Falling Through the Gaps of Global Health Governance: A Case Study of Health Inequities Among IDPs in Ethiopia

Applied Research Project Group 8
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List of Acronyms

ARP	Applied Research Project
IGHD	Institute for Global Health and Development
GHG	Global Health Governance
WHO	World Health Organisation
LMICs	Low- and Middle- Income Countries
PPPs	Public Private Partnerships
INGOs	International Non-Governmental Organisations
NGOs	Non-Governmental Organisations
IDPs	Internally Displaced Persons
DSI	Durable Solutions Initiative
IHRL	International Human Rights Law
MSF	Médecins Sans Frontières / Doctors Without Borders
ICRC	International Committee of the Red Cross
IFRC	International Federation of the Red Cross and Red Crescent Societies
UNHCR	United Nations High Commissioner for Refugees

Executive Summary

Framing the Challenge & Methodology:

This Applied Research Project (ARP) was conducted in partnership with the Institute for Global Health and Development–Guinea Bissau (IGHD). The project investigates how structural inequities in the Global Health Governance (GHG) system manifest in the health outcomes of Internally Displaced Persons (IDPs) in Ethiopia.

Data collection involved two main components: a targeted literature review and ten semi-structured interviews with professionals from key global health organisations. These included the World Health Organisation (WHO), International Committee of the Red Cross (ICRC), Médecins Sans Frontières (MSF), the Global Fund, and Gavi.

Key findings

1. There are multiple **IDP-specific structural barriers and challenges** regarding health access, including; inadequate health infrastructure, neglect of mental health, and geographic isolation and limited transport options.
2. **Government accountability and engagement** is essential for effective health governance, especially in settings that require structural investments that require more than medical intervention that IOs alone cannot provide.
3. **Poor coordination of actors** in the system hampers the development of local ones, causes inefficiency in funding flows, and can lead to actors taking on more than their mandate instructs.
4. **Operational challenges,** particularly that of security risks in active conflict regions, impacts the delivery of services by IOs.
5. **The humanitarian-development gap** shows a tension between short-term emergency-driven responses and the need for sustainable strategies that align with national systems.
6. **Power dynamics and donor influence** mean there is a persistent misalignment between donor agendas and national health priorities.

Recommendations

1. **Strengthen state capacity and promote domestic resource mobilization.**
2. **Empower civil society to enhance accountability.**
3. **Rethink aid relationships and expand South–South collaboration.**

Introduction

This research project was commissioned by the Institute of Global Health and Development (IGHD) - Guinea Bissau, in partnership with the Geneva Graduate Institute. The IGHD's mission focuses on promoting equity in global health by amplifying the voices of those who are often left behind. Their perspective is grounded in a critical observation that global health governance institutions were historically created by a few, for a few, with little regard for those on the margins. This project, therefore, set out to investigate how these inequities emerge, with the hope of identifying what radical changes are needed to make the system more inclusive.

This study will be conducted through the case study of Internally Displaced Persons (IDPs) in Ethiopia. We chose the case study of IDPs for several reasons. First, IDPs are among the most vulnerable and least visible populations in national and global health systems, and often struggle to access basic health services. Unlike refugees, who receive international protections, IDPs remain within their own country and often struggle to access basic health services. Secondly, Ethiopia has a very high number of IDPs; as of 2024, over 4.5 million people were internally displaced (OCHA, 2024). This context positions Ethiopia as a relevant case study to investigate how the GHG system operates in fragile settings, and the broader structural issues within global health governance. To guide this exploration, we use the following key definitions:

- Global Health Governance is defined as "the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and non-state actors to deal with challenges to health that require cross-border collective action to address effectively" (Fidler, 2010). This project focuses largely on the role of International Organisations (IOs) and International Non-Governmental Organisations (INGOs), but the roles of state governments are also discussed.
- Health equity is defined as "the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically" (Solar & Irwin, 2005).

These definitions set the foundation for examining how GHG structures operate, whom they serve, and who remains marginalized in their processes. Our research uses a mixed-methods approach; firstly we conduct a literature review that maps existing research on global health governance, health equity, and the specific vulnerabilities of IDPs. Secondly, we proceed with semi-structured interviews with global health actors from several international organisations including WHO, ICRC, MSF, the Global Fund, and Gavi.

The findings from this study are used to draw broader conclusions about the role of governments and the limitations of current GHG mechanisms, followed by a critical

discussion on the radical changes needed to improve health equity for marginalized groups such as IDPs.

I. Literature Review

Research on the inequities overlooked by the GHG system spans a wide range of debates. To effectively address the main research question and stay within the project's scope, this literature review provides a structured analysis. We begin with an overview of the GHG system at a macro level, examining its governance structures and their impact on health equity. This is followed by a focused exploration of health outcomes specific to the case study on IDPs in Ethiopia. Through this approach, the literature review aims to uncover challenges within the GHG system by identifying structural gaps that perpetuate health inequities

1. Background and Context of the Global Health Governance System

Global Health Governance (GHG) is defined by Fidler (2010:3) as “the use of formal and informal institutions, rules, and processes by states, intergovernmental organisations, and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively”. Fidler emphasises the complexity and broad nature of this concept, which encompasses various actors and agendas. Wenham et al., (2023) trace the roots of global health governance back to the colonial era when colonising powers sought to protect their militaries from novel diseases encountered in foreign territories. This imperialist backdrop set the stage for the formal establishment of the World Health Organization (WHO) after World War II, marking a shift in the coordination of global health efforts (Wenham et al., 2023). Recent literature on the background of the GHG system emphasises the central role played by the revolution of the system in the late 1990s/mid 2000s (Fidler, 2010) (Wenham et al., 2023) (McInnes, Lee & Youde, 2019).

The motivation for the revolution is debated, but a common argument in the literature is that health was securitised (Wenham, et al., 2023), where global health was reconsidered as national and international security issues (Fidler, 2010). Other authors highlight the catalytic role played by the response to HIV, which crystallised a set of moral conceptions related to health and the need to address global crises (Busby, 2010). This revolution generated the emergence of a new global health regime, led to increases in funding and the emergence of global health as a high-priority foreign policy agenda (Fidler 2010). Fidler (2010:1) described this evolution as making global health “an essential part of the equation of international relations”, fostering a cosmopolitan and rights-based approach to health (Wenham et al., 2023).

2. Challenges Within the Global Health Governance System

The literature reveals significant challenges currently facing the GHG system today. One major challenge is that the transformation of the system led to an 'explosion' of actors influencing GHG outcomes (Fidler, 2010:9). Traditional players such as the WHO have been joined by a myriad of NGOs, philanthropic foundations, and public-private partnerships (PPPs) (Kentikelenis & Rochford, 2019). This development has resulted in what Fidler (2010) terms a "regime complex" and "a collective of partially overlapping and nonhierarchical regimes" (2010:9), drawing on the work of Raustiala and Victor (2004). Patterson refers to it as a "sometimes confusing morass of norms, institutions, funding mechanisms and nonstate actors" (2018:164) and Kickbusch and Reddy apply the concept of 'gridlock' to the existing multilateral system, citing institutional inertia and fragmentation (2015). Youde (2012:4) underscores the "chaotic" nature of this multi-actor system, where efforts to create new organisations often overshadow strengthening existing ones. This diffusion of authority has led to fragmented leadership and responsibility, which McInnes et al. (2019) argue played a role in the inadequate response to the Ebola crisis. The same authors refer to the multilevel governance system as resembling a 'bumper car track' where different regimes can work together but also often collide with each other (McInnes et al., 2019:274).

The second major challenge highlighted by Youde (2012) is the misalignment between donor funding priorities and actual health needs. Funding is often directed at specific diseases rather than strengthening overall health systems, limiting the system's ability to address underlying health challenges and respond effectively to new threats (Youde, 2012). Fidler (2010), similarly notes that health issues attracting the most foreign policy attention are typically those perceived as threats to state interests, leading to an imbalance in GHG outcomes. This prioritisation, which Fidler (2010) refers to as the "prioritisation dilemma," results in uneven distribution and quality of GHG initiatives. McInnes et al., (2019:267) argue that international health cooperation often reflects the interests of powerful states over equitable health needs, exacerbating disparities.

The literature reveals a predominant focus on disease-specific initiatives, with less attention given to the broader impact of the GHG system on population health or the well-being of specific groups, such IDPs. This focus limits understanding of how GHG influences health outcomes from a bottom-up perspective that includes the voices of marginalised communities. Fidler (2010) also emphasises that solutions effective in one context may not be directly applicable to another, underlining the importance of tailored approaches. Although the existing literature provides valuable insights into the structure and challenges of the GHG system, it often remains at the macro level, focusing on institutional fragmentation and funding imbalances.

The role of NGOs and other non-state actors is either underexplored or generalised, indicating a need for more nuanced analyses that delve into how these actors operate within

the system and impact health equity. For this reason, examining specific case studies, such as Ethiopia's IDP populations, is essential for contextualising these macro challenges and uncovering the GHG system's role in perpetuating health inequities by looking at groups that may fall through gaps of the system.

3. Concept of Health Equity

Health equity is defined as "the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically" (Solar & Irwin, 2005). This concept emphasises that access to healthcare should be fair and based on need rather than social, cultural, geographic or economic advantage. Amin et al. (2011) add that health equity represents "the absence of systemic disparities in health" which is essential for addressing the needs of vulnerable populations. Ultimately, as Schneider et al. (2013) posits, health equity is crucial because lack of access to healthcare often exacerbates existing health issues and may lead to preventable additional health complications.

The literature on health equity reveals disparities not only between high- and low-income countries but also within communities of varying socio-economic advantage (Amin et al., 2011). In low-income countries, health systems often struggle with financial constraints, limited healthcare infrastructure, and shortages of medical professionals, which further widen the inequities (Kenkre et al, 2011). The consequences of underfunded health systems, specifically in Africa, became evident during the 2014 Ebola outbreak and Covid-19 pandemic where marginalised groups suffered disproportionately (Keita et al., 2022). These crises highlighted how structural gaps in health governance exacerbate vulnerability for the poorest populations.

In their discussion of vulnerable communities and health policy, Schneider et al. (2013) emphasise that effective health policies must prioritise both health access and vulnerability. Similarly, Amin et al., (2011) expand on this, proposing that an equitable health system is as fundamental as a fair legal or democratic political system, protected by the right to the highest attainable standard of health and other human rights. Building on this, Kenkre et al., (2011) emphasise that resources should be allocated based on need, with payment structures adjusted to individuals' ability to pay, ensuring access for all. However, they highlight that efforts toward health equity have often focused more on reducing disparities between countries than within them. Therefore, advancing equity in healthcare requires addressing the living conditions of impoverished and marginalised groups extending beyond healthcare to include social and economic support. To understand how these inequities manifest in real-world contexts, we will examine the case of internally displaced people in Ethiopia.

4. Case Study Background

Drawing on various author's perspectives on the challenges within the GHG system, Ethiopia provides a compelling context for analysis. Fidler's (2010) concept of the "prioritisation dilemma" highlights how health interventions often prioritize global visibility over local needs, leading to gaps in marginalized communities. This is particularly evident in Ethiopia, a country facing severe internal displacement. As of 2021, Ethiopia recorded some of the highest annual displacement figures globally, driven by conflict, climate shocks, and political instability (Tesfaw, 2022).

4.1 History of internal displacement and health inequities

IDPs are defined as individuals or groups of people who are forced to flee or to leave their homes due to armed conflict, violence, human rights violations, or natural and human-made disasters, yet remain within their country's borders (AU, 2009; UNGPIDP, 1998). Unlike refugees, who cross international borders and receive support from international agencies such as UNHCR, IDPs are dependent on their national governments for protection and assistance (Mooney, 2005; Tesfaw, 2022). In Ethiopia, this distinction is significant. Despite facing conflict and natural disasters, IDPs often lack formal recognition and access to international aid, leaving them reliant on fragile state systems for essential services. This gap in protection exposes IDPs to heightened vulnerabilities, particularly in health access, as they remain largely invisible within global health governance frameworks. Specifically in Ethiopia, internal displacement is primarily driven by conflict, climate-related disasters, and large-scale infrastructure projects (Tesfaw, 2022; Maru, 2017). According to the International Organization for Migration (IOM), approximately 4.5 million people were internally displaced as of 2024 (OCHA, 2024). Conflict-induced displacement remains the most significant factor, followed by environmental shocks such as drought and flooding. Maru (2017) also highlights development-induced displacement, where infrastructure projects force communities from their homes without adequate resettlement support. IDPs have a myriad of multifaceted health concerns and experiences, therefore understanding and enumerating IDPs unique health status and associated risk factors, is vital for their equitable access to healthcare (Mitra, 2022). Despite WHO's interventions in the region, gaps remain due to the absence of resource-sensitive approaches tailored to displaced populations (Feyssa 2024). Unlike refugees, who benefit from international legal protections, IDPs often rely solely on national policies, which are frequently inconsistent and underfunded (UN, 2021).

4.2 Health Implications of Internal Displacement

According to Fufa (2020), IDPs in Ethiopia face multiple challenges, including poverty, hunger, property damage, loss of family members, and a decline in moral well-being. OCHA (2020) further highlights that IDPs, especially those in collective sites, experience deplorable living conditions, limited access to basic services, few opportunities to rebuild livelihoods, protection risks, and broader security concerns.

Research on IDPs is notably scarce, particularly in low- and middle-income countries, where displacement is often unaccounted for in health strategies (Cantor et al., 2021). Existing studies tend to focus primarily on IDPs living in camps, overlooking the majority who reside in host communities. This creates a critical bias, as those outside of camps experience even greater barriers to healthcare access due to invisibility in public health records. Furthermore, research concerning IDPs has also been disproportionately centered on mental health concerns like post-traumatic stress disorder (PTSD), depression, and anxiety (Cantor et al., 2021). While mental health is undeniably critical, this narrow focus often overshadows other pressing health needs, such as chronic diseases, maternal health, and non-communicable illnesses. This limited scope contributes to significant blind spots in policy planning and health service delivery, particularly for IDPs living outside formal camps.

4.3 The Health of Internally Displaced Persons: Global Policy Perspectives

IDPs face significant health risks due to the absence of strong international protections. Unlike refugees, who are covered by binding international frameworks like the 1951 Refugee Convention, IDPs are not protected under specific international law, leaving them vulnerable to gaps in health service provision Rae (2011). The Kampala Convention, adopted by the African Union in 2009, is the first legally binding regional agreement to protect and assist IDPs. It outlines the responsibilities of states to prevent displacement, protect those who are displaced, and provide durable solutions (AU, 2009).

While the Kampala Convention marks a significant step forward, its implementation remains inconsistent, particularly in fragile states like Ethiopia. National and regional frameworks often face resource constraints and political challenges that limit their effectiveness (Rae, 2011). As a result, IDPs are frequently left without adequate health services and protection.
IDPs rights are also referenced in broader human rights frameworks, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR). However, unlike refugee protections, these rights are non-binding, leading to disparities in international health support (OHCHR 1966a; 1966b) As a result, United Nations agencies often prioritize refugees over IDPs, contributing to unequal access to health services.

4.4 Ethiopia's Health Policy for Internally Displaced Persons

Despite the large number of IDPs in Ethiopia, there is limited information on their specific health problems (Owoaje, et al 2016). Historically, Ethiopia did not adopt a formal health policy until the early 1960s, with the support of the World Health Organization (WHO). Currently, the Health Sector Transformation Plan II (HSTP II, 2021), emphasises broader determinants of health including: population dynamics, food availability, and acceptable living conditions. However, IDPs remain largely "invisible" within public health systems, often unenumerated, and unrecognised at multiple levels (Mitra, 2022).

In this regard, the Ethiopian government's 2024 strategy on displacement, as outlined in the solutions to internal displacement in Ethiopia (2024) document, identifies the need for reliable data and stronger coordination among government and NGOs to address IDP health needs. The strategy includes:

1. Establishing a unified national data collection system to monitor displacement trends, assess IDP needs, and track responses across local and regional authorities.
2. Enhanced coordination with humanitarian partners to improve service delivery and monitor changes in IDP living conditions
3. Durable Solutions Initiative (DSI) launched in 2019, which focuses on voluntary return, relocation, and local integration of IDPs. This strategy aims to align humanitarian aid with long-term development goals, including health, infrastructure, and education improvements (Ethiopian Government, 2024).

While national policies in Ethiopia have made strides towards more integrated and sustainable solutions for IDPs, the effectiveness of these initiatives heavily relies on broader support from GHG mechanisms. Global health actors play a critical role in extending health services and coordinating large-scale interventions. Examining the contributions of GHG agencies in Ethiopia provides insight into both the progress made and the gaps that persist in delivering equitable health outcomes for displaced populations.

4.5 Global Health Governance and Internally Displaced Persons Interventions

Ethiopia's efforts to address health inequities for IDPs have been supported by key GHG actors, including the World Health Organization and Gavi, the Vaccine Alliance. These collaborations focus on improving healthcare access for displaced populations, particularly in conflict-affected regions like Amhara, Oromia, and Tigray. The WHO has partnered with Ethiopia's Ministry of Health to strengthen emergency health responses, especially in IDP camps. This includes deploying mobile clinics, distributing essential medical supplies, and supporting the Health Extension Program (HEP) to reach underserved communities (Haileamlak, et al., 2023). Similarly, Gavi has contributed to Ethiopia's immunization programs, prioritizing vaccine access for displaced and vulnerable populations through the REACH Consortium, which targets zero-dose children in conflict zones (Gavi, 2023). Despite these efforts, barriers remain. Limited infrastructure, insufficient health facilities, and inadequate data collection complicate service delivery for IDPs, who are often described as the *"hardest to reach"* due to mobility challenges, and lack of formal addresses (Wong, 2015; Baal & Ronkainen, 2017). Many IDPs remain invisible in public health records, making it difficult for health actors to allocate resources effectively. This gap highlights the need for improved data mechanisms and stronger coordination between GHG actors and Ethiopian health authorities.

5. Research Gaps

The case of IDPs in Ethiopia offers a compelling case study for investigating the gaps and limitations within the GHG system regarding health equity and access. This is relevant because despite the significance of the issue, there is limited evidence on how global health initiatives address their specific vulnerabilities, particularly in low- and middle- income countries (LMICs) (Morina et al., 2018). Research is often focused on encamped IDPs rather than those integrated into local/host communities, partly because camp-based populations are more visible and concentrated, especially in African contexts. This creates a significant research gap, leaving the health needs of community-integrated IDPs largely unexamined. Additionally, while mental health concerns like PTSD, depression, and anxiety are often studied (Cantor et al., 2021), broader health issues, including maternal health, chronic diseases, and non-communicable illnesses, remain largely underexplored. This selective focus limits effective health interventions and policy development for IDPs living in diverse conditions. More broadly, studies of healthcare access among vulnerable populations in Africa reveal similar gaps. Acquah-Hagen et al., (2021) found that identifying which vulnerable populations would benefit most from improved healthcare access remains a challenge in Ghana. This lack of granular data, the authors argue, limits policymakers ability to make informed decisions and adequately address the needs of these communities. In the context of Ethiopia, while there is substantial documentation of displacement, there is limited research on how the GHG system contributes to addressing these health challenges.

II. Methodology

This research project uses a qualitative case study approach to explore structural inequities in the GHG system as they relate to IDPs in Ethiopia. Given the complex, multi-actor nature of GHG, qualitative methods were essential to capture both broad system-level insights and experience-based perspectives from practitioners in the field. Data collection involved two main components: a targeted literature review and ten semi-structured interviews with professionals from key global health organisations. These included the World Health Organisation, International Committee of the Red Cross (ICRC), Médecins Sans Frontières (MSF), the Global Fund, and Gavi.

- Sampling and Recruitment

Participants were identified and contacted through purposive sampling, targeting individuals with direct experience in health interventions for IDPs in Ethiopia. Recruitment was facilitated via collaboration with our partner institute for Global Health and Development, and through our own networks in International Geneva given the privileged location in regard to the presence of many actors within the GHG sphere. The selection of participants aimed to

reflect a diverse range of perspectives, including policy design, field implementation, and coordination between international and local health actors.

- **Interview Process**

Interviews were conducted both face-to-face in Geneva and via video call where the interviewees were based overseas and consented to such conditions. This hybrid approach allowed for flexibility and broader reach, while maintaining the depth of conversation typical of qualitative inquiry. It should be noted that recipients of the healthcare services within Ethiopia were not interviewed in order to prevent risk of harm that may arise due to the necessity to ask what may be personally difficult questions in a video-call environment. Additionally the views of interviewees are the personal views of such interviewees, and do not necessarily represent the official positions of their organisation.

Interview questions focused on:

- The role of their organisation in addressing the IDP health context in Ethiopia.
- What gaps they have found in the local context or in the GHG system in general.
- How their organisation might operate differently in different contexts.
- The impact of funding and donor policies on service delivery and in their work in general.
- Their relationship with other health actors.

To protect confidentiality and encourage openness, anonymity was guaranteed to all interviewees. This was particularly important given the sensitive nature of the discussions, which often involved critiques of GHG policies and interventions.

- **Ethical Considerations and Limitations**

Potential limitations identified in relation to this project include interviewees being subject to respondent bias and the 'interview effect', due to the overall nature of our research being to uncover inequities in relation to the GHG system, and the potential want to defend practices of the system within which they work. To mitigate these limitations, we used a range of open-ended questions and selected participants we believed would be comfortable offering honest critique. A further limitation to note is that all interviewees were from within the GHG system rather than recipients of its services, which may have limited the understanding of on-the-ground realities for IDPs, however this choice was made with ethical sensitivity in mind to avoid potential harm or distress.

- **Positionality and Research Assumptions**

As researchers, we acknowledge the broader lack of literature focused on displaced individuals in African contexts and the persistent invisibility of IDPs within healthcare systems. This lack of representation contributes to both research and programmatic knowledge gaps. Despite these limitations, this study aims to contribute evidence-based evaluations while remaining transparent about the contexts and facts outside its scope.

Finally, it is crucial to note that this research project was undertaken during the time of USAID funding cuts across the global health sector. As these cuts occurred during the process of this research, while interviewees acknowledged them, their exact ramification remains unclear. As a result, this element which will certainly change the face of the GHG system, is largely not reported in our analysis.

III. Analysis

As our research progressed, we realised that the gaps identified in the context of IDPs in Ethiopia were not isolated but pointed to broader structural weaknesses within the GHG system. What began as a focused examination of health access for Ethiopian IDPs evolved into a deeper analysis of systemic challenges that extend beyond this specific case. This analysis is therefore structured in two parts: first, the context on IDP vulnerability in Ethiopia is discussed, presenting the findings from our interviews and literature review, and illustrating the specific health challenges and barriers faced by displaced populations. Second, we focus on the system-level challenges in the GHG system using the Ethiopian case study to reflect on broader governance gaps and structural issues.

1. Understanding Internally Displaced Persons' Vulnerability

Displacement in Ethiopia represents a highly dynamic and politically sensitive phenomenon. Interview data indicates that displacement is rarely the result of a singular crisis but rather emerges from overlapping and protracted drivers, including ethnic tensions, environmental degradation, and structural governance failures. As an interviewee explained, displacement becomes cyclical when root causes are unaddressed: "*People are forced to return to places where nothing has changed; where there is no infrastructure and where the threats remain. Then they flee again*." In such cases, humanitarian responses, such as ICRC's deployment of mobile health and nutrition teams, and contingency planning with pre-positioned health kits, often provide immediate relief but are not designed for long-term recovery, nor do they address underlying vulnerabilities. Without structural reform or reintegration strategies, such as programs aimed at helping IDPs re-establish themselves in their original communities or successfully integrate into new ones through housing, education, and sustainable livelihoods, displacement remains an ongoing crisis rather than a resolved issue. One interviewee, reflecting on his work in Oromia, described a context of "*transience and unpredictability,*" where new IDP communities form rapidly in areas previously considered stable.

These populations often lack access to basic infrastructure, with displaced families arriving in host areas "*without pots or firewood*" and unable to access clean water. These are not temporary camps but long-term humanitarian crises that unfold in real-time, straining already under-resourced health systems. This challenge is compounded by the fact that many health systems are not designed to support mobile populations. As one interviewee said, "*The design of the public health program... is not fit to the needs of this sort of new global population*." The impermanence of IDP settlements makes conventional health planning nearly impossible. Another interviewee emphasized that mobile clinics, although necessary, only serve as stopgap measures rather than sustainable solutions.

1.1. Internally Displaced Persons' Health Challenges

Health challenges facing IDPs in Ethiopia extend far beyond access to hospitals or medicine. Interviews revealed deeply interconnected barriers involving sanitation, mental health, gender equity, and access rights. Among these, environmental health was frequently raised as foundational. One interviewee explained that newly displaced communities often lack the most basic tools to purify water or cook: "*They are consuming water that is not clean… they will have digestive or other types of problems*." IDPs often resettle in remote and underserved areas where government investment in infrastructure is minimal. This choice is not always voluntary; rather, it is often influenced by factors such as conflict, land availability, and political marginalization. In Ethiopia, regions affected by ethnic conflict or political instability are less likely to receive government support or investment, pushing displaced communities to areas with little infrastructure. An interviewee noted that these populations rely on temporary mobile services that are under-resourced and unable to meet long-term health demands: "*People have very little to no access to healthcare because the government doesn't invest there.*" In such contexts, clean water, sanitation facilities, and even basic medical supplies are often unavailable. Service delivery depends on mobile units, which although critical for emergency care, are temporary, and restricted in scope. This reliance on short-term solutions underscores the need for more sustainable and integrated health infrastructure.

Mental health emerged as a critical yet neglected area, in practice, for IDPs in Ethiopia. One interviewee described the psychological toll of displacement: "*They are told to be grateful they are alive- but what about everything they have lost*?" Despite the profound mental health impact, interviewees noted that mental health interventions are often culturally irrelevant and fail to address evolving needs. This reflects a broader biomedical bias in emergency responses, where physical injuries are prioritized over psychological trauma. As a result, mental health remains underfunded and inadequately addressed in humanitarian settings.

IDPs also face a range of structural barriers that severely limit their access to healthcare. Displacement frequently invalidates health insurance, stripping families of their coverage. One interviewee remarked: "*You have invested in that health insurance, and it's worth nothing anymore*." Transportation was another persistent challenge. In remote areas, health facilities are often unreachable, and public transport is virtually non-existent. An interviewee also highlighted that since many IDPs are relocated to zones *"where there is no public*

transport," they are forced to walk hours to access basic services. Another interviewee highlighted the lack of medical specialists in these regions: *"You might have a midwife, but no gynaecologist,"* illustrating how fragmented healthcare access undermines maternal and emergency care.

Gender inequities further compound these health challenges. An interviewee also explained that in some patriarchal communities, women require male authorization to access medical services. This dependency, already prevalent in certain regions, is amplified by displacement, making it even more difficult for women to secure timely healthcare.

The health challenges faced by IDPs reflect broader issues of political marginalization, poor planning, and unequal legal recognition. A humanitarian actor summarized this gap: "*Health is also a political thing*." Without long-term investment and holistic governance reform, health outcomes for IDPs will remain precarious. These inequities are not simply a result of political exclusion or resource scarcity but are also symptomatic of structural failures in the GHG system. Addressing them requires not only immediate humanitarian relief but also a rethinking of how health governance includes displaced populations.

1.2. The Role of Governments: Accountability & Engagement

The analysis of health challenges facing IDPs in Ethiopia reveals not only gaps in humanitarian response but also critical issues in government accountability and engagement. As the primary duty-bearers, states hold the legal and moral obligation to protect IDPs under frameworks such as the Kampala Convention. However, in practice, the visibility and support extended to IDPs remains inconsistent and politically charged. This section examines the role of governments in addressing health inequities for IDPs, focusing on key themes such as; State responsibility and visibility, engagement with coordination mechanisms, NGO-State transitions, limits of humanitarian substitution, donor dependency and state ownership, neutrality and modes of engagement, and advocacy vs. access.

1.2.1. State responsibility and the visibility of Internally Displaced Persons

One interviewee experienced in work with IDPs highlighted a fundamental divergence between international actors and government approaches in delivering services to displaced populations. While IOs operate under the principle of neutrality and provide aid across conflict lines, governments are reluctant to provide humanitarian access to areas controlled by non-state actors. Although this case is not specific to Ethiopia, this reluctance creates barriers to assistance in conflict-affected regions where IDPs are concentrated. It heightens vulnerability and restricts health service delivery, increasing the risk of preventable illness and mortality. IDPs are unique in that they remain within their borders, placing them under state jurisdiction. However, their presence is often perceived by states as politically sensitive, particularly in conflict zones.

As one interviewee noted, the presence of IDPs can challenge state narratives of control and stability, making them politically and administratively difficult to acknowledge. An interviewee with experience in public health noted that this mirrors how states handle public

health emergencies: acknowledging large-scale displacement or crises can be politically inconvenient or even economically damaging. As a result, some governments downplay displacement figures or restrict humanitarian access to maintain an image of control. This strategy not only marginalizes IDPs but also renders them structurally invisible in national planning and response mechanisms.

Political dynamics further deepen these vulnerabilities. An interviewee noted that governments may avoid recognizing certain IDP groups to maintain political legitimacy: "*Sometimes IDPs are not recognized because they probably come from the 'other' ethnicity… so they can consider a certain segment… not to be supported.*" In such cases, access to aid is not determined by need alone but also by political legitimacy and identity. Humanitarian actors often operate within these constrained environments, where recognition is tied to political narratives and power dynamics.

1.2.2. Limits of humanitarian substitution

An important issue raised by interviewees is that IOs alone cannot address the complex challenges faced by IDPs. For instance, an interviewee from the Global Fund highlighted that, despite their significant investments in malaria reduction through medications and increased bed nets, malaria persists in regions like Ethiopia. This is largely due to underdeveloped civil infrastructure and poor sanitation, which fuel mosquito proliferation. This underscores a key limitation, humanitarian aid alone is not enough. Broader systemic issues like water management, sanitation, and public health infrastructure are responsibilities that only the state can sustainably address. Effective health governance thus requires more than medical intervention; it demands structural investments that IOs alone cannot provide.

1.2.3. Donor dependency

Importantly, while not specific to Ethiopia, an interviewee working in health financing also raised concerns about the unsustainability of health financing mechanisms in contexts overly reliant on international donors and GHG initiatives; "*Some governments have outsourced their health systems.*" This dependence on external funding disincentivizes national investment in healthcare and reduces state ownership. It also leaves governments vulnerable to global funding shifts and economic downturns, directly impacting their capacity to manage health crises independently. Furthermore, it weakens governmental accountability, as health financing becomes an external issue rather than a domestic priority.

1.2.4. Limited engagement with coordination mechanisms

An interviewee from the WHO cluster initiative described varying degrees of state engagement with the health cluster mechanism. In some contexts, Ministries of Health actively co-chair these clusters, enhancing coordination and alignment with national strategies. However, this involvement can also be restrictive when IO mandates or priorities conflict with state political interests.

In Ethiopia, the engagement of government authorities with IOs was described as limited and reactive. While the cluster formally operated through the Ministry of Health, its participation was often symbolic, surfacing mainly during acute crises like cholera outbreaks. Government involvement, according to the interviewee, was largely to access data and IO networks during emergencies, with little to no strategic engagement beyond that. This fragmented participation weakens long-term planning and shifts the burden of leadership and coordination to humanitarian actors, who are then left to bridge critical gaps in service delivery. The lack of sustained government engagement not only disrupts continuity but also reflects a broader gap in political will to integrate IDPs into national health strategies.

1.2.5. Cultural & Contextual Sensitivity

A recurring theme across interviews was the mismatch between standardized care models and the lived experiences of displaced populations. One aspect of this disconnect lies in the design of interventions. Describing food aid in Ethiopia and South Sudan, one interviewee observed: "*The food donations don't respect the cultures… they give wheat, but people don't eat wheat*." This seemingly small oversight can have real implications for nutrition and trust. Similarly, another interviewee highlighted the shortcomings of clinical responses to malaria: "*We were providing medications and bed nets, but without investing in infrastructure and sanitation… the mosquito will still be there*." Their observation underscores the limits of biomedical solutions when delivered without consideration of environmental conditions.

A deeper concern raised across interviews was the persistence of epistemic hierarchies that prioritize Western technical expertise over local knowledge. An interviewee noted that governments often "*prefer consultants from Europe rather than someone from a neighbouring country,*" attributing this to colonial legacies that continue to shape notions of legitimacy. This reliance on foreign experts not only displaces local capacity but also undermines the sustainability of interventions. An Interviewee from Gavi acknowledged this dynamic, admitting that Gavi has historically "*set up parallel systems or flown consultants into a country, flying them out again.*" While he noted that Gavi is now trying to shift toward national systems, he acknowledged that this transition has been uneven.

One of the interviewees from MSF emphasized the reputational cost of externally driven programming: "*We are perceived as Europeans coming to do our business*." To counter this, MSF has begun shifting decision-making to regional hubs in Amman and Bogotá, though they acknowledged that these remain exceptions in a system still dominated by Global North actors. Collectively, these accounts demonstrate that cultural and contextual insensitivity within global health governance not only reduces the effectiveness of interventions but can also reinforce marginalization. When care is standardized, culturally detached, or imposed from above, it risks reproducing the very inequities it seeks to resolve. Without genuine engagement with local realities, what people eat, how they heal, and who they trust, global health interventions, despite being well-funded, risk missing their mark. Addressing the needs of displaced populations demands not only resources but a fundamental shift in how knowledge, legitimacy, and partnership are understood. This need for systemic

transformation becomes even more apparent when examining the operational tensions within the humanitarian response.

2. Global Health Governance Actors: Key Challenges and Barriers

The following sections will expand the analysis to a global system level, examining how these systemic challenges manifest across international actors, funding mechanisms, and coordination strategies, revealing how structural gaps contribute to health inequity for marginalised populations.

2.1. Coordination Challenges and Actor Oversaturation

A myriad of authors claim an "explosion" of actors during the revolution of the GHG system in the late 1990s/early 2000s created "overlapping and non-hierarchical regimes" (Fidler, 2010:9) and has caused "institutional inertia and fragmentation" (Kickbusch and Reddy, 2015). Throughout our interviews, it was found that there is certainly no doubt that there are overlapping operations of actors within the system which is far from ideal, but there was notably less definiteness on considering the number of actors as a core problem.

Particular attention was paid to the high number of global actors resulting in the overshadowing of national partners. For example, one interviewee from MSF was adamant that in some cases there are national and local organisations that may do better work, but the proliferation of global actors in the same space hampers the development of the local ones, and therefore the broader development of the country. This echoes Youde (2012) who discussed the overshadowing of the efforts to strengthen existing actors and systems. On a similar note, it was pointed out that national authorities cannot handle so many global organisations in their country. Even the mundane tasks of the national authorities such as meetings, and having all of the actors asking the same questions, means that coordinating and managing the expanse of global actors is incredibly difficult. An interviewee from Gavi recalled one instance where a single health ministry was dealing with roughly 67 different funders for the same programme.

This links into the broader challenge of funding within the GHG system as this fragmentation can create a mismatch between available resources and priorities. Funding may not flow from the right organizations to the right areas, reducing the overall effectiveness of health interventions. For instance, *"You can have a million bed nets but you won't have help for diabetes"*. Overall an interviewee from MSF summarised it as *"We have an architectural problem and a managerial problem in the way we do things"*. Notably to reflect challenges on the side of partner countries, an interviewee described how a West African country despite receiving the most per capita, due to coordination challenges, has not effectively absorbed these resources in their health system and developed in the way it could have. This has not specifically to do with actor saturation but rather between donors and the government. Such donation coordination challenges can be assumed to have connections to the oversaturation of actors. However, in many cases, the donor has an agenda such as a focus on

a specific disease/s, which links them with a specific global actor to whom the funding flows. This seems to reproduce competition and results in inefficiency.

In Ethiopia specifically, coordination between actors was also seen as a challenge. We learned there are actors such as Family Health International, International Medical Corps, Ethiopian Midwives Association, and several others alongside the well-established ones such as ICRC, MSF and UNICEF. While some may be local and some international, an interviewee from the ICRC pointed out that there should be "coordination of the activities so that there is complementarity rather than competition". On a wider note, MSF sometimes has to assume responsibility for things that are not within their usual mandate due to a lack of coordination.

However, on the positive side, several interviewees (both those who worked for the WHO and some who did not) referred to the WHO Health Cluster as an initiative that works to do exactly that - coordinate activities in a certain place. The WHO Health Cluster initiative holds a budget themselves and coordinates with partners who are often already in place in the field. Furthermore, the different mandates of the organisations can work to complement each other in some circumstances. A former head of a WHO Health Cluster Initiative described the polio and other vaccination programmes run between the WHO and UNICEF, where UNICEF does the logistics and distributes them, supplying necessities such as fridges for storage, while WHO provides training for the health workers/vaccinators. On top of this, the Gates Foundation takes care of quality control and ensures proper implementation. In some cases then it seems, that the existence of several actors in the same space works to the benefit of the health intervention.

Finally, there are also some perspectives that coordination is improving. An IDP and public health specialist stated that at first, the diversity of having so many different actors was both a strength and a weakness - but echoed others in that the coordination challenges led to inefficiency. Now though, he says, coordination efforts have improved. It is also worth noting that as an interviewee pointed out, if there was one single organisation there would probably be fewer resources mobilized for health. As a way of moving forward, the interviewee believes consolidation is something that is going to have to be looked at over the next 10 years, ideally producing an aid system that does not have as much dependency attached. Interestingly, the question for international organisations like Gavi is; *"do we consolidate with somebody else or do we try to run ourselves out of business?"* There is therefore a balance to be found in the coordination of actors on the ground, donors, and national authority control that allows for complementary rather than competitive interventions.

A surprising point brought up by several members of international health organisations was that in some areas, there is a lack of working global health actors. One humanitarian actor explained that while working in Oromia, where there was active conflict, there were unfortunately not many actors present. In situations like this, ICRC often ends up working alone or with MSF as they have ways of working that allow them to respond quickly in active conflict zones. An interviewee from MSF also detailed how in conflict zones there are very few actors. This seems to suggest that whilst there may be challenges linked to the

oversaturation of actors in general, there are also coordination problems, as in some areas there are not *enough* actors. This operational challenge is explored further in the following section of the analysis. Ultimately, there certainly seems to be a problem with the number and placement of international actors. However, to simply claim it as 'there are too many actors' oversimplifies the problem, potentially leading to solutions that would not be effective and might leave some programmes high and dry.

2.2. Operational challenges

A key operational challenge for global health actors from the perspectives of our interviewees was security risks faced in regions affected by active conflict. As previously discussed, this leads to an absence of global health actors in these contexts. This challenge was often the first one mentioned by interviewees from MSF and ICRC.

One mentioned the growing violations of international humanitarian law meaning health workers are targeted, and more generally referred to the fact that security risks dissuade other organisations, that do not have expertise in security management, from working in such locations. This results in bigger empty spaces that organisations like MSF feel they have to cover. A humanitarian actor working on the ground detailed how teams of healthcare staff cannot be sent to areas with active fighting, and this stretched into more specific security conditions like road conditions being destroyed as part of the fighting, meaning physical barriers stopping health access due to security issues. Linked to both security and coordination efforts, an interviewee pointed out that over 350 million people currently live in areas controlled by non-state actors. The government of this country then can view the international organisation as collaborating with this armed group, threatening their status of working in the country - both administratively via visas but also in some cases detaining and killing. Whilst this is a question of neutrality, it is also a question of security - a challenge explaining the reason for an absence of actors in some regions and perhaps coordination challenges in others.

Organisations like ICRC have methods to work with weapons bearers which can address this lack of healthcare interventions to an extent. It was described how having open, prior dialogue with parties to the conflict means healthcare access can be enabled as soon as possible, rather than two months after the conflict ends. This preparedness, involving rapid assessments, is one-way organisations are addressing the security risks and attempting to still facilitate healthcare interventions in light of security risks.

2.3. Navigating Neutrality: Modes of Humanitarian engagement

A critical insight from our interviews was the different ways humanitarian actors engage with state and non-state authorities. These distinctions are largely shaped by mandates and guiding principles. For UN agencies and global financing mechanisms like Gavi and the Global Fund, engagement is primarily through formal state institutions, particularly ministries of health. This approach enhances their legitimacy and aligns with national health policies but often limits their ability to operate in conflict-affected areas where governments control is weak. According to a WHO official, the Health Cluster avoids engaging with de facto authorities, limiting its capacity to deliver aid in contested regions.

In contrast, The Global Fund and Gavi maintain relationships with diverse government types, irrespective of political status. This flexibility enables them to operate in politically unstable regions where state legitimacy is uncertain. Humanitarian organizations like MSF and the ICRC adopt a neutral and pragmatic approach, engaging with all relevant authorities including armed groups to secure access to affected populations. In Ethiopia, the ICRC collaborates with public health institutions such as; the Ethiopian Disasters and Risk Management Commission, which authorizes IDP responses, and the Ethiopian Public Health Institute, responsible for medical emergencies and implementation, while maintaining neutrality to avoid political entanglements. MSF similarly prioritizes needs-based access, even in non-state-controlled areas such as Afghanistan. This neutrality facilitates broader operational reach, particularly where government channels are inaccessible. These divergent strategies reflect two paths: legitimacy through state channels versus access through neutrality, each with its own trade-offs and limitations.

2.4. Operational Trade-offs: Advocacy vs Access

This divergence extends into the debate on advocacy versus access. Humanitarian organisations. MSF representatives reflected on the delicate balance between highlighting ground realities which may contradict the official narratives and maintaining access to populations in need. Highlighting political or human rights violations can strain relationships with authorities, risking expulsion or restricted access. In contrast, UN agencies often adopt a more visible advocacy role. This approach draws international attention to neglected crises, but it also risks closing doors in humanitarian diplomacy, limiting on-the-ground access. While each approach carries its trade-offs, this divergence can be understood as a functional division of labour within the GHG landscape, where both access-oriented neutrality and advocacy-driven engagement play complementary and essential roles.

2.5. Balancing Immediate Relief with Long-Term Solutions in Humanitarian Response

Interviews with humanitarian actors revealed a tension between short-term emergency-driven responses and the need for sustainable strategies that align with national systems. Broadly, NGOs fall into two distinct categories. Those that focus on rapid responses and those focused on long- term development. The first category, emergency responders, aim to deliver immediate relief during acute crises. This approach was reflected in an interview with a

WHO member who explained that the cluster system is typically activated only when national authorities are overwhelmed. In short-term crises, mobile clinics and temporary facilities provide urgent care. However, in protracted situations like Ethiopia's IDP crisis, this model struggles to adapt. Humanitarian services often end when funding cycles lapse, even if displacement remains unresolved. As one interviewee noted, the closure of camps does not necessarily mean that conditions have improved or that IDPs can safely return home. The gap between funding cycles and long-term needs often leaves IDPs stranded in makeshift camps without sustainable health infrastructure. One humanitarian actor described these camps as "abandoned", where deteriorating sanitation creates vulnerabilities to diseases like cholera, exacerbated by contaminated water and poor hygiene. This disconnect points to a broader flaw in the current NGO model, which is reactive and fragmented, prioritizing short-term relief over long-term development.

A core challenge here is that NGOs often lack the capacity and institutional mandate to align their work with national frameworks. This limitation stems from their primary focus on emergency relief rather than sustainable development, coupled with dependence on short-term funding. As a result, NGO interventions are typically temporary and isolated, which undermines their ability to contribute to long-term health solutions or system-wide capacity-building. This gap disrupts the continuity of care, especially in contexts of chronic displacement where short-term aid cannot address underlying vulnerabilities.

Conversely, the second category of actors emphasizes long-term development and resilience-building. This approach is vital in contexts of protracted displacement, where temporary solutions become permanent. An ICRC health coordinator in Ethiopia noted that too much focus remains on short-term aid, sidelining root-cause solutions. This perspective was echoed by an interviewee who advocated for a shift towards the humanitarian-development-peace nexus, where emergency relief transitions into development, and ultimately, peacebuilding. Such a shift, while complex, is essential for equipping displaced populations with the tools to rebuild their lives - this includes economic development, employment opportunities, social inclusion, and conflict resolution.

The Global Fund and Gavi arguably exemplify more structural, systems-oriented actors. Rather than direct implementation, The Global Fund channels resources through national Ministries of Health, reinforcing state ownership and encouraging them to integrate IDPs into broader health strategies. Similarly, Gavi adopts a strategy centred on national ownership and long-term planning. They prioritize multi-year frameworks designed alongside national agencies, allowing for sustainable capacity-building.

In summary, the divide between immediate relief and sustainable development is a central challenge in GHG. For real change, humanitarian interventions must transition from isolated relief efforts to integrated, state-supported health solutions. Bridging this gap is critical to advancing health equity for IDPs and other marginalized communities.

3. Global Health Governance & Power Dynamics

Power dynamics are central to GHG and our interviews revealed multiple layers of imbalance between donors, implementing organisations and recipient countries.

3.1 Donors, Mandates, and the Limits of Country Ownership

A recurring theme was the misalignment between national priorities and the agendas of IOs and donors. Donor-funded programs sometimes do not reflect what governments or local communities identify as their most urgent health needs, undermining national ownership, especially in contexts where governments have limited control over resource allocation.

However, interviewees also noted that national ownership is shaped not only by external pressures but also by the strength of domestic leadership. A Southeast African country for example was cited by an interviewee as a model of assertive national ownership, with a centralized health strategy that requires all donor and IO activities to align with national frameworks. This approach ensures that external actors support, rather than bypass, national systems.

At the same time, IOs are not always free to set their priorities, as these are often influenced by donor expectations. This can create tensions between on-the-ground needs and donor-driven agendas. Nevertheless, several organizations-including MSF, the Global Fund, and Gavi have implemented mechanisms to protect their operational independence. MSF, for instance, refuses government funding, allowing it to respond solely based on humanitarian needs. The Global Fund uses a pooled funding model to reduce bilateral political influence, enabling engagement even in politically sensitive contexts. Gavi's governance structure, which includes equal representation of donor and recipient countries on its board, also exemplifies efforts to balance power and promote more equitable decision-making.

3.2 Structural Imbalances Between International and Local Actors

A second major power asymmetry concerns the relationship between international "Western" actors and local expertise. Local organizations are often relegated to implementing roles despite their deeper understanding of community needs. Heavy reliance on international staff not only drives up costs but also sidelines local professionals and stifles the development of context-specific solutions. This imbalance raises fundamental questions about trust and the willingness of international NGOs to share decision-making power. As interviewees from MSF emphasized, shifting the centre of gravity in global health governance toward the Global South is essential; regional actors must have greater leadership and agenda-setting power. The roots of these power disparities lie in the very architecture of the GHG system. Built in the post–World War II era, it reflects the geopolitical hierarchies of that time, with decision-making power concentrated among a few dominant states. The norms and institutional structures that emerged from this period continue to embed systemic inequities, limiting the voice and influence of low-income countries in global health governance today.

3.3 Donor Influence on Humanitarian Implementation

Donor dependency was also highlighted as a subtle force shaping the priorities and behaviour of implementing actors. Even when donor expectations are not explicitly stated, implementers often operate under implicit pressure to align with perceived donor preference both to secure continued funding and to remain in good standing within donor relationships. This creates a climate of uncertainty and anxiety, particularly given the short-term nature of many funding cycles. As a result, humanitarian organisations might adjust their programs not based solely on community needs but also on what they believe donors want to see. This raises questions about the autonomy of humanitarian action and reveals the deeper structural imbalances in the aid system where power resides disproportionately with funders.

3.4 The Constraints of Earmarked Funding

Another challenge is the prevalence of earmarked funding aligned with IO's mandates, which can limit national flexibility. While substantial resources may be allocated to specific health issues, countries could often achieve greater overall impact by directing those funds toward broader health system priorities, free from externally imposed constraints. While such vertical programs have achieved notable progress in targeted areas, they can constrain national governments, who are unable to reallocate funds to pressing health needs such as maternal health or non-communicable diseases. This rigidity can hinder integrated health system strengthening.

3.5 Toward Self-Sufficiency and Domestic Resource Mobilisation

The reality is that the structure of donor funding itself often makes it difficult for countries to fully dictate and own their health programs. As one interviewee put it, genuine ownership requires states to take greater responsibility. Several interviewees echoed this sentiment emphasizing the need to shift towards greater self-sufficiency.

An interviewee from Gavi emphasised the importance of stronger inter-ministerial collaboration between health and finance ministries to enable domestic resource mobilization. These perspectives align with calls to move beyond donor-driven aid models and towards integrated country-led strategies. However, such shifts require strong governance, institutional capacity, and public trust to be effectively implemented. However, the pursuit of self-sufficiency also exposes vulnerabilities in governance structures, where gaps in accountability and instances of corruption can significantly undermine progress and the quality of health services

Conclusion

Insights collected from our interviews with global health professionals highlighted significant challenges and inequities within the GHG system. To address these challenges, our analysis points to several possible solutions, both at the IO level, and within national policy

frameworks. While further research is necessary to deepen these recommendations, our findings offer a foundation for strategic improvement.

In the context of IDPs in Ethiopia, addressing health inequities requires political commitment and legal recognition. The root causes of displacement - primarily conflict, political instability, and environmental crises, must be addressed to enable sustainable return and reintegration. However, in the absence of that capacity, IDPs should be politically and legally acknowledged to be registered to access state services. Furthermore, improving the relationship between host communities and IDP communities would allow more equal access to health interventions. Stronger implementation of the principles of the Kampala Convention likely offers a way forward in recognising IDPs and asserting their rights in practice. This responsibility for general structural reform and reintegration strategies often lies with national authorities.

Health-wise, broader sanitation contexts need to be improved - access to clean water, and sanitation infrastructure such as functional latrines, is vital to stop the reversal of work done by health interventions. On the side of international actors, there are two main threads of solutions to be considered. The first is improved coordination, the second is a reassessment of the programmes implemented by global actors, and their long-term vision. As discussed in the section on the possible oversaturation of actors, coordination should be a priority for global actors working in this field. This should potentially be via encouraging more agency and control from national governments.

Finally, it seems to be widely acknowledged that how humanitarian aid is currently conducted is flawed. While there is some degree of reflexivity in the field, greater emphasis on long-term programmes rather than reactive projects, working within national frameworks, would increase the sustainability of these programmes. Although many IOs seem to operate within these frameworks, there is clear room for improvement. Strengthening this alignment could also help bridge the gap between "development" and "humanitarian aid," which currently fails to address root causes and perpetuates dependency.

Radical Thinking

Moving away from conclusions and potential steps forward on the IO level, there is a need to explore possible radical changes in broader aspects of power balances. There is a power shift being explored (insert info on Lusaka agenda), but we aim to propose additional ways in which inequities in the GHG system could be addressed. There is a need to think critically about 2 radical changes that would benefit the system and challenges previously discussed.

One possibility is the strengthening of civil society organisations in order to hold health ministries and government powers accountable for providing equal and suitable healthcare services for all people. This would require a process of power redistribution within a state gradually giving civil society representatives more power.

Civil society can play a crucial role in holding governments accountable particularly in the context of co-financing agreements with GHG actors. However, this accountability depends on the level of transparency governments maintain about the funding of their health systems. When combined, transparency and active civil society engagement have the potential to promote country ownership. More specifically, in the context of Ethiopia, this can entail ensuring IDP representatives have a dialogue with authorities and civil society organisations can act as platforms to amplify the voice and needs of the IDP community and other groups/communities who face inequities in the system. This power transition could also foster a greater recognition of IDPs and provide more emphasis on addressing root causes of conflict and insecurity. On a broader level, civil society engagement could allow for a more sustainable way of implementing programmes, with a focus on solutions rather than crisis response by giving a stronger voice to the people that need it the most.

Additionally, to promote country ownership, there is a need to rethink aid relations. Now more than ever it is evident that countries need to move beyond existing aid relations focused on North South relationships and seek new partnerships. There is already a wide range of literature exploring the benefits of South South collaboration by sharing knowledge, technologies and resources. Beyond monetary resources this could include sending health practitioners in areas facing emergencies. Additionally, humanitarian aid aimed at addressing health emergencies can be more effectively mobilized and coordinated within the continent to strengthen regional response capacity. Ultimately South South collaboration can promote a collaborative network between countries and is rooted in solidary and horizontal relationships between actors. This can help alleviate some of the power asymmetries discussed above and promote country ownership.

Annex

Annex A: Supporting Literature Outside Central Scope:

Call for a Global fund for displacement:

In 2019, upon the request of 57 member states, the UN Secretary-General established an independent panel to address the global crisis of internal displacement. In its 2021 report, the panel advocated for a fundamental shift in the international community's response to internal displacement (Bilak, 2021). Their analysis highlighted that the billions of dollars spent annually on humanitarian aid serve primarily as short-term relief, which is ultimately unsustainable. In 2021, the global economic cost of internal displacement was estimated at $20.5 billion, a figure likely underestimated (Bilak, 2021). The panel argued that continued reliance on humanitarian agencies to provide prolonged support is inadequate and may disincentivize governments from taking responsibility for durable solutions (Bilak, 2021). They emphasised that tackling these challenges requires long-term planning, sustained investment, and broad collaboration (Bilak, 2021).

The panel also identifies a pervasive neglect by governments, UN agencies, and media in addressing the needs of internally displaced persons (IDPs), contributing to their relative invisibility and lower prioritisation in policy agendas (UN 2021). They attributed part of the problem to the ongoing perception of internal displacement as primarily a humanitarian issue, arguing that humanitarian action alone cannot provide the sustainable solutions needed (UN 2021). The panel also underscored the need for states to recognize the rights of IDPs as full citizens and residents, advocating for safe and dignified conditions that support IDPs' well-being, rather than merely facilitating their return to unstable regions (UN 2021). To address these concerns, the panel proposed the creation of a global fund for displacement, designed to partner with governments, the private sector, financial institutions, and local civil society to implement sustainable solutions. The fund's primary goal would be to provide governments with the financial and technical assistance needed to establish durable solutions, integrated into national development plans, to maximise positive, lasting impacts on individuals and communities (Bilak, 2021).

World Health Organisation (WHO) and the Global Fund to fight AIDS Tuberculosis and Malaria

To address the contextual involvement of major actors in addressing IDPs health in Ethiopia, this section focuses on two key players in the GHG system: the WHO, a central traditional actor, and the Global Fund, a more recently developed PPP. The WHO reports that four countries in the Greater Horn of Africa: Ethiopia, Somalia, South Sudan, and Sudan, have enhanced collaboration through a cluster coordination system that integrates health-related

concerns, in response to humanitarian emergencies (WHO, 2023b). As the cluster lead, the WHO oversees 40 sub-national hubs, providing coordination, guidance, and technical support during crises. In Ethiopia, the WHO partners with 23 organisations to deliver emergency health support, sustain essential services, and enhance capacities for disease outbreak prevention, preparedness, and response (WHO, 2022). According to the WHO, healthcare capacity particularly in Tigray has nearly collapsed, with only 3% of health facilities operational as of 2022 (WHO, 2022).

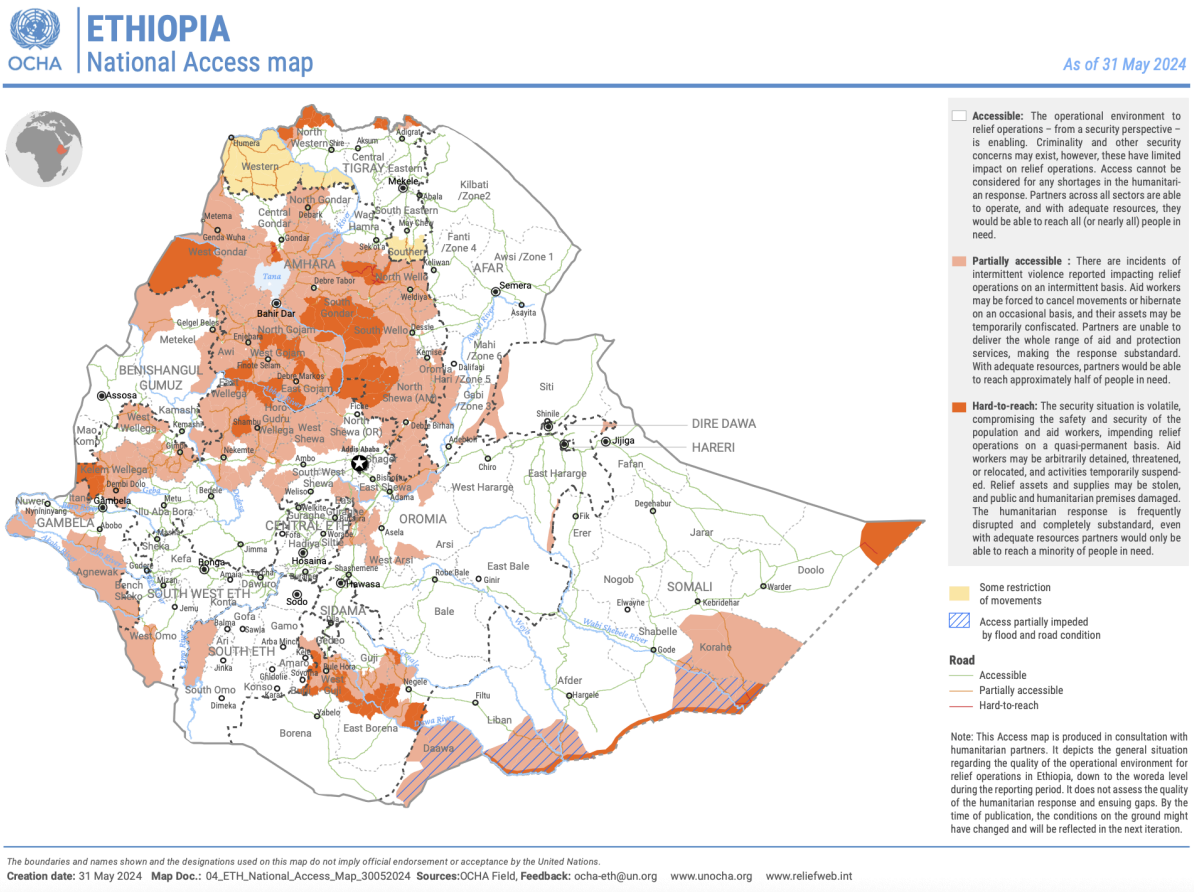
Moving on to the Global Fund, which has complimented the efforts of the WHO by focusing on communicable diseases and strengthening health systems in conflict-affected areas, the Global Fund has sought to expedite its support through an emergency fund specifically designed for what it calls "challenging operating environments", which includes countries like Ethiopia (The Global Fund, 2024a). Since 2003 the Global Fund has invested $3 billion in the country and approved an additional $2.5 million of emergency funds in September 2024 to support essential HIV, TB, and malaria services in conflict-affected northern regions (Global Fund, 2024b). To facilitate effective implementation, the Fund collaborates with UNICEF and WHO, integrating the grant into existing support frameworks (Global Fund, 2024b). The four northern regions of Ethiopia, which represent 36% of the national population, account for 40% of HIV cases and 47% of malaria cases, underscoring the region's strategic importance for the Global Fund (Global Fund, 2024b).

A noted challenge by interviewees, outside the scope of our focus:

<u>Challenge of corruption:</u>

An interviewee from the health cluster highlighted a troubling disconnect between global health governance (GHG) frameworks and field-level realities. Despite existing regulations, enforcement is often inconsistent, allowing donor funds to flow to the lowest-cost implementers – even when they fail to meet quality standards. For instance, some NGOs cut corners by deploying under qualified teams, compromising the standard of care.

Annex B: Ethiopia National Access Map (as of 31 May 2024)



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Creation date: 31 May 2024 **Map Doc.:** 04_ETH_National_Access_Map_30052024 **Sources:**OCHA Field, **Feedback:** ocha-eth@un.org www.unocha.org www.reliefweb.int

Annex C: Table of interviewees (with consented levels of anonymity)

Name	Organisation	Expertise
Silas Mukangu	ICRC	Health Activities Coordinator, In Kenya and Ethiopia
Reveka Papadopoulou	MSF	MSF International Board
Susana de Deus	MSF	Former Executive director of MSF Brazil
Paula Gil Leyva	MSF	Diverse experience in MSF missions
Dr Issa Barry		Public health physician with experience in the coordination and management of humanitarian action, including work with internally displaced persons (IDPs) in the Sahel region and Burkina Faso
Sacha Bootsma		Former WHO Health Cluster Coordinator Ethiopia
David Kinder	GAVI	Senior international economic and public policy professional, director of development finance
Senior Staff Member	Global Fund	East African country fund portfolio manager
Senior Staff Member	Global Fund	Public health specialist focused on health financing and the design and management of public health programs in sub-Saharan Africa
Anonymous		Specialist in humanitarian work of International organisation in Ethiopia

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