Localization in the Health Cluster Coordination: A Baseline Analysis of the Barriers, Enablers, and Good Practices

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INTRODUCTION

The Grand Bargain

In the 2016 World Humanitarian Summit (WHS), a group of donors and humanitarian actors committed to improving the efficiency and effectiveness of the humanitarian system in delivering assistance to the affected people by focusing on a set of strategic commitments that aspired to transform Partnership, Financing, Capacity Strengthening, and Coordination. The signatories to the Grand Bargain also acknowledge that achieving a more efficient, effective, and accountable humanitarian outcome for affected populations is intricately linked to two factors: quality funding and localization- referred to as the enabling priorities for the Grand Bargain outcomes. The localization goal is to increase support for the leadership, delivery, and capacity of local responders and the participation of affected communities in addressing humanitarian needs.

Nearly eight years after its conceptualization, the Grand Bargain is yet to deliver fully on a substantial scale against the commitments -this is not to undermine the progress made so far, though suboptimal. The gap between the well-intended localization policies and the expected results remains huge. Fortunately, localization is still very much on the top agenda among policymakers thanks to a renewed focus from donors and advocacy calls demanding a more concrete acceleration of progress in tackling some of the barriers to effective L/NA participation in the humanitarian system.

Box 1: Grand Bargain Localization Commitments

"Grand Bargain is about working together efficiently, transparently, and harmoniously with new and existing partners, including the private sector, individuals, and non-traditional funding sources. This requires us to innovate, collaborate, and adapt mindsets" (Istanbul, May 2016)

Commitment 2.1: Increase and support multiyear investments in the institutional capacities of local and national responders, including preparedness, response, and coordination.

Commitment 2.2: Understand better and work to remove or reduce barriers that prevent organizations and donors from partnering with local and national responders in order to lessen their administrative burden.

Commitment 2.3: Support and complement national coordination mechanisms where they exist and include national and local responders in international coordination mechanisms as appropriate and in keeping with humanitarian principles.

Commitment 2.4: Achieve by 2020 a global, aggregated target of at least 25% of humanitarian funding to local and national responders as directly as possible to improve outcomes for affected people and reduce transaction costs.

Commitment 2.5: Develop, with the Inter-Agency Standing Committee (IASC), and apply a localization marker to measure direct and indirect funding to local and national responders.

Commitment 2.6: Make greater use of funding tools that increase and improve assistance delivered by local and national responders such as UN-led country-based pooled funds (CBPFs), the IFRC Secretariat's Disaster Relief Emergency Fund (DREF), and other pooled funds.

Grand Bargain Enabling Priorities:

1. Funding: A critical mass of quality funding is reached that allows an effective and efficient response, ensuring visibility and accountability.
2. Localization: Greater support is provided for the leadership, delivery capacity of local responders, and the participation of affected communities in addressing humanitarian needs. (Grand Bargain 2.0, June 2021)

Inter-Agency Standing Committee (IASC): Localization in Humanitarian Coordination

As a Grand Bargain signatory and the Inter-Agency Standing Committee (IASC) Global Health Cluster Lead Agency (GHC CLA), WHO is responsible for promoting and supporting collective action at global and country levels to ensure more effective, efficient, and predictable humanitarian health action. At the center of WHO's approach to coordinating the multiagency cluster platform lies the principles of equitable partnerships as a pillar to working collaboratively for collective outcomes for public health[1]. In leading the health cluster, WHO engages a diverse group of actors from the United Nations (UN), International Non-Governmental Organizations (INGO), and L/NAs, including public institutions hence contributing directly to the Grand Bargain core commitment (2.3) to strengthen local coordination mechanisms and involve L/NAs in international coordination mechanisms.[2,3]

L/NAs have played crucial roles in delivering public health assistance in humanitarian settings and have been instrumental in the recent COVID-19 pandemic response[4]. With effective partnerships, L/NAs have further demonstrated the capability to provide long-term solutions to health care, especially in post-conflict areas[5]. Therefore, accelerating localization in the health cluster is of immense value to the overall goal of an efficient health response.

To escalate the integration of L/NAs into the humanitarian coordination mechanism, the IASC Operational Policy and Advocacy Group (IASC OPAG) outlined a set of strategic recommendations to strengthen the participation, representation, and leadership of L/NAs in humanitarian coordination. The IASC localization guidance issues a clear call to action for humanitarian coordinators at all levels, urging them to bolster the meaningful engagement of L/NAs in all humanitarian coordination mechanisms, national or international. They urge for concrete action in the seven areas: Participation and Representation, Leadership, Capacity Strengthening, Resourcing for Coordination, Visibility: Preparedness, Response, Humanitarian Development, Peace Collaboration, and strengthening Accountability and Monitoring of localization in humanitarian coordination[6].

Goal

Creating a significant and positive transformation in how the L/NAs are engaged in the Health Cluster coordination is a top strategic priority for the GHC, as reflected in the GHC's 5-year strategic plan (2020-2025)-strategic priorities 1.3 and 4.2[7]. The GHC committed to two iterative processes to advance localization in the health cluster, beginning with developing a localization strategy that would be followed by a rigorous implementation at the country and global levels. The health cluster localization strategy will outline a set of relevant priorities and recommendations derived from the comprehensive analysis of the barriers, good practices, and enablers of localization in health cluster coordination.

Specific Objectives

This study aims,

1. To assess the general perceptions on localization implementation in the health cluster.

[1] Health Cluster guide: A practical handbook. Geneva: World Health Organization; 2020. License: CC BY-NC-SA 3.0 IGO.
[2] As of November 2023, there were 67 signatories including WHO as the Global Health Cluster Lead Agency. See the full list of signatories here.
[3] Grand Bargain Workstream 2, Commitment 2.3 https://interagencystandingcommittee.org/sites/default/files/migrated/2021-11/Commitments%20and%20core%20commitments%20by%20workstream.pdf
[4] coopcanada2020. Localize or Perish: What You Need to Know about Localization. Cooperation Canada. Published October 28, 2020. Accessed January 11, 2024. https://cooperation.ca/localize-or-perish/
[5] Murdie A, Barney M. Localizing the NGO Delivery of Health from the Outside In. Daedalus. 2023;152(2):181-196. Accessed January 9, 2024. https://www.jstor.org/stable/48728679
[6] IASC Guidance on Strengthening Participation, Representation and Leadership of Local and National Actors in IASC Humanitarian Coordination Mechanisms | IASC. interagencystandingcommittee.org. https://interagencystandingcommittee.org/operational-response/iasc-guidance-strengthening-participation-representation-and-leadership-local-and-national-actors
[7] Global Health Cluster Strategy 2020-2025. healthcluster.who.int. Accessed March 8, 2024. https://healthcluster.who.int/publications/m/item/global-health-cluster-strategy-2020-2025

2. To identify enablers and barriers, Initiatives, and recommendations to strengthen L/NA's representation, participation, and leadership in the health cluster coordination.

Research Questions

i. What are the general perceptions among the health cluster stakeholders- about the progress of localization and strategic contributions of the L/NAs in the cluster coordination? (SO1)
ii. What are the enablers and initiatives to strengthening L/NA's equitable representation, participation, and leadership in the health cluster coordination? (SO2)
iii. What are the barriers/risks to including L/NA in the leadership of the health cluster? What are the effective strategies to enhance L/NA leadership in the health cluster? (SO2)

METHODOLOGY

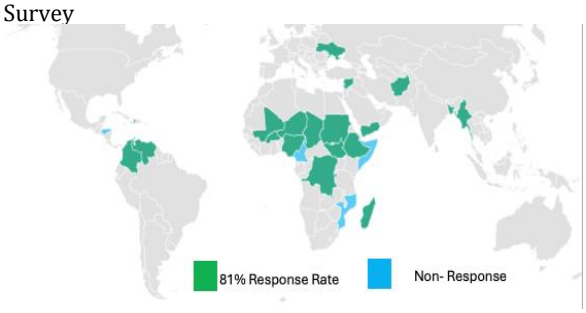
Study Design: We used a mixed-method design involving qualitative and quantitative techniques to collect data for the scoping analysis.

Study Sites: This study examines the localization practice focusing on the health clusters in Ethiopia and Northwest Syria (coordinated from Gaziantep, Turkey) coordinated) as a case study. These two country health clusters were prioritized in consultation with the GHC for in-depth analysis because of the protracted nature of the crisis and the long experience with many L/NAs- giving a rich source of information to understanding the realities of the barriers and good practices for the engagement of L/NAs in the health cluster.

Data Collection

i. Desk Review of Secondary Data: A literature search using the keywords and related concepts of aid localization, humanitarian coordination, and local actors generated more than 50 documents from peer-reviewed research publications; policy documents, and localization analysis reports from other clusters/organizations for review.
ii. Cross-sectional Survey: GHC administered a web-based self-administered questionnaire targeting all the Health Cluster Coordinators (HCC) to provide the most up-to-date insights. The data was collected from November to December 2023 with an 81% response rate.

Figure 1: Response to the GHC Localization Baseline Survey



iii. Qualitative data collection: We collected primary qualitative data through Focused Group Discussions (FGD) and Key Informant Interviews (KII) from informants who were familiar with the localization discourse, possessed critical coordination/leadership/program experience in a humanitarian setting, and were engaged on the subject at the policy or operational. The study participants were selected through Non-Probability Purposeful and Snowball sampling techniques representing local authorities and other L/NAs, INGOs, and the UN. A total of 37 informants from the two countries (Ethiopia,16 and Northwest Syria,21) were interviewed. In addition, 03 FGDs were conducted in the two countries. Additionally, 08 informants from the global level- 01 INGO, 02 NNGOs, 02 Global Clusters, and 2 AORs were also interviewed.

Data Analysis: The quantitative data from the cross-sectional survey were analyzed using descriptive statistics of frequency/proportions and means, and the categorical data presented in bar and pie charts. Qualitative data from the interviews was analyzed first through data-driven line-by-line coding of the transcripts - allowing the codes to emerge from the data inductively. Subsequently, the researchers performed a secondary analysis of the coded data to derive the themes.

Table 1: Profile of Key Informants

Country Key Informant Interviews	Ethiopia (16)	Gaziantep, Turkey (21)
Health Cluster Coordinator (HCC)	01	01
Sub-national HCC	01	-
Health Cluster Support Officer, Public Health Officer	01	01
INGO Partners	04	07
UN Health Cluster Partners	03	07
OCHA	01	02
Donor	01	03
L/NA: Most of the L/NAs were interviewed through FGDs at the recommendations of the country team	03 (No WLO, RLO, CSO, FBOs)	
Local Authority, Ministry of Health	01 (Sub-national)	
Focused Group Discussions (FGD)	01 with Sub-national NNGOs	2 FGDs with NNGOs and Local Authority

FINDINGS

A. Overview of the Humanitarian Context

Ethiopia

Demography: The vastness of the country alone poses a challenge to country-wide coordination. Ethiopia is the 10th largest country in Africa and the second most populous with an estimated population of 126.5 million people (49.8%, Female).[8] Governed in a federal system, the country has 12 ethnolinguistic administrative regions that are further subdivided into zonal and woreda units.[9]

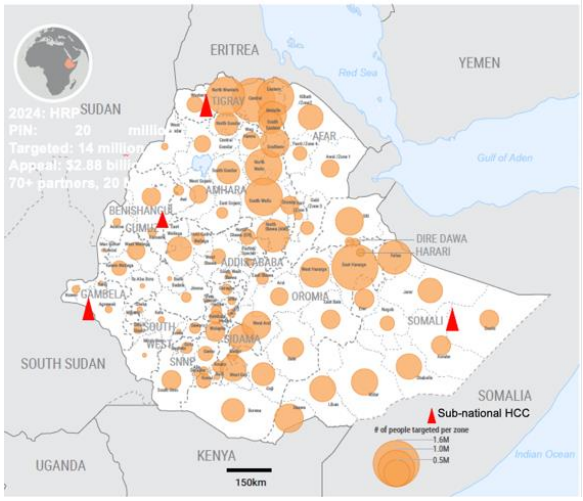
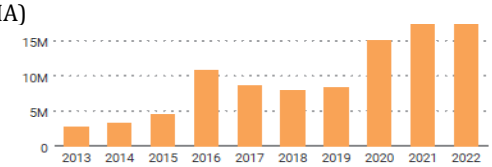


Figure 2: Ethiopia, People Targeted HRP 2023 (UNOCHA)



Humanitarian Overview: Ethiopia faces a country-wide complex, protracted humanitarian crisis triggered by armed conflict, intercommunal clashes, and climatic hazards (drought, floods). By January 2024, the UN estimated about 3.5 million people were internally displaced, and 15.4 million were projected to be food insecure. There were about 1 million refugees and asylum seekers in the country[10]. The drought and flood had affected 7 million (mainly in the Eastern and Southern Regions of Somalia and Oromia). Insecurity was impeding access to affected people. Since August 2022, the country has been responding to the Cholera outbreak that has left 1.2 million people at risk and 30,000 cases, especially in the southern parts of Oromia, Somali, and Sidama regions[11,12]

[8] Ethiopia - Population, Female (% Of Total) - 1960-2019 Data | 2020 Forecast. tradingeconomics.com. https://tradingeconomics.com/ethiopia/population-female-percent-of-total-wb-data.html
[9] Ethiopia: Administrative map (as of October 2020) - Ethiopia | ReliefWeb. reliefweb.int. Published December 24, 2020. Accessed February 20, 2024. https://reliefweb.int/map/ethiopia/ethiopia-administrative-map-october-2020
[10] Ethiopia - Complex Emergency Fact Sheet #1, Fiscal Year (FY) 2024 - Ethiopia | ReliefWeb. reliefweb.int. Published January 8, 2024. Accessed February 23, 2024. https://reliefweb.int/report/ethiopia/ethiopia-complex-emergency-fact-sheet-1-fiscal-year-fy-2024
[11] Ethiopia: Cholera Outbreak - Flash Update #8 (as of 20 June 2023) - Ethiopia | ReliefWeb. reliefweb.int. Published June 21, 2023. https://reliefweb.int/report/ethiopia/ethiopia-cholera-outbreak-flash-update-8-20-june-2023
[12] Ethiopia Cholera Outbreak - DREF Final Report (MDRET028) - Ethiopia | ReliefWeb. reliefweb.int. Published January 30, 2024. Accessed February 22, 2024. https://reliefweb.int/report/ethiopia/ethiopia-cholera-outbreak-dref-final-report-mdret028

Humanitarian Coordination: Overall, the Government of Ethiopia and the Humanitarian Country Team (HCT) are responsible for the coordination of the humanitarian response with the Ethiopia Disaster Risk Management Commission (EDRMC) chairing the National Disaster Risk Management (DRM) Technical Working Group (TWG) and United Nation Office for Coordination of Humanitarian Affairs (UN OCHA) co-chair. 11 clusters are in principle co-led by the relevant Government line ministry and the UN Cluster Lead Agencies (CLA). The Inter-Cluster Coordination Group (ICCG) is established nationally and decentralized to six sub-national (regional) levels in Oromia, Tigray, Somali, Afar, Amhara, and Benishangul-Gumuz. World Health Organization (WHO) is leading the health cluster response with 74 partners (34 International NGOs and 20 National NGOs) alongside the Ministry of Health as co-lead. Four (Tigray, Somali, Benishangul-Gumuz, and Gambella) out of the 12 regions had a sub-national health cluster appointed (2 from WHO, 2 NNGO co-lead)[13]

Figure 3: Number of People Targeted, Ethiopia HRPs

Northwest Syria

Now in its 13th year, the protracted humanitarian crisis in Syria is one of the largest globally and is taking on a worsening trajectory. The complexity of the conflict is fueled by continued fighting between several armed groups with various international backing, leading to a complex crisis with significant territorial fragmentation.

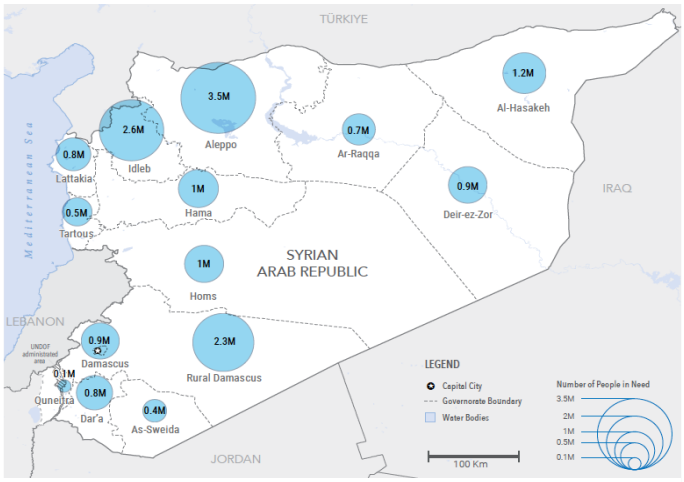


Figure 4: People in Need in Syria (2024 Humanitarian Needs Overview Feb, 2024)

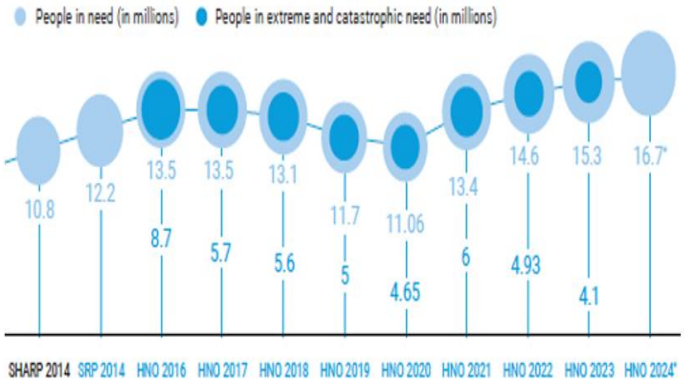


Figure 5: Syrian Arab Republic: 2024 Humanitarian Needs Overview (Feb, 2024)

Humanitarian Overview: By the end of 2023, the UN estimated that nearly 7 out of 10 Syrians required humanitarian assistance, with most of the affected people living in the Northwest and Northeast territories where conditions are reportedly unsuitable for safe, informed, and voluntary refugee returns[14]. Escalating food insecurity and ongoing economic downturn with potential funding cuts add to the large scale and severity of the situation. Given the limited resources entering the affected territories, the situation is dire because of the devastating earthquakes in February 2023. The non-renewal of UN Security Council Resolution 2672 (2023) has constrained humanitarian access to more than 4 million people who need humanitarian Northwest assistance in Northern Aleppo and Idlib[15]. The escalation in hostility in the Northwest since October 2023 is inflicting more suffering[16].

[13] Ethiopia. healthcluster.who.int. Accessed February 20, 2024. https://healthcluster.who.int/countries-and-regions/ethiopia
[14] https://www.unocha.org/syrian-arab-republic
[15] https://reliefweb.int/report/syrian-arab-republic/syrian-arab-republic-2024-humanitarian-needs-overview-december-2023?gad_source=1&gclid=CjwKCAiA29auBhBxEiwAnKcSgguVOa8ukNUh-BjwggJ1QdJR1YsZvJmr_y4ik9ols0D8AnBb8Ud0oRoCoaUQAvD_BwE
[16] https://www.usaid.gov/sites/default/files/2024-01/2024-01-10_USG_Syria_Complex_Emergency_Fact_Sheet_3.pdf

The 2024-2025 Humanitarian Response Plan (HRP) aims to provide essential services for a targeted 13 million out of 15.3 million in need of humanitarian assistance at an estimated $4.4 billion. In general, a drastic funding shortfall is anticipated in 2024. In 2024, the health cluster will maintain access to comprehensive life-saving primary and secondary health services for an estimated 3.81 million people in Northwest Syria (NWS) through a network of 198 primary healthcare facilities and 74 functioning hospitals[17]. A cholera outbreak has added to the health crisis. Attacks on healthcare facilities were recorded in September and October 2023, highlighting the persistent threats healthcare providers face. There are persistent gaps in services for Non-Communicable Diseases, e.g., oncology, cardiovascular services, medical waste management, maternity and pediatrics services, and other specialized services, particularly in Jarablus and Idleb[18].

Humanitarian Coordination: The Humanitarian Liaison Group (HLG) maintains coordination oversight of the Inter-Cluster Coordination for about 10 active clusters. Eight of the clusters are co-led by either International NGOs (INGOs) INGO or Local and National NGOs. WHO leads the Health Cluster Northwest Syria with multiple task forces co-chaired by LNNGOs.
Regarding health service delivery, the LNNGOs account for most -they make up 71% of the 45 health cluster partners. There are several capacity-strengthening initiatives with organizations based in Gaziantep. The initiatives predominantly focus on grant management and could increase their focus on leadership and sustainability. Strengthening local leadership emerges as a crucial element for fostering inclusivity and sustainability.

B. Localization: General Operational Perceptions

Defining Localization: Different entities have provided varying but related definitions of the term without agreeing on a single, See Box 2. Many actors dispute the meaning and the politics of the localization term, although almost all of them unanimously agree on the importance of localization[19]. Unfortunately, the debates have generated more questions than answers and are sometimes viewed as counterproductive to the implementation[20]. It has become clear from other literature that the success of localization or the make-up of a locally led response depends on the context in question[21].

> "Localization is the key, especially for any engagement of interventions, specifically for humanitarian life-saving interventions but also even for developmental programs. It is a must to localize…" (UN KII, Ethiopia)

Unlike the desk review, the interviews did appear to exhibit a less heterogeneous understanding of localization. Generally, the understanding of localization was influenced by the field of practice. Respondents from a program delivery background viewed localization in the context of processes and relationships of programmatic delivery of assistance through a local partner.
On the other hand, informants with a coordination mandate viewed localization in the context of participation, representation, and leadership in coordination. Overall, nearly all the

[17] HRP Health Sector Chapter_DRAFT2_WoS Health_Clean_Final CLA cleared 17th Jan 2024 (3).docx
[18] https://reliefweb.int/report/syrian-arab-republic/turkiye-cross-border-health-cluster-bulletin-october-2023
[19] Unpacking Localization. https://www.icvanetwork.org/uploads/2021/08/Unpacking-Localization-ICVA-HLA.pdf
[20] Fast L, Bennett C. HPG Report/Working Paper from the Ground up It's about Time for Local Humanitarian Action HPG Report.; 2020. https://odi.cdn.ngo/media/documents/From_the_ground_up_its_about_time_for_local_humanitarian_action.pdf
[21] Barbelet V, Davies G, Flint J, Davey E. Interrogating the evidence base on humanitarian localisation: a literature study. ODI: Think change. Published June 30, 2021. https://odi.org/en/publications/interrogating-the-evidence-base-on-humanitarian-localisation-a-literature-study/

respondents (government, UN, INGO, and NNGO) expressed a universal acknowledgment of the importance of the local actors and what in essence localization is trying to achieve.

Measurement of progress: Asked about their perception of the overall progress of localization in the health cluster and the basis of their assessment, the respondents registered a widespread consensus about a significant improvement in the engagement of L/NAs, and that there were remaining gaps to address the sub-national level. On the criteria/measurement used to qualify the assessment, there was recognition that better indicators were required. Even though there was no stand-alone framework to assess the progress of localization within the health cluster, the partners had improvised or customized several indicators to measure localization in the cluster. Most indicators were process indicators that measured whether the requirement was met, e.g., L/NAs are present in meetings or lead technical working groups (TWGs), and the number of training sessions. These indicators fell short in assessing the achievement of the conditions that must be met to qualify for meaningful engagement. In the context of localization, where L/NAs drive the response, for instance, the output and quality of that engagement are essential dimensions to assess.

Box 2: Various Definitions of Localization

- "A process through which a diverse range of humanitarian actors are attempting, each in their own way, to ensure local and national actors are better engaged in the planning, delivery, and accountability of humanitarian action, while still ensuring humanitarian needs can be met swiftly, effectively and in a principled manner" (International Council of Voluntary Agencies)
- A collaborative process that aims to prioritize local actors, Civil Society Organizations (CSO), and local public institutions in the humanitarian system and response (Group Urgence Rehabilitation Development Association)
- A process of recognizing, respecting and strengthening the independence of leadership and decision making by national actors in humanitarian action, in order to better address the needs of the affected population" (Australian Red Cross, Pacific)
- "A process of recognizing, respecting, and strengthening the independence of leadership and decision-making by local and national actors in humanitarian action, in order to better address the needs of affected populations" (SCI Inter-Agency Toolkit)
- Localising humanitarian response is a process of recognising, respecting and strengthening the leadership by local authorities and the capacity of local civil society the needs of affected populations and to prepare nation 2017)

Box 3: Example of Localization Indicators in use in Ethiopia and Northwest Syria Health Clusters

- Percentage of local partners within the cluster's overall partner network
- Number of local partners attending the monthly cluster meetings
- Percentage of local partners attending the monthly cluster meetings
- Number of strategic task forces co-chaired by local and national NGOs
- Frequency of consultations between local partners and cluster coordination team
- Number of local partners actively intervening during health cluster meetings.
- Availability of interpretation during monthly health cluster meetings
- Number of local and national NGOs reporting regularly to the health cluster coordination team
- # L/NA included in the health cluster Strategic Advisory Group, meeting attendance
- The proportion of EHF allocated to local NGOs
- Project performance-based indicators
- Consultation between the HCC focal point and government counterpart, meeting frequency

"…we also show the progress of our local national organizations first in terms of delivering the Primary healthcare system in our operational area… but we don't have a clear indicator, to measure the progress from zero to hero..." (INGO KII, Ethiopia)

Defining "Local": Defining a "local" actor is complicated by several arguments over its relativity to who, what, and the complex linkages to power, access, and risks[20]. A commonly applied definition of an L/NA is that proposed by the IASC Humanitarian Financing Task Team Working Groups (IASC HFTTWG).

Box 4: IASC Humanitarian Financing Task Team Working Groups, Defining L/NA

1. Local and national non-state actors are "Organizations engaged in relief that are headquartered and operating in their own aid recipient country and which are not affiliated to an international NGO".
Note: "A local actor is not considered to be affiliated merely because it is part of a network, confederation or alliance wherein it maintains independent fundraising and governance systems" (text endorsed by GB signatories). Local and national non-state actors include,

1.1 National NGOs/Civil Society Organisations (CSOs): National NGOs/CSOs operating in the aid recipient country in which they are headquartered, working in multiple subnational regions, and not affiliated with an international NGO. This category can also include national faith-based organizations.

1.2 Local NGOs/CSOs: Local NGOs/CSOs operating in a specific, geographically defined, subnational area of an aid recipient country, without affiliation to an international NGO/CSO. This category can also include community-based organizations and local faith-based organizations.

1.3 Red Cross/Red Crescent National Societies: National Societies that are based in and operating within their own aid recipient countries.

1.4 Local and national private sector organizations: Organisations run by private individuals or groups as a means of enterprise for profit, that are based in and operating within their own aid recipient countries and not affiliated to an international private sector organization.

2. National and sub-national state actors are "State authorities of the affected aid recipient country engaged in relief, whether at local or national level" (text endorsed by GB signatories). This includes:

2.1 National governments: National government agencies, authorities, line ministries, and state-owned institutions in aid recipient countries e.g. National Disaster Management Agencies (NDMAs). This category can also include federal or regional government authorities in countries where they exist.

2.2 Local governments: Sub-national government entities in aid-recipient countries exercising some degree of devolved authority. See the IASC HFTWG for details of definitions that are not included in the above categorization

During the field interview, in nearly all instances, the nomenclature of "L/NA" was automatically used to refer to one group of actors- the 'classical/formal NNGO'. There was little to no ideation about this term to include the other groups of local actors e.g., Women-Led Organizations, Refugee Led Organizations, and Organizations for People with Disability to mention a few. The interviews also exposed some limitations of the IASC HFTTWG criterion for some actors who were registered internationally but perceived their operations as national. For instance, in Syria, some NGOs are internationally registered but operate inside Syria and perceive themselves as NNGOs.

"…as organization XX, we are considered as INGO but at the end of the day we are local" (FGD Northwest Syria)

Multiple Dimensions of Localization: The localization discourse has adequately examined the funding dimensions emphasizing the need to remove policy and compliance barriers to access funding for local partners, and power shift to equitable decision-making among others. However, the other important dimensions besides funding e.g., equitable partnership, and

institutional development have attracted relatively little attention or investment.[22,23,24] Both the IASC OPAG guidance for Localization and the Grand Bargain caucus of funding for Localization highlight the need to monitor Localization beyond funding metrics.[25] A multifocal perspective is crucial in capturing the diverse qualities of an effective and efficient locally-led response.

C. Drivers of Localization: Enablers, Risks, and Barriers.

Researchers have noted the daunting challenges in understanding the evidence for the drivers of localization for two reasons; first, comprehending the input-output interactions in a complex system such as the humanitarian space is not straightforward. Secondly, the available evidence about the drivers is mainly linked to perceived benefits and not the effectiveness of the intervention.[26,21] Most reports on the results of localizations are derived from the description of process changes, e.g., an increase in the number of L/NA, rather than the impact of the change. Finally, limited research investigates localization in the health sector[27].

1. Enablers of Localization in the Health Cluster Coordination

Most of the reported factors in this study are interventions derived as a circumstantial necessity or a result of external force on actors, echoing the findings of Fast and Bennett, (2020) who argued that changes in localization were largely attributed to a necessity or is forced upon international actors.

i. Access Constraints for International Actors

Armed conflict has a multidimensional effect on localization and humanitarian operations at large. During an armed conflict, the major concerns have been related to safety and security risks that result in limited physical access, disruption of organization establishments, amplified humanitarian needs, fragmented territories and authorities, and political legitimacy.[28,29] All these outcomes of armed conflict appear to have tremendously and directly affected the pace and approach to the engagement of L/NA in the cluster response coordination. UN/INGOs have been forced to enter a program partnership with L/NAs to reach the affected people in contexts where access is constrained for security or restrictions imposed by the local authorities.

At the country level, the partnerships with the L/NA have proven crucial in reaching the affected people, as evidenced in Syria and Ethiopia interviews. There, the engagement of L/NA in the health cluster was perceived to have rapidly advanced in part out of necessity, i.e., due to the inevitable consequences of the ongoing conflict in these regions as testified by the interviewees (R1, R2, R3, R4, R6). Relatedly, the vast geographic expanse added to the access

[22]Localization in practice: emerging indicators and practical recommendations - World. ReliefWeb. https://reliefweb.int/report/world/localisation-practice-emerging-indicators-and-practical-recommendations
[23]Barakat S, Milton S. Localisation Across the Humanitarian-Development-Peace Nexus. Journal of Peacebuilding & Development. 2020;15(2):147-163. doi:https://doi.org/10.1177/1542316620922805
[24]Alcayna, T. and Al-Murani, F. 2016. Local and international collaboration in urban humanitarian responses: perspectives from the Philippines, Colombia and South Sudan. IIED Working Paper. IIED, London. http://pubs.iied.org/10802IIED
[25]Caucus on Funding for Localisation: Collective Monitoring and Accountability Framework. Accessed January 15, 2024.https://interagencystandingcommittee.org/sites/default/files/migrated/2023-05/Grand%20Bargain%20Caucus%20on%20funding%20for%20localisation_Monitoring%20and%20accountability%20framework_VF.pdf
[26]Barbelet V. Rethinking Capacity and Complementarity for a More Local Humanitarian Action HPG Report about the Authors.; 2019. https://cdn.odi.org/media/documents/12957.pdf
[27] Murdie A, Barney M. Localizing the NGO Delivery of Health from the Outside In. Daedalus. 2023;152(2):181-196. Accessed January 9, 2024. https://www.jstor.org/stable/48728679
[28] Elkahlout G, Milton S, Yaseen T, Raweh E. Localisation of humanitarian action in War-torn Countries: The experience of local NGOs in Yemen. International Journal of Disaster Risk Reduction. 2022;75:102921. doi:https://doi.org/10.1016/j.ijdrr.2022.102921
[29]Emergency Gap Series 03: The challenges of localized humanitarian aid - World | ReliefWeb. reliefweb.int. Published November 25, 2016. Accessed January 6, 2024. https://reliefweb.int/report/world/emergency-gap-series-03-challenges-localised-humanitarian-aid

constraints leading to a growing call for coordination mechanisms to become more decentralized and accessible for L/NAs.

"…the environment where we are currently working is obliging us to work with local (partners)…It's off-limits for a lot of national NGOs, even international NGOs, and UN…" (UN KII, Ethiopia)

"…you (health cluster) will not have personnel in all the locations, so needs to engage the partners who are on the ground to support quality coordination…" (UN KII, Ethiopia)

ii. Country Based Pooled Funds (CBPF) support for L/NA in the Health Cluster

The mounting global humanitarian needs and the consequent strain on resources have brought the Grand Bargain localization commitments into sharper focus. Despite the slow and limited progress towards the Grand Bargain financing commitment to direct 25% of the funds to L/NAs, there are also some encouraging efforts to strengthen capacity and increase financial access for L/NAs. Notably, traditional humanitarian organizations have taken the lead in developing localization strategies with clear accountabilities[30]. USAID, for instance, has set a target for 50% of all its programs to be led by local actors throughout the program cycle by 2030[31] Localization policy advocates continue to push for donors to show more support by pressuring and holding INGOs accountable for more robust localization, reducing bureaucratic policies and requirements to provide more means in the hands of L/NAs- less paper, more aid.[32,33,34,35,36]

Within the humanitarian coordination systems, there are some efforts to unlock some of the perennial obstacles to funding access. For example, the allocation of CBPF to L/NAs rose, and the leadership at the global level promoted a more robust engagement with L/NA in CERF UFE's design and implementation[37]. In October 2022, IASC endorsed a common position to guide the administration of overhead costs to L/NAs[38] During the last three years (2020-2023), L/NA access to the CBPF has significantly increased from 28% in 2022 to 40% in 2023[39]. However, the net result of the CBPF allocation may be diminished by comparing the total CBPF of USD 1.1 billion against the total requirement of USD 51.5 billion in 2023[40],[41].

[30]Promoting Equitable Partnerships with Local Responders in Humanitarian Settings DG ECHO Guidance Note.; 2023. https://ec.europa.eu/echo/files/policies/sectoral/dg%20echo%20guidance%20note%20-%20promoting%20equitable%20partnerships%20with%20local%20responders%20in%20humanitarian%20settings.pdf

[31] A. https://www.usaid.gov/sites/default/files Renewed Commitment to Localization in Pursuit of Locally Led Action for Sustainable Solutions /2022-12/USAIDs_Localization_Vision-508.pdf

[32] Moshtari M, Ghasem Zaefarian, Vanpouke E. How Stakeholder Pressure Affects the Effectiveness of International-Local Nongovernmental Organization Collaboration in Localization of Humanitarian Aid. Nonprofit and Voluntary Sector Quarterly. Published online September 26, 2023. doi:https://doi.org/10.1177/08997640231196886

[33] Rethinking the constraints to localization of foreign aid. Brookings. https://www.brookings.edu/articles/rethinking-the-constraints-to-localization-of-foreign-aid/

[34] Mulder F. The paradox of externally driven localization: a case study on how local actors manage the contradictory legitimacy requirements of top-down bottom-up aid. Journal of International Humanitarian Action. 2023;8(1). doi:https://doi.org/10.1186/s41018-023-00139-

[35] Joint Analysis and Recommendations for the Grand Bargain Annual Review 2019. Accessed January 11, 2024. https://www.christianaid.org.uk/sites/default/files/2022-07/c4c-altp-joint-paper-jun-2019.pdf

[36] https://www.chsalliance.org/get-support/article/sharing-good-practices-and-learnings-on-localisation-workshop-hosted-by-shifting-the-power-project-and-the-chs-alliance/

[37] As local as possible: progress in making localization in humanitarian action a reality | Humanitarian Action. humanitarianaction.info. Published December 8, 2023. Accessed January 15, 2024. https://humanitarianaction.info/document/global-humanitarian-overview-2024/article/local-possible-progress-making-localization-humanitarian-action-reality

[38] IASC Guidance on Provision of Overheads to Local and National Partners. (IASC OPAG). Accessed March 9, 2024. https://interagencystandingcommittee.org/sites/default/files/migrated/2022-11/IASC%20Guidance%20on%20the%20Provision%20of%20Overheads%20to%20Local%20and%20National%20Partners_0.pdf?_gl=1

[39] https://cbpf.data.unocha.org/

[40] https://reliefweb.int/report/world/global-humanitarian-overview-2023-enaresfr

[41] https://humanitarianaction.info/document/global-humanitarian-overview-2024/article/local-possible-progress-making-localization-humanitarian-action-reality

Despite the relatively small volume of the CBPF compared to the overall funding requirements, the findings from field interviews underscored the immense value of the CBPFs in facilitating localization by enabling L/NA access to funding. Respondents overwhelmingly referred to the CBPF's contribution in support of L/NAs. The unanimous acknowledgment of CBPF as an enabler may reflect the overall confidence and awareness about the fund mechanism, given the NNGO's close involvement in the EHF governance and allocation processes both nationally and recently decentralized. This also implies that the health cluster and UN OCHA must consistently ensure open, timely, two-way, transparent, and broader communication and engagement of the L/NAs in the EHF process at all levels. Similarly, advocacy efforts should target more donors to augment the funding volume challenged through this mechanism. This will promote and maintain trust – key pillars to meaningful engagement. Informants frequently referred to CBPF as the single source of direct funding to L/NAs in the cluster and perceived a more substantial role of L/NA in its administration and governance. The high level of L/NA engagement with the cluster was partly attributed to the CBPF eligibility requirement for the partner to coordinate with the cluster.

" … the (EHF) funding insist international NGOs to include the local NGOs to give an opportunity to work with International NGOs to capacitate the local NGO…" (INGO, Ethiopia KII)

Box 5: Examples of Funding Initiatives to Support L/NA

Country-Based Pooled Fund (CBPF): Ethiopia HRP 2023 highlights a strategic commitment to strengthen the Localization Working Group and build the capacity of national NGOs to enable their meaningful engagement in humanitarian response, in line with the country's operationalization of the HCT NNGO Engagement Strategy. Up to 36% of the Ethiopian Humanitarian Fund (EHF) was allocated to local organizations in 2022. The number of L/NAs receiving EHF increased from three in 2018 to fifteen in 2022. The EHF advisory body – the most senior governance structure for the fund decision is now made of 3 NNGOs and one NNGO is included in the Technical Review Committee that assesses and recommends projects for EHF funding (UN, Ethiopia, May 2023)

Aid for Northern Syria (AFNS): The AFNS initiative was established as an interim solution while the UN refined its operational modality post the UNSC mandate. It has a strong support for localization where it demonstrates flexibility to prioritize, capacitate, and fund SNGOs at scale. In the fund's first allocation in Jan 2023, it allocated 70% of the fund (USD $25million) was allocated to NNGOs (AFNS February 2023)

iii. External Pressure for Localization

From the quality of funding, removing barriers to funding access, incentivizing localization, to holding INGOs accountable for localization, donors have the key to influencing the behavior of humanitarian actors hence the quality of collaboration and engagement between the partners at many levels.[42] Studies on NGO coordination structures and localization debate highlighted reluctance among INGOs to move forward despite being aware of the localization commitments.[43] Many reports emphasize the role of donors in influencing the uptake of localization.[28,44,45]

"…INGOs like XX used to receive funding from funding agencies and then do the implementation directly by themselves. So, we were not giving enough attention to the local partners unless the donor requested that you need to work with local partners, these arrangements were not given to us unless we saw that, it was not that much in the picture to work with local partners…" (INGO KII, Ethiopia)

From the country-level interviews during this study, the donor decision to include 'participation in the cluster coordination' as an eligibility criterion for the CBPFs appears to have resulted in a dramatic increase in the level of cluster engagement. In the face of perceived low levels of commitment especially among INGOs, they suggested that pressure from the donors may have been the primary force behind the existing partnerships with L/NAs.

[42] Els, C. (2018) 'On the road to 2020: Grand Bargain commitment to support national and local responders'. Maynooth, Co. Kildare: Trocaire (www.trocaire.org/sites/default/files/resources/policy/on-the-road-to-2020-localisation-the-grand-bargain.pdf).
[43] NGO Coordination Structures and the Localization Debate Recommendations Paper. https://www.interaction.org/wp-content/uploads/2021/01/NGO-Coordination-Structures-and-the-Localization-Debate.pdf
[44] INGOs and the Localisation Agenda. HAD. https://had-int.org/ingos-and-the-localisation-agenda/
[45] Charter for Change: From commitments to action Progress Report, 2018-2019 - World | ReliefWeb. reliefweb.int. Published September 20, 2019. Accessed January 10, 2024. https://reliefweb.int/report/world/charter-change-commitments-action-progress-report-2018-2019

Organizations that had funding partnerships were also encouraging their recipients to participate in the clusters.

The cluster partners have played a catalytic role in advancing localization in the cluster through advocacy. Throughout the interviews, there was a broad strategic agreement among actors on the need to engage L/NAs better. In NWS, L/NAs reportedly organized into strong networks that facilitated consultations and empowered their engagement on strategic levels.

"… they (NNGO) are very consultative. If 4 people from the national are coming to a meeting, generally, they make consensus before among themselves, how to raise …" (R7, Northwest Syria)

iv. Support from Sub-national Authorities

As the primary bearer of duty to protect its people (UN Resolution 46/181), the leadership of national governments, through its policies and attitudes, can be restrictive or productive to the quality of collaboration between INGOs and L/NAs, hence affecting the quality of localization in humanitarian response. Studies from disaster responses in Asia showed that governments with a solid disaster coordination involvement empowered and positively influenced L/NA's engagement in disaster response, however, crises from natural disasters were arguably less fraught with the controversies that occur in conflict settings[26, 46] Additionally, some INGOs are responding to government restrictions (INGOs) by "nationalizing." This 'forced' nationalization of INGOs has drawn positive and negative reviews. From a decentralization point of view, the nationalization of an INGO is viewed as a progressive step, while from a political standpoint, some advocates argue that "nationalization" falls short in rebalancing the power dynamics between INGO and L/NA.[47]

According to the IASC protocols, clusters are activated to fill a leadership and coordination gap when the government is unable or unwilling. The CLA is strongly encouraged to work in a collaborative spirit to strengthen the capacity of national authorities. One way of strengthening capacity is to distribute the governance role of the cluster co-leadership with government bodies and NGOs where appropriate and possible.[48] By December 2023, WHO was reportedly co-coordinating with the Ministry of Health (MoH) in 05 clusters and with INGOs in 10 settings[49]. A similar level of shared leadership was reported by the Health Cluster Coordinators in the Nov 2023 survey- there were 04 MoH Co-coordinators, 10 for INGOs, and no L/NA coordinators at the time.

2. Barriers and Risks to Localization in the Health Cluster

The obstacles identified mainly reflect the general humanitarian response and coordination situation, with a few specific examples drawn directly from health cluster coordination. Many of the core challenges are familiar and discussed exhaustively in several documented literature, but they remain the primary source of dissatisfaction with the progress of localization. In general, the barriers to localization sprout from the systemic, complex, inherent issues related to the politics and policies of the humanitarian system. The report focuses on the gaps arising from the cluster practice level. Some factors are not obstructive per se but continue to affect the

[46] Schenkenberg, E. (2016, November). The challenges of localized humanitarian aid in armed conflict. Médecins Sans Frontières. https://www.aL/NAp.org/system/files/content/resource/files/main/msf-egs03-the-challenges-of-localised-humanitarian-aid-in-armed-conflict-.pdf

[47] Robillard S, Atim T, Maxwell D. Localization: A "Landscape" Report a Feinstein International Center Publication.; 2021. https://fic.tufts.edu/wp-content/uploads/Localization-FINAL-12.30.21.pdf

[48] Guideline CLUSTER COORDINATION at COUNTRY LEVEL IASC Sub-Working Group on the Cluster Approach and the Global Cluster Coordinators' Group.; 2015. https://interagencystandingcommittee.org/sites/default/files/migrated/2019-02/reference_module_for_custer_coordination_at_country_level_2015.pdf

[49] https://healthcluster.who.int/publications/m/item/health-cluster-dashboard-q4-december-2023

dialogue on localization. The barriers/risk factors discussed in this section emerge from a similar group of themes as the enabling factors discussed in the earlier section, demonstrating that improvement is still necessary despite progress.

i. Funding Constraints

The need for progress on the global commitments to improve financing to L/NAs is well documented. Prohibitive technical and compliance requirements to access adequate quality and quantity funds remain rampant for many L/NAs, who are parochially limited to implementing partner roles. Without proper funding, L/NAs cannot attract and retain skilled staff for technical, governance, and coordination functions.

Unsurprisingly, funding barriers dominated the localization discussion during the interviews. The rapid decentralization of the coordination mechanisms through the Area Based Coordination Mechanism has drawn sharp criticism for not including the health cluster representation in some crucial decision-making processes. In regions where the ABC lacked the health cluster sub-national presence, there needed to be a clear mechanism to ensure health cluster input into the CBPF funding decision-making. The health cluster perceived the exclusion as disempowering to the cluster's capacity to engage with partners thus risking localization. L/NAs at the sub-national levels also expressed a lack of awareness and inclusion into the ABC and the sub-national CBPF governance process (L/NA FGD, Ethiopia)

> "Our criticism is that not all clusters have (a) presence at the sub-national level…, but still we were unable to be part of those selection meetings that OCHA organized or some of the regions were the last EHF because in exactly in those regions we did not have dedicated cluster coordinators…" (UN KII, Ethiopia)

ii. Political risks

The influence of government may have undesired consequences and risks to the localization discourse, primarily where there exists politicization and instrumentalization of aid impacting humanitarian principles.[50,51] The extent to which local politicians take charge of localization language can have a counter-productive effect and result in threats to the support for localization[52]. The technical capacity of L/NAs to uphold humanitarian standards and ethical principles under strong political pressures has been questioned mainly by international actors. The broad perception-driven concerns about the weak technical capacity of L/NA continue to throw sand in the localization wheels even though there is insufficient evidence to support such claims.[43,46] The challenge of applying humanitarian principles is complex and not limited to L/NAs only.

This study elicited a strong reliance on L/NAs to bridge the gap between the INGO/UN in circumstances where the international community had imposed restrictions whether on legitimacy grounds or safety and security access risks. While the NNGO's close ties with the local community including governments are a prodigious strength that allows assistance to reach people in need, it could also spell a latent political vulnerability and risk for coordination in the absence of respect for ethical leadership. The perceived strength of the NNGO ties with the government appeared to be conditional upon the government's whims and may cease upon a perceived provocation.

> "…if the political environment changes, (the) government can shut down your shop and go away for INGO. With local organizations, it's not easy to do that as long as they don't provoke government seriously…" (UN KII, Ethiopia)

[50] Ehrenfeld, Andrew P, "Politicization of Humanitarian Aid in the 21st Century" (2021). *ETD Collection for Fordham University*. AAI28496531. https://research.library.fordham.edu/dissertations/AAI28496531

[51] Sarah Vuylsteke a Principled Response: Neutrality and Politics.; 2021. Accessed April 12, 2024. https://sanaacenter.org/files/When_Aid_Goes_Awry_05_Neutrality_and_Politics_en.pdf

[52] https://reliefweb.int/report/world/charter-change-commitments-action-progress-report-2018-2019

Other scholars have pointed out that affected people from communities that did not trust or dispute the government authority were prone to negatively view the association of humanitarian actors with such state structures potentially impacting the acceptance of such actors. The interviews revealed hints of covert constraints for L/NAs' operation in areas/regions where they are politically-ethnically viewed as foreign.

"Since 1991, everything has been 'ethnicized' in Ethiopia. So, when you look at some of the local NGOs, even if it's not supported by documents, you feel that this NGO is affiliated to this ethnic group or this ethnic party…to a party…there is this assumption that they might have affiliations. …but I am not sure. If for example, an Oromo-dominated NGO goes to Somalia and tries to play a coordinator role. I don't know how they would be accepted. (UN KII, Ethiopia)

iii. Inaccessible humanitarian coordination platforms

Logistical barriers: In geographically vast areas, it was notably a challenging logistical feat to get the ground-based L/NAs to participate in the national or even some sub-national level coordination due to physical distance, costly transportation, and safety access risks. As a result, the perception was that the ground-based L/NAs were partially engaged in the health cluster.

"…but coming in person with the cluster Weekly or by weekly, without funding very difficult for the local and they cannot afford…" (L/NA FGD, Ethiopia)

"Again, it's not easy for all organizations or people to cross-border. So, the participation from the people in the front lines service provision in Syria, their physical presence in Gaziantep meetings may not be frequent" (R1, NWS KII)

Language barrier: Some saw the use of foreign language in local coordination as a barrier to the meaningful engagement of L/NAs, especially in the sub-national coordination.
Other literature has cited the heavy use of jargon that L/NAs do not widely understand as a barrier to communication on the coordination platforms.

"…at national levels, language is not an issue, but in some instances, for sub-national levels… specifically, the Regional Health bureaus may prefer to have these coordination platforms using the local languages" … This is because the matter that they want to express their issues and things that can be solved in a very easy and smooth manner (R7 77-8)

Lack of awareness about the coordination platforms: The L/NAs located at the sub-national and lower levels were reportedly unaware or not familiar with the existing health cluster coordination structures they're at level (R2, R3, R9). As a result, there was partial engagement of L/NAs in local coordination. One informant at the global level informant noted that the high number of L/NAs in the clusters improved their participation as part of localization. However, they confirmed the limited mapping and participation of 'minority' organizations e.g. WLO, and PWDs as a risk to equitable representation.

"…I'm not sure if the coordination platforms and engagement calls are fit for these local partners or not…because most of the headquarters are stationed in Europe or the US for the INGOs and our working culture might be similar to the UN agencies, including the WHO, but for the local partners, you know that they treat themselves as a local partner. Some of the set up the local partners might differ from the INGOs and the networking…" (INGO KII, Ethiopia)

"When you go down to the Woreda level (sub-sub-national), they are not well aware of to have like coordination platform." (INGO KII, Ethiopia)

"…the only aspect around participation is there has been a challenge bringing on board, you know, organizations that are excluded, this includes organizations of persons with disabilities and WLO (KII, Global Cluster 2)

iv. Low Commitment and Prioritization

Despite strong global and donor policies on localization, progress has been slow due to an inadequate change in practice. At the policy level, the vicious debates about local capacity and

"…when we brought a lot of the commitment to open spaces for Women-Led Organizations to coordinate, they (cluster coordinators) said, yes, but it's too complicated. It's not very efficient. We're having to use our time, which is already so limited, and so many competing priorities, doing the recruitment, it's very complicated to get someone on board and then to work together to have a good partnership. It takes a lot of work on our side, is it the best use of our time?" (KII, a Global Cluster 1)

associated fiduciary and legal risks have stalled the progress in L/NA access to funding. Overall, very little of the humanitarian funding trickles down to L/NAs. In addition, there is a significantly low reporting on funding distribution. There was also a perceived lack of commitment at the cluster leadership level and the cluster partners level as well. According to the GHC survey, many HCCs did not think the L/NAs were prioritizing the localization agenda. While the global stakeholders interviewed cited an active pushback from some of the country cluster coordinators on advancing localization

v. Power imbalance

There is an increasing level of L/NA representation and participation in the different levels of the IASC Coordination mechanisms[53]. A survey of 2,360 coordination structures across 30 humanitarian operations in 2022 showed that 83% of the Humanitarian Country Teams (HCT)- the highest level of the country-based humanitarian coordination platform- had at least a L/NAs represented, and L/NAs accounted for only 10% of HCT seats. The same survey found that 37% of clusters, sectors, and Areas of Responsibility had L/NAs represented in their global leadership. This is low compared to the overall presence of L/NA in the clusters.

"…INGO 20% of the HC partners, 80% local NGOs but we see that still, the power is in the hands of INGOs" (R5 10.14, Gaziantep KII)

Globally, more than half (51%) of the clusters/sectors/AOR members were L/NAs. The L/NA were represented in 95% of the cluster SAG- occupying 35% of the SAG membership at national and global levels. However, at the global level alone, the representation of L/NA is low. Of the 10 clusters analyzed, with a total of 120 SAG members (Range 7-26, mode 8), L/NAs accounted for only 13% of the SAG membership. See Box 10

Some HCTs have progressed to develop their localization strategy to guide their localization efforts.[37,54] The longstanding issue of dominance by UN/INGO is not confined to program partnerships only; it also extends to the coordination stage. Even though L/NAs constituted nearly

Box 9: A Snapshot of L/NAs' Engagement in the Health Cluster (Global Health Cluster Survey, Jan-Feb 2024)

L/NA Representation in the Health Cluster

- NNGOs accounted for nearly half (46%) of the 763 Health Cluster HRP partners are NNGOs.
- About half (49%) of all partners participating in the Health Cluster were NNGOs. In Northwest Syria, L/NAs accounted for 70% of the Health Cluster partners.

Sharing Leadership: Health Cluster Co-Coordination

- National Health Cluster Co-coordination: 60% of Health Clusters had national Co-coordinators- all from INGO and MoH. No NNGO Co-coordinator at national level.
- Sub-national Health Cluster Co-Coordination (SNHCC): 235 SNHCC (21% Female). 30% of SNHCC were from UN, 21% by MoH, 5% by NNGOs.

Inclusion of L/NAs in the strategic decision-making

- 60% of the Health Clusters had a Strategic Advisory Group (SAG).
- 25% of SAG members were from NNGOs. INGO 25%, UN 32%, MoH 5%, Donors 3%, Observers 9%
- Women-led Organizations (WLO) accounted for only 4.8% of all L/NA in SAG

Technical Working Groups

- National NGOs co-chaired only 14% of the 93 TWG
- UN agencies co-chaired 73% of TWG in the cluster

[53] https://reliefweb.int/report/world/charter-change-commitments-action-progress-report-2018-2019
[54] Proposed Somalia Localisation Action Plan for 2023-2024 Proposed Somalia Localisation Action Plan for 2023-2024. Accessed January 15, 2024. http://somaliangoconsortium.org/silo/files/proposed-localization-action-plan-2023.pdf

half (49%) of the health cluster membership globally, they were significantly underrepresented in the health cluster's prominent decision-making bodies, e.g., SAG and Technical Working Groups (TWG)- according to the GHC survey of the health clusters. The data did not show evidence of including L/NAs in the shared leadership of the cluster governance at the time.

Table 2: Representation of L/NAs in Global Cluster SAGs

Cluster	#Total SAG Members	#L/NA members	%
Global Education Cluster[55]	19	7	37%
Global Nutrition Cluster[56]	12	0	0%
Global WASH Cluster[57]	12	4	33%
Global Protection Cluster[58]	26	3	12%
Global Food Security Cluster[59]	8	0	0%
Global Camp Coordination Camp Management Cluster[60]	8	0	0%
Global Early Recovery Cluster[61]	8	0	0%
Global Emergency Telecommunication Cluster[62]	7	1	14%
Global Logistics Cluster[63]	8	0	0%
Global Shelter Cluster[64]	12	0	0%
Total	**120**	**15**	**13%**

vi. Perceived disconnection between the local, national, and global coordination platforms.

The L/NAs informants widely perceived a weak linkage between the sub-national coordination platforms and centralized national and global health clusters. They cited weak sub-national coordination capacity and an inadequate information flow/exchange between the subnational and national levels casting doubts on whether their voices were captured at the higher level or crucial information trickling down. Similarly, they also expressed possible gaps in communication and visibility between the GHC and L/NAs at the country level. These perceptions are important because failure to address them can the confidence in the coordination platform as an information exchange arena further reducing interest in participation. This break in coordination and strategic alignment between the country and global level was also reiterated as a challenge to the implementation of localization.

> "…at the global level, we are supporting countries, and we are also generating demands from countries for them to reach out. Localization at some point is also an issue of, sometimes coordination team… So, you might find sometimes you've reached out to this to Country, and shared with them all these other aspects, but you know there is no response yet. when you look at it, there's a very big need for promoting localization. So, I'll mention that has been a challenge, especially at the global level when you plan and yet some of the some of the works that you're planning depends on the countries that you are engaging with…" (KII, Global Cluster 1)

vii. Perception of Low L/NA Capacity

International actors (INGO, UN) have long held generalized perceptions-driven opinions that L/NAs have a low capacity to adhere to humanitarian principles and carry risks to neutrality and impartiality.[21] According to the GHC Survey, the HCC frequently cited the lack of L/NA technical capacity for coordination, neutrality, governance, and operations as barriers to localization in health cluster coordination. The views expressed through the survey strongly related to those contained in a study that concluded that international actors viewed capacity

[55]Global Education Cluster. Governance. https://www.educationcluster.net/about-us/governance
[56]Global Nutrition Cluster. Strategic Advisory Group. https://www.nutritioncluster.net/about-us/gnc-strategic-advisory-group
[57]Global WASH Cluster. Strategic Advisory Group. https://www.washcluster.net/sag
[58]Global Protection Cluster. Strategic Advisory Group. https://www.globalprotectioncluster.org/about/our-structure/strategic_advisory_group
[59]Global Food Security Cluster. Strategic Advisory Group. https://fscluster.org/page/gfsc-strategic-advisory-group-sag
[60]CCCM Cluster. Strategic Advisory Group. https://www.cccmcluster.org/about-us/strategic-advisory-group
[61] United Nations Development Programme. Global Cluster for Early Recovery. https://www.undp.org/geneva/global-cluster-early-recovery-gcer
[62]Emergency Telecommunications Cluster (ETC). Strategic Advisory Group (SAG). Minutes of Meeting, 7-8 February 2023 . https://www.etcluster.org/document/strategic-advisory-group-sag-minutes-meeting-7-8-february-2023
[63] Logistics Cluster. Strategic Advisory Group. https://logcluster.org/en/strategic-advisory-group#:~:text=The%20overall%20objective%20of%20the
[64]Shelter Cluster. Global Strategic Advisory Group. https://sheltercluster.org/strategic-advisory-group/global-strategic-advisory-group

based on their strength and tended to focus heavily on organizational and technical capacity (governance, management, technical capacity, and humanitarian standards)[26].

During the interviews, international actors were concerned about the neutrality of L/NA co-coordinators receiving funds from UN/INGOs that are members of the health cluster. Field-based international actors also raised similar issues of capacity gaps among L/NA- an opinion that the L/NAs sharply disagreed with. For instance, L/NAs operating in the protracted crisis refuted the generalized claims of low capacity, they demanded focused capacity strengthening in resource mobilization and donor access. Overall, there is no substantial research evidence to support the widely held opinion about the claims that L/NAs have less capacity for principled actions than their international counterparts. However, these claims have become so established that they obstruct dialogue on meaningful engagement with L/NA perpetually engaging on unequal terms[47]. This is not to say that L/NAs have all the capacity, nor haven't there been any compromise incidents.

> "My only concern…yes we may give them that co-leadership role, but because they also get funding from us, it may skew the relationship…" R3 351

> "We don't need a capacity building…we need capacity strengthening…because after 12 years it's not fair..." (FGD, NWS)

viii. Legitimacy and Visibility risks.

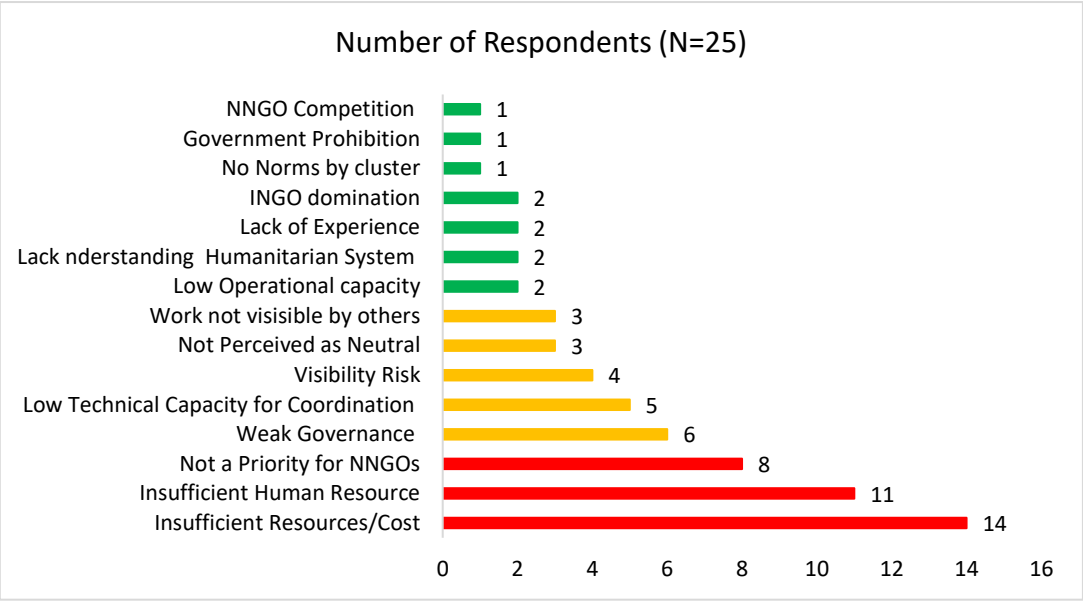
Reports have indicated a dissatisfaction among L/NAs over the sub-optimal level of recognition of the work of L/NAs by international partners is a risk to localization. The perceived unfair attribution of credit is both a source of frustration and mistrust. The inertia to publicize L/NA contribution may be partly due to underlying fears of the consequence on the organization's visibility and positioning for resource mobilization[34]. During the global interview, an NNGO lamented the INGO for deliberately overshadowing the work of L/NAs. The informant further pointed out the lack of mediating mechanisms where L/NAs could seek redress for this type of conduct. The cross-sectional survey of the health cluster coordinators identified similar visibility concerns and INGO dominance.

> "…we (NNGOs) feel used by the international actors to fulfil a checklist for localization..." (NNGO KII, Global level)

According to the informants, the double hatting of WHO staff on coordination was both praised and critiqued. While the sharing of coordination tasks by WHO program staff was instrumental in establishing crucial linkages between partners at the lower level and the HCC at the regional level, thereby contributing to the expansion of the CLA coordination capacity, the staff executing these tasks were occasionally perceived as biased toward their organizational interests and visibility. This perception raises significant questions about their neutrality and risk to trust which is fundamental to meaningful participation in the cluster.

> '…we're not here to promote WHO or to do advertisement for WHO… I see within WHO…a need to understand the importance of engaging...they (WHO staff) come with the information products about what the health cluster…(saying) WHO (did) this...WHO…WHO….one health cluster coordinator there, he was also very much WHO this WHO that…" (R1 275)

Figure 2: Barriers to leadership, representation, and participation of NNGOs in the health cluster. (GHC Survey, Nov 2023)



Box 10: Initiatives by different Global Cluster/AORs to Increase L/NA engagement

Enhance inclusion of L/NA in Global Leadership: One Cluster revised the leadership eligibility criteria allowing the inclusion of more L/NA in its global governance structure. "We had to go through a whole governance review to make sure our criterion for membership… because it used to be that they (L/NA) had to be operational in two contexts. We had to change the criteria and everything so that we (could) have local organizations and specifically WLO as part of our governance system" (KII Global Cluster 1)

Implementation Support to Country Clusters/AOR: Four of the global clusters/AOR had dedicated localization personnel to drive and maintain strategic and operational oversight on localization in the cluster. In one case, the CLA routinely maps out the different localization initiatives based on the different dimensions outlined in the IASC guidance- across various countries under its AOR. This way, the agency had a clear understanding of the existing L/NAs with a focus on WLO in the GBV sub-cluster or AOR on the country level. Capacity strengthening programs were then designed and targeted to the identified gaps in select countries to support WLO in taking on Coordination roles. Specifically, the agency had mobilized resources through funded projects that were providing training and other governance capacity-strengthening initiatives for L/NAs in 4 countries. (KII Global Cluster 2)

Global Advocacy: One CLA was encouraging the country clusters to prioritize localization in the HRPs. However, due to the structural limitation of the HRP to capture all relevant details, they had found other useful strategies to ensure localization was still strongly reflected alongside or annexed to an HNO or HRP document. "...this is very useful because in that strategy, localization is mainstream, so we are losing kind of opportunities to shout about it in detail, but we're trying to find other opportunities to mainstream it. So, it can have an equal if not louder voice and in a more sustainable voice" (KII, Global Cluster 3).

Improved Monitoring: First the CLA developed a localization Conceptual framework through a strong engagement of their regional and country cluster/AOR in a regional consultation workshop. This process resulted in clear commitments to ensure L/NA is part of governance and decision-making through SAG and Co-coordination. They also developed a monitoring indicator and dashboard that tracks progress and is used to inform decision-making for course correction (KII, Global Cluster 4).

RECOMMENDATIONS

Following the review of the drivers of localization, the recommendations below are framed to outline the major focus of the health cluster localization strategic plan. For the health cluster leadership to i) comprehensively address a meaningful L/NA engagement within the ambit of the health cluster coordination and ii) effectively contribute to the broader dimensions of localization outside the cluster coordination platform; the issues outlined in this section should be assiduously addressed in the strategic plan. The local contextual dynamics must be considered when adapting specific interventions recognizing the substantial contextual differences across many operations.

1. **Ensure a Strong institutional leadership and commitment to Localization**: Ensure internal strategic alignment and prioritization across the three levels of the organization to advance localization in the cluster. Increase the awareness, buy-in and muster support from the organization's leadership to empower the clusters to undertake the appropriate interventions towards meaningful engagement of L/NAs based on the strategy to be developed. Adequate human resource capacity in the cluster will be crucial for implementing and monitoring the localization process.
2. **Mobilize Resources for Localization**: The barrier analysis identified funding constraints both for the cluster and for the L/NAs as the single most significant barrier to localization. It is emphasized that the realization of the anticipated long-term gains requires an initial investment in the necessary structures and processes to install the optimal capacity that is as local as possible. The strategic plan shall prioritize efforts to empower L/NAs to mobilize quality funding while engaging donors to invest in the required capacity and tools to advance the shift towards a more locally-led response.
3. **Improve Leadership Sharing in the Health Cluster:** Where the context permits, increase the engagement of L/NAs in the health cluster leadership through co-coordination at national and sub-national levels to transfer and share the capacity for coordination. A transparent assessment, recognition, accountability, and capacity monitoring must guide the sharing and distribution of leadership roles. At both country and global levels, it is key to ensure an equitable proportion of L/NA in the strategic decision-making designated bodies e.g., Strategic Advisory Groups and funding governance bodies.
4. **Strengthen Representation and Participation**: As evidenced from the baseline survey, L/NAs constitute more than 50% of the health cluster's partners, however, they are substantially under-represented in different processes that drive the coordination. The cluster should aim to enhance the representation and quality of participation by undertaking interventions that diversify the L/NA base, promote access and equal participation for L/NA; and recognize and value their capacity in health cluster decisions.
5. **Capacity Strengthening and Sharing:** The perception of low capacity among L/NA is so dominant that it is impeding progress on localization. Tension exists between international and local actors in defining and assessing capacity. Capacity strengthening has suffered from a lack of a systematized approach and the limited impact of current approaches due to a lack of long-term investments and mutual mistrust among others. The interviews and baseline survey reiterated the perception-based lack of capacity among L/NA.

   Addressing the capacity issues in the health cluster will be crucial to realizing the complementarity that local and international bring on board the cluster platform. The capacity-strengthening initiatives should be based on shared respect for each other's capacity for a specified responsibility. A generalization of low capacity across the board is distracting. Capacity strengthening should not be viewed as a pre-condition, but rather an integral process to an effective partnership. It is also essential to ensure a balanced

localization activism. Localization activism that focuses on the absolute exclusion of international actors will be counterproductive by fueling the existing resistance.

In line with the Grand Bargain aspiration of "as local as possible and as international as necessary" capacity strengthening and sharing should focus on building complementary roles that maximize the strengths of local and international actors in the health cluster. To do this, capacity strengthening and sharing prioritization should be mutually defined, assessed, and approached. The key scope for capacity strengthening and sharing should empower L/NAs i) to take up leadership ii) navigate international systems including access and governing funding iii) provide people-centered and quality services.

Conflict Sensitivity and Coordination: Armed conflict is one of the more powerful determinants of localization- fluctuating as a trigger and a risk to localization. More than half of the health clusters are coordinating conflict-related humanitarian response. The health cluster leadership (coordinators, co-coordinators) should be supported to acquire the skills for a conflict-sensitive analysis and ensure that the localization process does not amplify the negative impact of conflict while safeguarding quality and ethical humanitarian response.

6. **Define the boundaries and Impact of the localization in the health cluster**. Build consensus on the scope (operational definitions, result areas, principles) and desired outcomes of the localization to clarify and create an operational and strategic cohesiveness on intended achievement, expectations, and the limitations in the cluster. This will give the cluster a clear strategic focus and monitoring plan amidst the complex debates on localization.
   Demonstrate the Impact of Localization: To address the need for valid data demonstrating the impact of localization in the health cluster, the GHC should develop a comprehensive result-based monitoring system based on process indicators and medium-long-term outcome indicators. Simultaneously, build an internal process that facilitates learning and inspires change by continuously generating cause-effect knowledge and information.