolonising global health: if not now, when? *BMJ Glob Health* 2020; **5**. DOI:10.1136/bmjgh-2020-003394.
5. Pfadenhauer LM, Mozygemba K, Gerhardus A, *et al.* Context and implementation: A concept analysis towards conceptual maturity. *Z Evid Fortbild Qual Gesundhwes* 2015; **109**: 103–14.
6. Urrieta L Jr, Noblit GW. Cultural Constructions of Identity: Meta-Ethnography and Theory. Oxford University Press, 2018.
7. Noblit GW, Hare RD. Meta-Ethnography. 1988. SAGE Publications, Inc. https://www.doi.org/10.4135/9781412985000
8. France EF, Ring N, Noyes J, et al. Protocol-developing meta-ethnography reporting guidelines (eMERGe). *BMC Med Res Methodol* 2015; **15**: 103.
9. Morse JM. Theoretical saturation. *Encyclopedia of social science research methods* 2004; **3**: 1122–3.
10. Majone G. Evidence, Argument, and Persuasion in the Policy Process. Yale University Press, 1989.
11. Hawkins B, Holden C. Framing the alcohol policy debate: industry actors and the regulation of the UK beverage alcohol market. *Critical Policy Studies* 2013; **7**: 53–71.
12. Koon AD, Hawkins B, Mayhew SH. Framing and the health policy process: a scoping review. *Health Policy Plan* 2016; **31**: 801–16.
13. Barnett M, Duvall R. Power in International Politics. *Int Organ* 2005; **59**: 39–75.
14. Norris FH, Stevens SP, Pfefferbaum B, Wyche KF, Pfefferbaum RL. Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. *Am J Community Psychol* 2008; **41**: 127–50.
15. Holling CS. Resilience and Stability of Ecological Systems. *Annu Rev Ecol Syst* 1973; **4**: 1–23.
16. Folke C, Carpenter SR, Walker B, Scheffer M, Chapin T, Rockström J. Resilience thinking: integrating resilience, adaptability and transformability. *Ecol Soc* 2010; **15**. https://www.jstor.org/stable/26268226.
17. Campanella TJ. Urban resilience and the recovery of New Orleans. *J Am Plann Assoc* 2006. https://www.tandfonline.com/doi/abs/10.1080/01944360608976734.
18. Gifun JF, Karydas DM. Organizational attributes of Highly Reliable complex systems. *Qual Reliab Eng Int* 2010; **26**: 53–62.
19. Rose A. Defining and measuring economic resilience to disasters. *Disaster Prevention and Management: An International Journal* 2004; **13**: 307–14.
20. Castleden M, McKee M, Murray V, Leonardi G. Resilience thinking in health protection. *J Public Health* 2011; **33**: 369–77.

21. Gillespie S. Poverty, Food Insecurity, HIV Vulnerability and the Impacts of AIDS in sub-Saharan Africa. IDS Bulletin. 2008; **39**: 10–8.

22. Kruk ME, Myers M, Varpilah ST, Dahn BT. What is a resilient health system? Lessons from Ebola. *Lancet* 2015; **385**: 1910–2.

23. Odhiambo J, Jeffery C, Lako R, Devkota B, Valadez JJ. Measuring health system resilience in a highly fragile nation during protracted conflict: South Sudan 2011–15. *Health Policy Plan* 2019; **35**: 313– 22.

24. Ziglio E, Azzopardi-Muscat N, Briguglio L. Resilience and 21st century public health. *Eur J Public Health* 2017; **27**: 789–90.

25. Pas R van de, van de Pas R, Ashour M, Kapilashrami A, Fustukian S. Interrogating resilience in health systems development. Health Policy and Planning. 2017; **32**: iii88–90.

26. Koeva S, Department of Health Economics and Management, Faculty of Public Health, *et al.* HEALTH SYSTEM RESILIENCE: CONCEPT DEVELOPMENT. Journal of IMAB - Annual Proceeding (Scientific Papers). 2020; **26**: 3251–8.

27. Resilient systems: The next big evolution in global health. 2015; published online May 8. https://www.rockefellerfoundation.org/blog/resilient-systems-the-next-big-evolution-in-global-health/ (accessed July 27, 2021).

28. USAID. From Fragile to Resilient Health Systems: A Journey to Self-Reliance Meeting Report. USAID, 2019. https://www.usaid.gov/sites/default/files/documents/1864/From_Fragile_to_Resilient_Health_Sys tems-Meeting_Report_TR-19-362.pdf.

29. USAID. Blueprint for Global Health Resilience. 2021 http://www.usaid.gov/sites/default/files/documents/Blueprint_for_Global_Heatlh_Resilience.pdf

30. Health security. https://www.who.int/health-topics/health-security (accessed Oct 25, 2021).

31. Thomas S, Keegan C, Barry S, Layte R, Jowett M, Normand C. A framework for assessing health system resilience in an economic crisis: Ireland as a test case. BMC Health Services Research. 2013; **13**. DOI:10.1186/1472-6963-13-450.

32. Kieny M-P, Evans DB, Schmets G, Kadandale S. Health-system resilience: reflections on the Ebola crisis in western Africa. *Bull World Health Organ* 2014; **92**: 850.

33. Barasa E, Mbau R, Gilson L. What Is Resilience and How Can It Be Nurtured? A Systematic Review of Empirical Literature on Organizational Resilience. *Int J Health Policy Manag* 2018; **7**: 491–503.

34. Turenne CP, Gautier L, Degroote S, Guillard E, Chabrol F, Ridde V. Conceptual analysis of health systems resilience: A scoping review. *Soc Sci Med* 2019; **232**: 168–80.

35. Lapão LV, Silva A, Pereira N, Vasconcelos P, Conceição C. Ebola impact on African health systems entails a quest for more international and local resilience: the case of African Portuguese speaking countries. *Pan Afr Med J* 2015; **22 Suppl 1**: 15.

36. McKenzie A, Abdulwahab A, Sokpo E, W. Mecaskey J. Building a resilient health system: Lessons from Northern Nigeria. 2015; published online April 10. https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/5994 (accessed July 16, 2021).

37. Ager AK, Lembani M, Mohammed A, *et al.* Health service resilience in Yobe state, Nigeria in the context of the Boko Haram insurgency: a systems dynamics analysis using group model building. *Confl Health* 2015; **9**: 30.

38. Achour N, Price ADF. Resilience strategies of healthcare facilities: present and future. *&ctx_ver=Z* 2010; **39**: 88.

39. Zhong S, Hou X-Y, Clark M, *et al.* Disaster resilience in tertiary hospitals: a cross-sectional survey in Shandong Province, China. *BMC Health Serv Res* 2014; **14**: 135.

40. Topp S, Flores W, Sriram V, Scott K. Critiquing the concept of resilience in health systems. *News & Commentary Retrieved* 2016; **5**.

41. Topp SM. Power and politics: the case for linking resilience to health system governance. BMJ Glob Health. 2020; **5**. DOI:10.1136/bmjgh-2020-002891.

42. Abimbola S, Topp SM. Adaptation with robustness: the case for clarity on the use of 'resilience' in health systems and global health. *BMJ Global Health* 2018; **3**: e000758.

43. Anderson E-L, Beresford A. Infectious injustice: the political foundations of the Ebola crisis in Sierra Leone. Third World Quarterly. 2016; **37**: 468–86.

44. Barasa EW, Cloete K, Gilson L. From bouncing back, to nurturing emergence: reframing the concept of resilience in health systems strengthening. *Health Policy Plan* 2017; **32**: iii91–4.

45. Gilson L, Barasa E, Nxumalo N, *et al.* Everyday resilience in district health systems: emerging insights from the front lines in Kenya and South Africa. *BMJ Glob Health* 2017; **2**: e000224.

46. Critiquing the concept of resilience in health systems. https://healthsystemsglobal.org/news/critiquing-the-concept-of-resilience-in-health-systems/ (accessed July 16, 2021).

47. Cairns E. Ebola is Still Here: Voices from Liberia and Sierra Leone on response and recovery. Oxfam International, 2015.

48. Sheikh S, Sarwar S, Reed C. Teaching methods that help to build resilience to extremism Rapid Evidence Assessment. 2011. https://dera.ioe.ac.uk/3597/1/3597_DFE-RR120.pdf.

49. Therrien M-C, Normandin J-M, Denis J-L. Bridging complexity theory and resilience to develop surge capacity in health systems. *J Health Organ Manag* 2017; **31**: 96–109.

50. Blanchet K, Nam SL, Ramalingam B, Pozo-Martin F. Governance and Capacity to Manage Resilience of Health Systems: Towards a New Conceptual Framework. *Int J Health Policy Manag* 2017; **6**: 431– 5.

51. McKenzie A, Abdulwahab A, Sokpo E, Mecaskey JW. Creating the Foundation for Health System Resilience in Northern Nigeria. *Health Syst Reform* 2016; **2**: 357–66.

52. Bayntun C, Rockenschaub G, Murray V. Developing a health system approach to disaster management: A qualitative analysis of the core literature to complement the WHO Toolkit for assessing health-system capacity for crisis management. *PLoS Curr* 2012; **4**: e5028b6037259a.

53. Anderson B. What Kind of Thing is Resilience? *Politics* 2015; **35**: 60–6.

54. Meagher K. Lebanon – the failed state: how politics and policy shapes population health and wellbeing. https://r4hc-mena.org/2020/09/30/lebanon-the-failed-state-how-politics-and-policy-shapes-population-health-and-wellbeing/ (accessed Oct 25, 2021).

55. Sheikh K, Gilson L, Agyepong IA, Hanson K, Ssengooba F, Bennett S. Building the field of health policy and systems research: framing the questions. *PLoS Med* 2011; **8**: e1001073.

56. Fridell M, Edwin S, von Schreeb J, Saulnier DD. Health System Resilience: What Are We Talking About? A Scoping Review Mapping Characteristics and Keywords. *Int J Health Policy Manag* 2020; **9**: 6–16.

57. Bhandari S, Alonge O. Measuring the resilience of health systems in low- and middle-income countries: a focus on community resilience. *Health Res Policy Syst* 2020; **18**: 81.

58. Lee BY, Wedlock PT, Mitgang EA, *et al.* How coping can hide larger systems problems: the routine immunisation supply chain in Bihar, India. *BMJ Glob Health* 2019; **4**: e001609.

59. van de Pas on September R. Beyond resilience. 2015; published online Sept 10. https://www.internationalhealthpolicies.org/blogs/beyond-resilience/ (accessed May 11, 2021).

60. van de Pas R. Beyond resilience. *Articles Retrieved* 2016; **4**.

61. medico international. Resisting Resilience. medico international. 2015; published online June 9. https://www.medico.de/en/resisting-resilience-16103/ (accessed July 23, 2021).

62. Evans B, Reid J. Dangerously exposed: the life and death of the resilient subject. *Resilience* 2013; **1**: 83–98.

63. Evans B, Reid J. Exhausted by resilience: response to the commentaries. *Resilience* 2015; **3**: 154–9. 16. van de Pas on July R. Resisting Resilience: The revenge of the zombies. 2015; published online July. https://www.internationalhealthpolicies.org/blogs/resisting-resilience-the-revenge-of-the- zombies/ (accessed July 23, 2021).

64. Biddle L, Wahedi K, Bozorgmehr K. Health system resilience: a literature review of empirical research. *Health Policy Plan* 2020; **35**: 1084–109.

65. Paterson J, Berry P, Ebi K, Varangu L. Health care facilities resilient to climate change impacts. *Int J Environ Res Public Health* 2014; **11**: 13097–116.

66. Zhong S, Clark M, Hou X-Y, Zang Y, FitzGerald G. Development of key indicators of hospital resilience: a modified Delphi study. *J Health Serv Res Policy* 2015; **20**: 74–82.

67. Zhong S, Clark M, Hou X-Y, Zang Y, FitzGerald G. Validation of a framework for measuring hospital disaster resilience using factor analysis. *Int J Environ Res Public Health* 2014; **11**: 6335–53.

68. Dobalian A, Stein JA, Radcliff TA, *et al.* Developing Valid Measures of Emergency Management Capabilities within US Department of Veterans Affairs Hospitals. *Prehosp Disaster Med* 2016; **31**: 475–84.

69. Khan Y, O'Sullivan T, Brown A, *et al.* Public health emergency preparedness: a framework to promote resilience. *BMC Public Health* 2018; **18**: 1344.

70. Meyer D, Kirk Sell T, Schoch-Spana M, *et al.* Lessons from the domestic Ebola response: Improving health care system resilience to high consequence infectious diseases. *Am J Infect Control* 2018; **46**: 533–7.

71. Brattheim B, Faxvaag A, Seim A. Process support for risk mitigation: a case study of variability and resilience in vascular surgery. *BMJ Qual Saf* 2011; **20**: 672–9.

72. Franklin BD, Panesar SS, Vincent C, Donaldson LJ. Identifying systems failures in the pathway to a catastrophic event: an analysis of national incident report data relating to vinca alkaloids. *BMJ Qual Saf* 2014; **23**: 765–72.

73. Falegnami A, Bilotta F, Pugliese F, *et al.* A multicountry comparative survey about organizational resilience in anaesthesia. *J Eval Clin Pract* 2018; **24**: 1347–57.

74. Merandi J, Vannatta K, Terrance Davis J, McClead RE, Brilli R, Bartman T. Safety II Behavior in a Pediatric Intensive Care Unit. Pediatrics. 2018; **141**: e20180018.

75. Patriarca R, Falegnami A, Costantino F, Bilotta F. Resilience engineering for socio-technical risk analysis: Application in neuro-surgery. *Reliab Eng Syst Saf* 2018; **180**: 321–35.

76. Gizelis T-I, Karim S, Østby G, Urdal H. Maternal Health Care in the Time of Ebola: A Mixed-Method Exploration of the Impact of the Epidemic on Delivery Services in Monrovia. *World Dev* 2017; **98**: 169–78.

77. Sochas L, Channon AA, Nam S. Counting indirect crisis-related deaths in the context of a low-resilience health system: the case of maternal and neonatal health during the Ebola epidemic in Sierra Leone. Health Policy and Planning. 2017; **32**: iii32–9.

78. Ray-Bennett NS, Corsel DMJ, Goswami N, Ghosh A. Understanding reproductive health challenges during a flood: insights from Belkuchi Upazila, Bangladesh. *Gates Open Res* 2019; **3**: 788.

79. Kozuki N, Ericson K, Marron B, Lainez YB, Miller NP. The resilience of integrated community case management in acute emergency: a case study from Unity State, South Sudan. *J Glob Health* 2018; **8**: 020602.

80. Mash BJ, Mayers P, Conradie H, Orayn A, Kuiper M, Marais J. How to manage organisational change and create practice teams: experiences of a South African primary care health centre. *Educ Health* 2008; **21**: 132.

81. Witter S, Wurie H, Chandiwana P, *et al.* How do health workers experience and cope with shocks? Learning from four fragile and conflict-affected health systems in Uganda, Sierra Leone, Zimbabwe and Cambodia. Health Policy and Planning. 2017; **32**: iii3–13.

82. Raven J, Wurie H, Witter S. Health workers' experiences of coping with the Ebola epidemic in Sierra Leone's health system: a qualitative study. *BMC Health Serv Res* 2018; **18**: 251.

83. Brooke-Sumner C, Petersen-Williams P, Kruger J, Mahomed H, Myers B. 'Doing more with less': a qualitative investigation of perceptions of South African health service managers on implementation of health innovations. *Health Policy Plan* 2019; **34**: 132–40.

84. Thude BR, Juhl AG, Stenager E, von Plessen C, Hollnagel E. Staff acting resiliently at two hospital wards. *Leadersh Health Serv* 2019; **32**: 445–57.

85. Banerji D. The people and health service development in India: a brief overview. *Int J Health Serv* 2004; **34**: 123–42.

86. Galtung J. Trade or Development: Some Reflections on Self-Reliance. *Econ Polit Wkly* 1976; **11**: 207–18.

87. Hope KR. Self-reliance and participation of the poor in the development process in the Third World. *Futures* 1983; **15**: 455–62.

88. Lal P. Self-reliance and the state: the multiple meanings of development in early post-colonial Tanzania. *Africa* 2012; **82**: 212–34.

89. Tickner JA. Local Self-Reliance versus Power Politics: Conflicting Priorities of National Development. *Altern Lab Anim* 1986; **11**: 461–83.

90. Mark Green's legacy and priorities for the next USAID administrator. https://www.cgdev.org/blog/mark-greens-legacy-and-priorities-next-usaid-administrator (accessed Sept 24, 2021).

91. USAID's redesign efforts have shifted over time. https://oig.usaid.gov/node/233 (accessed Sept 24, 2021).

92. Igoe M. Can USAID use 'transition' metrics to help countries become more self-reliant? Devex. 2018; published online Jan 26. https://www.devex.com/news/can-usaid-use-transition-metrics-to- help-countries-become-more-self-reliant-91932 (accessed Sept 24, 2021).

93. USAID Transformation and the Journey to Self-Reliance. http://modernizeaid.net/usaid-transformation-2/ (accessed Sept 24, 2021).

94. Saldinger A. What would Biden's foreign aid policy look like? Devex. 2020; published online Aug 19. https://www.devex.com/news/what-would-biden-s-foreign-aid-policy-look-like-97930 (accessed Sept 24, 2021).

95. Jobson GA, Grobbelaar CJ, Mabitsi M, et al. Delivering HIV services in partnership: factors affecting collaborative working in a South African HIV programme. *Global Health* 2017; **13**: 3.

96. Palen J, El-Sadr W, Phoya A, et al. PEPFAR, health system strengthening, and promoting sustainability and country ownership. *J Acquir Immune Defic Syndr* 2012; **60 Suppl 3**: S113–9.

97. Medhanie M. Reconciling Self Reliance & External assistance in the Development Process. 2016. https://thesis.eur.nl/pub/47661/MMehretab_oodledata_temp_turnitintool_1174500135._935_1478676831_3625.pdf.

98. The Journey to Self-Reliance. https://www.usaid.gov/selfreliance (accessed Sept 24, 2021).

99. Baru S. Self-Reliance to Dependence in Indian Economic Development. *Social Scientist* 1983; **11**: 34–46.

100. Biersteker TJ. Self-reliance in theory and practice in Tanzanian trade relations. *Int Organ* 1980; **34**: 229–64.

101. Ibhawoh B, Dibua JI. Deconstructing Ujamaa: The legacy of Julius Nyerere in the quest for social and economic development in Africa. *African Journal of Political Science* 2003; **8**: 59–83.

102. Bissio R. Paris declaration on aid effectiveness. *Human Rights Council, Session of the Working Group on the Right to Development, High Task Force on the Implementation of the Right to Development, January* 2008; **7**: 15.

103. Acting on the Call report 2019. https://www.usaid.gov/actingonthecall/2019-report (accessed Sept 24, 2021).

104. The Journey to Self-Reliance in practice: Examining USAID's efforts to operationalize its new agenda. https://www.cgdev.org/blog/journey-self-reliance-practice-examining-usaids-efforts- operationalize-its-new-agenda (accessed Sept 24, 2021).

105. Strategy for financing self-reliance. https://www.usaid.gov/open/financing-self-reliance (accessed Sept 24, 2021).

106. Chadwick V. French aid boss hits out at USAID's 'perverse' self-reliance strategy. Devex. 2019; published online July 9. https://www.devex.com/news/french-aid-boss-hits-out-at-usaid-s-perverse-self-reliance-strategy-95221 (accessed Sept 24, 2021).

Igoe M. Q&A: Why 'self-reliance' is the wrong goal for US aid. Devex. 2019; published online June https://www.devex.com/news/q-a-why-self-reliance-is-the-wrong-goal-for-us-aid-95098 (accessed Sept 24, 2021).

107. Mutahaba G. Foreign assistance and local capacity-building in Tanzania. *The European Journal of Development Research* 1989; **1**: 108–23.

108. Berer M. HIV/AIDS, sexual and reproductive health: intersections and implications for national programmes. *Health Policy Plan* 2004; **19 Suppl 1**: i62–70.

109. Fonchingong C, Fonjong LN. The concept of Self-reliance in Community Development in the Cameroon Grass fields. *Geojournal, Kluwer* 2003.

110. Commission S, Others. Report of the south Commission: The challenge of the South. 1990.

111. Hickling FW, Gibson RC. Decolonization of psychiatric public policy in Jamaica. *West Indian Med J* 2012; **61**: 437–41.

112. Hernández A, Ruano AL, Marchal B, San Sebastián M, Flores W. Engaging with complexity to improve the health of indigenous people: a call for the use of systems thinking to tackle health inequity. *Int J Equity Health* 2017; **16**: 26.

113. Johnson BB. Decolonization and Its Paradoxes: The (Re)envisioning of Health Policy in Bolivia. *Lat Am Perspect* 2010; **37**: 139–59.

114. Chomat AM, Kring B, Bekker LP. Approaching Maternal Health from a Decolonized, Systemic, and Culturally Safe Approach: Case Study of the Mayan-Indigenous Populations of Guatemala. In: Schwartz DA, ed. Maternal Death and Pregnancy-Related Morbidity Among Indigenous Women of Mexico and Central America: An Anthropological, Epidemiological, and Biomedical Approach. Cham: Springer International Publishing, 2018: 483–511.

115. Nkrumah K. Movement for Colonial Freedom. *Phylon* 1955; **16**: 397–409.

116. Nkrumah K. Neo-colonialism, the last stage of imperialism. https://www.abibitumi.com/wp-content/uploads/ppMigration/42994=1853-NeocolonialismThe-Last-Stage-of-Imperialism.pdf (accessed Feb 1, 2022).

117. Nkrumah K, Arrigoni R, Napolitano G. Africa must unite. Heinemann London, 1963.

120. Nyerere JK. Education for self-reliance. *Ecum Rev* 1967; **19**: 382–403.

121. Mora K. How Thomas Sankara Weaponized Coloniality. The Republic. 2021; published online Sept 8. https://republic.com.ng/august-september-2021/thomas-sankara-revolutionary/ (accessed Feb 1, 2022).

122. Fanon F. A Dying Colonialism. Grove/Atlantic, Inc., 1994.

123. Thiong'o N wa. Decolonising the mind: the politics of language in African literature. East African Publishers, 1992.

124. Achebe C. An Image of Africa. *Mass Rev* 1977; **18**: 782–94.

125. Memmi A. The colonizer and the colonized. Routledge, 2013.

126. Nandy A, Darby P. Challenging the ruling paradigms of the global knowledge system: Ashis Nandy in conversation with Phillip Darby. Postcolonial Studies. 2018; **21**: 278–84.

127. Césaire A. Discourse on Colonialism. NYU Press, 2001.

128. Oecd, OECD. Paris Declaration on Aid Effectiveness. 2005. DOI:10.1787/9789264098084-en.

129. Global leadership - USAID MOMENTUM. 2020; published online July 24.
https://usaidmomentum.org/what-we-do/strengthening-resilience/global-leadership/ (accessed Sept 24, 2021).

130. Five years of USAID forward. https://www.usaid.gov/news-information/fact-sheets/usaid-forward-five-years-and-counting (accessed Sept 24, 2021).

131. The Local Engagement Assessment Framework: A practitioner's guide to integrating country ownership into development projects. https://resourcentre.savethechildren.net/pdf/stc-book-lo-res-pdf.pdf/ (accessed Sept 24, 2021).

132. Chiu SWK, Ko LSF, Lee RPL. Decolonization and the movement for institutionalization of Chinese medicine in Hong Kong: a political process perspective. *Soc Sci Med* 2005; **61**: 1045–58.

133. Fanon F. The Wretched of the Earth. Grove/Atlantic, Inc., 2007.

134. Rodney W. Tanzanian Ujamaa and scientific socialism. *Afr Rev* 1972; **1**: 61–76.

135. Ahmed AK. The Rise of Fallism: #RhodesMustFall and the Movement to Decolonize the University. 2019. http://proxy.library.jhu.edu/login?url=https://www.proquest.com/dissertations-theses/rise-fallism-rhodesmustfall-movement-decolonize/docview/2187693841/se-2.

136. Chowdhury R. From Black Pain to Rhodes Must Fall: A Rejectionist Perspective. Journal of Business Ethics. 2021; **170**: 287–311.

137. In solidarity – Duke decolonizing global health working group. https://sites.duke.edu/dukedgh/in-solidarity/ (accessed Sept 24, 2021).

138. Affun-Adegbulu C, Adegbulu O. Decolonising Global (Public) Health: from Western universalism to Global pluriversalities. *BMJ Glob Health* 2020; **5**. DOI:10.1136/bmjgh-2020-002947.

139. Abimbola S, Pai M. Will global health survive its decolonisation? The Lancet. 2020; **396**: 1627–8.

140. Garba DL, Stankey MC, Jayaram A, Hedt-Gauthier BL. How Do We Decolonize Global Health in Medical Education? *Ann Glob Health* 2021; **87**: 29.

141. Who represents whom? A conversation on decolonizing humanitarian governance. Center For Global Development. https://www.cgdev.org/blog/who-represents-whom-conversation-decolonizing-humanitarian-governance (accessed Feb 1, 2022).

142. Fofana MO. Decolonising global health in the time of COVID-19. *Glob Public Health* 2021; **16**: 1155–66.

143. February RG on. #DecolonizeGlobalHealth: Rewriting the narrative of global health. 2019; published online Feb 11. https://www.internationalhealthpolicies.org/blogs/decolonizeglobalhealth- rewriting-the-narrative-of-global-health/ (accessed Sept 24, 2021).

144. Karan A. Opinion: How COVID Reveals The Hypocrisy Of The Global Health 'Experience'. NPR. 2021; published online April 18. https://www.npr.org/sections/goatsandsoda/2021/04/18/986820439/opinion-how-covid-reveals-the-hypocrisy-of-the-global-health-experience (accessed Sept 27, 2021).

145. Patterson A, Clark MA. COVID-19 and Power in Global Health. *Int J Health Policy Manag* 2020; **9**: 429–31.

146. Akugizibwe P. Dependency to decolonization in global health. 2020; published online Aug 14. https://republic.com.ng/vol5-no1/purse-strings-attached/ (accessed Sept 24, 2021).

147. Halais F. Biases in health care affect workers everywhere. Devex. 2020; published online Sept 10. https://www.devex.com/news/biases-in-health-care-affect-workers-everywhere-98043 (accessed Sept 24, 2021).

148. Hellmann F, Williams-Jones B, Garrafa V. COVID-19 and Moral Imperialism in Multinational Clinical Research. *Arch Med Res* 2020; **51**: 572–3.

149. Redesigning the FP2020 secretariat requires rethinking power and partnerships. 2020; published online Nov 3. https://familyplanning2020.org/news/redesigning-fp2020-secretariat-requires-rethinking-power-and-partnerships (accessed Oct 25, 2021).

150. Modernizing Foreign Assistance Network. The Way Forward: A Reform Agenda For 2014 and Beyond. 2014 https://modernizeaid.net/wp-content/uploads/2015/12/The-Way-Forward-A-Reform-Agenda-for-2014-and-Beyond.pdf.

151. Silenced voices in global health. https://www.thinkglobalhealth.org/article/silenced-voices-global-health (accessed Sept 24, 2021).

152. Nemutandani SM, Hendricks SJ, Mulaudzi MF. Decolonising the mindsets, attitudes and practices of the allopathic and indigenous health practitioners in postcolonial society: An exploratory approach in the management of patients. *Afr J Prim Health Care Fam Med* 2018; **10**: e1–8.

153. Lane S, Ayeb-Karlsson S, Shahvisi A. Impacts of the Global Gag Rule on sexual and reproductive health and rights in the Global South: A scoping review. *Glob Public Health* 2020; : 1–16.

154. Shawar YR, Ruger JP. The World Bank: Contested Progress on Rights-Based Health Discourse. In: Human Rights in Global Health: Rights-Based Governance in a Globalized World (eds: Meir BM, Gostin L). Oxford Press. 2018. DOI:10.1093/oso/9780190672676.003.0017.

155. Shawar YR, Prah Ruger J. The World Bank and the Right to Health: A Study of the Institution's Rights-Based Discourse. *Global Health Governance* 2018;https://papers.ssrn.com/abstract=3177192 (accessed Sept 24, 2021).

www.usaidmomentum.org

@USAID_MOMENTUM

@USAIDMOMENTUM

@USAID MOMENTUM