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OPERATIONAL CHALLENGES OF IMPLEMENTING HEALTH RESEARCH IN HUMANITARIAN SETTINGS

Lessons learned from R2HC funded studies

Maysoon Dahab

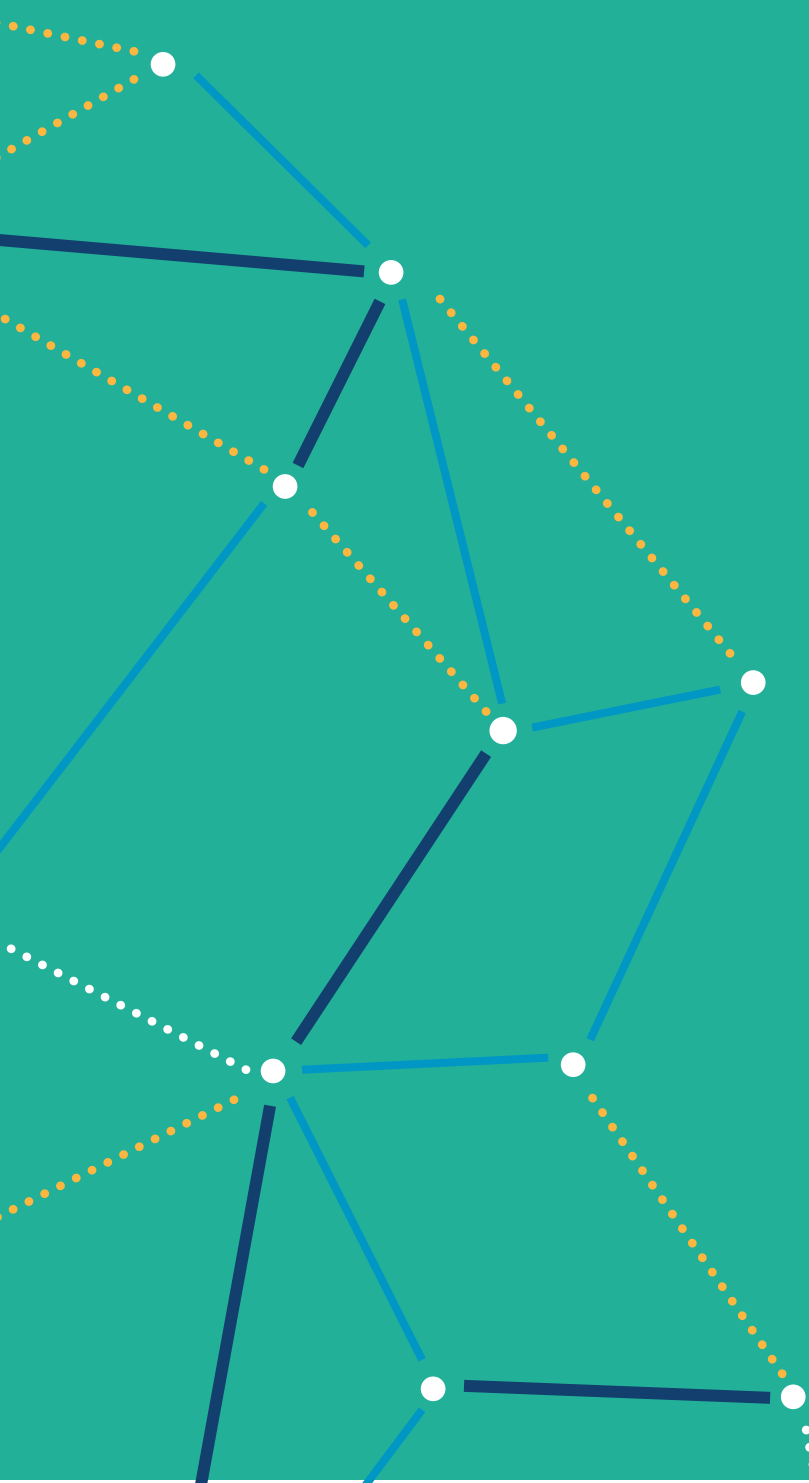


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SUMMARY

Elrha's **Research for Health in Humanitarian Crises (R2HC)** programme aims to improve health outcomes by strengthening the evidence base for public health interventions in humanitarian crises. The programme is funded through a strategic partnership between the Department for International Development (DFID) and the Wellcome Trust, with Elrha responsible for design, execution and management of the programme. Since the programme was initiated in 2013 there have been five annual calls for research proposals.

In seeking to develop guidance for its grantees, R2HC recognises that there is a lack of practical guidance for humanitarian health researchers on **the design, implementation, and management of public health research projects in challenging humanitarian contexts**. Despite a growing body of evidence on the effectiveness of health interventions in humanitarian crises in general, little is currently documented about the practical operational challenges of conducting such research in the field.

In recognition of this gap, the R2HC has **commissioned a synthesis of lessons learnt regarding the key barriers and facilitators of conducting public health research in challenging humanitarian context**, drawing off the experience of grantees funded in 2014 and 2015 whose research has finished or is close to completion. Now that the R2HC has been funding research for four years, a body of knowledge has accumulated reflecting individual research outputs, as well as a range of experience related to the conducting of research in humanitarian crises.



The following report seeks to present, in a clear and accessible manner, information on preliminary lessons learned from conducting public health research in challenging humanitarian contexts, and including detailed case studies that can be used to key illustrate lessons learned.

The findings of this preliminary report will contribute to a longer-term study documenting lessons learned from operational challenges related to conducting public health research in humanitarian settings, that will be used to inform the R2HC's development of future guidance tailored to its applicants and grantees. It is also intended to contribute to the wider humanitarian health research

community's common development of practical guidance on the design, implementation, and management of public health research projects in challenging humanitarian contexts.

This report integrates findings from, firstly, a brief desk-based **literature review** summarising existing debates around the application of rigorous health research designs in humanitarian contexts, and from key existing guidance in conducting field research on humanitarian public health issues in humanitarian contexts. Secondly, a **survey** of R2HC grantee reports identified shared perspectives, regular challenges, and common solutions encountered while carrying out humanitarian public health research. Thirdly, a **facilitated working group session** at the 2017 R2HC Research Forum which solicited reflections from participants on their experiences confronting key operational challenges in humanitarian health research.

Amongst the key findings from this report was that primary operational barriers to implementing humanitarian health research funded by R2HC were conflict and political instability leading to unrest, insecurity, and disruption of physical and communication infrastructures. These factors often restricted access to the study population and further complicated the ability of study teams to recruit and retain qualified research staff and/or to engage implementing partner staff in the research activities. Study teams in turn had to change implementation plans (e.g. delaying or cancelling key evaluation activities) and/or methodologies (e.g. changing design or outcome end points).

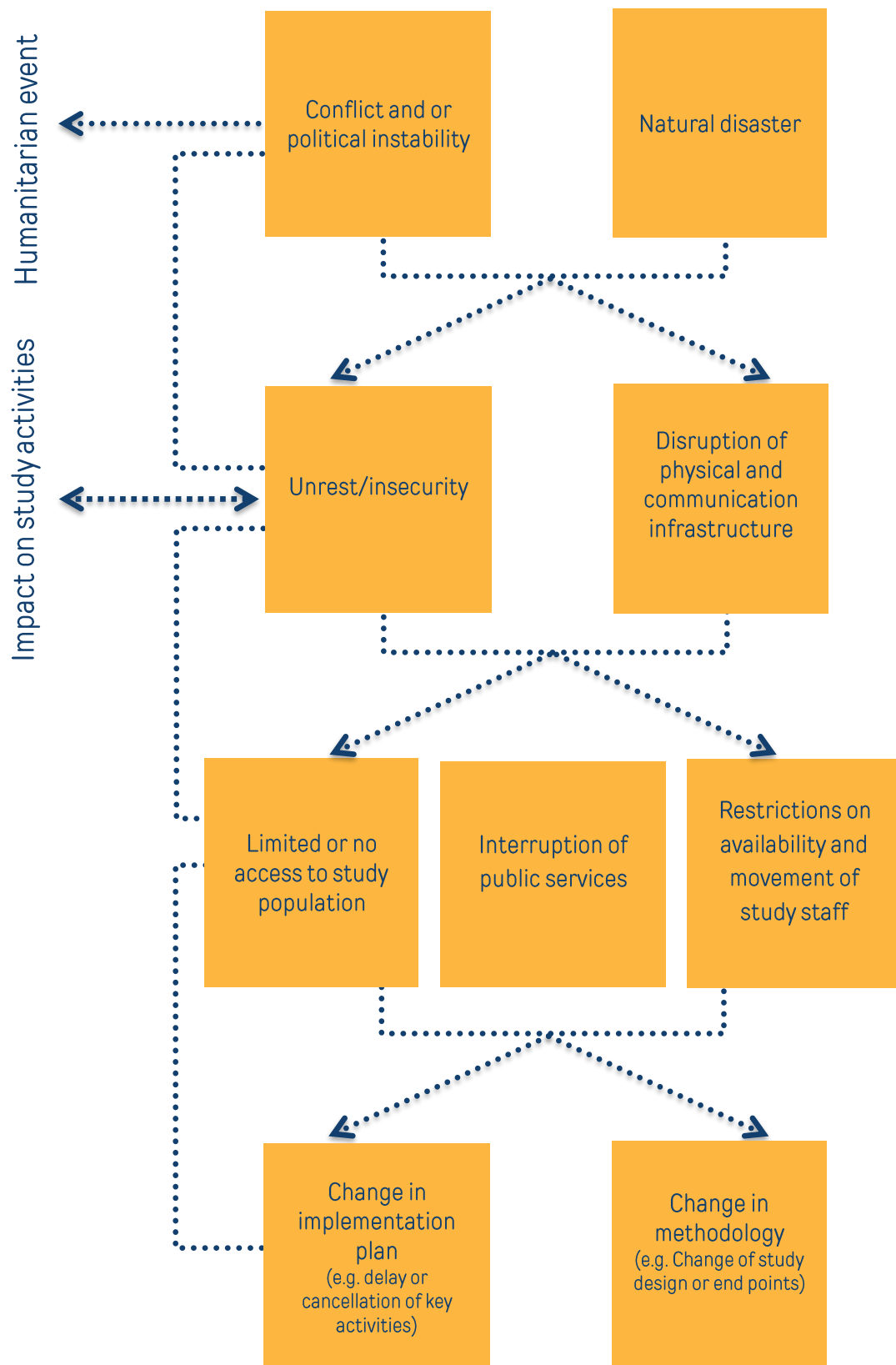
The most consistently reported facilitator to mitigate the impact of operational challenges in humanitarian settings was the development and maintenance of strong team partnerships that, in turn, facilitated the streamlining of quality data collection. Clear definition of roles and responsibilities of each partner, both at the outset and throughout the project, was thought to be key in maintaining strong partnerships.

The focus on partnerships should also include a clear emphasis on learning exchange between partners, not only on research methods, clinical skills, and project procedures, but also more generally on organisation development and functioning to provide a strong foundation for study activities. These plans should be built into the project proposal and budget.

The value of a strong communication plan, including regular face-to-face study team meetings was particularly emphasised by respondents. This was especially important given the high rates of turnover among personnel in the field which necessitates a focus on the establishment of a mechanism to regularly brief local field staff, especially newly hired individuals, on study activities.

To minimise bias in the evaluation of interventions being studied, study teams recommended, whenever possible, the hiring of research staff who can work independently from the implementing staff.

Figure1: Impact of humanitarian events on study implementation



BACKGROUND

Research on the effectiveness of health interventions in humanitarian crises is growing,¹ yet little is documented about the challenges of conducting such research in the field. Most of the available research^{2, 3} and sector-specific guidance⁴ to date have focused on the ethical dimensions of humanitarian research challenges. In the only peer-reviewed article published on the subject, Khatib R, et al. reported on the challenges of conducting an epidemiological study in the Palestinian context of chronic conflict.⁵ They found that some of the challenges faced during the study were similar to challenges raised by researchers in other low- and middle- income countries, such as cultural considerations and working in remote areas with limited resources. Other challenges however, such as access restrictions and working in a fragmented health care system, are specific to areas with chronic conflict.

A 2017 report on the proceedings of the 2016 ACF humanitarian nutrition conference also described operational challenges associated with humanitarian nutrition research studies.⁶ These included: security issues; a pipeline breakdown in delivering investigational study products; lack of accessibility to the study population; an acute conflict or natural disaster occurring on top of a chronic emergency situation; the ethical dilemma of targeting an intervention based on random selection rather than on needs present in the community, and how funding, timing and flexibility are challenged by the separation between programme and research funding sources, which have different timeframes and donor requirements. The report also mentioned human resource challenges, including difficulties recruiting national staff with the necessary research skills and experience. This difficulty, in turn, may lead to operational/support staff not being hired as planned and the overburdening of existing staff, who became responsible for both research and programme activities.

Elrha's Research for Health in Humanitarian Crises (R2HC) programme aims to improve health outcomes by strengthening the evidence base for public health interventions in humanitarian crises.⁷ Between 2014 and 2016 three funding calls resulted in 26 studies being funded. The R2HC and its associated studies presents an important opportunity to document lessons learned about the operational challenges of the conducting research in humanitarian settings.

This document presents the synthesis of lessons learned regarding the key barriers and facilitators of conducting public health research in challenging humanitarian contexts. It is hoped that these initial findings will be useful to academics and practitioners embarking on future humanitarian research and to informing the development of practical guidance on the design, implementation, and management of public health research projects in challenging humanitarian contexts.

METHODOLOGY

We reviewed 52 progress reports submitted for 26 on-going and completed studies funded by the R2HC since 201. The reports were submitted to R2HC between May 2014 and April 2017. For each submitted report we conducted a thematic analysis where the data was perused for key themes relating to the operational challenges of conducting humanitarian health research. The process was inductive in that the data was coded without trying to fit it into a pre-existing coding frame, or according to a pre-existing analytical preconception; in this way the analysis was data driven. The analysis was conducted in four broad steps. Firstly, we familiarised ourselves with the data in the progress reports. Secondly, we generated the initial codes by working “systematically through the entire data set, giving full and equal attention to each data item, and identifying interesting aspects in the data items that may form the basis of repeated patterns (themes)”.⁸ Thirdly we searched for themes by sorting the different codes into potential themes and collating all the relevant data extracts within the identified themes.⁹ Finally, we reviewed, defined and named the themes. We then used this list of themes to narratively describe and illustrate the operational challenges and facilitators of conducting humanitarian health research.

RESULTS

We report on operational barriers, facilitators, and lessons learned for future studies. Barriers are categorised into two groups – those related to, or exacerbated by, the humanitarian context and those more in common with studies conducted in other lower and middle-income countries (LMIC).

I. Barriers related to, or exacerbated by, the humanitarian context

Study teams reported that political crises and conflict often led to insecurity and political instability, while natural disasters resulted in damage to physical and communication structures. Both types of events reportedly lead to limited or lack of access to the study population, restrictions in the availability and movement of staff, and study materials movement. These humanitarian related challenges often impacted on study implementation by necessitating changes in the study implementation plan and/or methodology.

Key challenges arising from research in humanitarian contexts included the impact of such environments on a) the implementation plan; b) the research protocol and methodology; and c) programme and data quality.

These challenges and the impacts on the study activities are described in more detail below. (Relevant supporting quotes from R2HC grantees consulted in this study appear in *italics*):

a) Impact on implementation plans

Research teams found their initial implementation plans directly affected by the distinct challenges of working within a humanitarian context, with particularly critical implications for factors including timeline and budgets, staff coordination and logistics, human resource availability, and shifts in political will.

Timeline and budgets

Study teams reported that insecurity in the study sites led to lack of access to the study population. This, along with other events such as fuel shortage or strikes, led to delays and sometimes cancellation of key activities until security and logistics improved. This often had knock on effects on budgets which had to be stretched to accommodate alternative plans, such as, in one case, off-site training and lab testing. Time-wise, some teams dealt with delays by reducing the time allocated for follow-up activities, especially impact assessment at the end of the project.

“Society-wide logistical challenges also affected the partner’s functioning, including a fuel crisis, which significantly impeded transportation, and availability of items such as food, resulting in budget increases and delays”.

Staff coordination and logistics

Insecurity also led to additional restrictions in the movement of staff, with instances of visa restrictions for expatriates and, in one case, limited movement of staff from different ethnic groups. This often meant that expatriate investigators, or staff from different ethnic groups, were only able to provide remote training and supervision.

“One challenge has been brought on by the need to distribute study devices the day following enrolment. In addition to some challenges in locating families on the day after enrolment, the quick turnaround has posed a security concern. At the study site, it is generally necessary to plan movements for the team one week in advance and to submit these plans for security clearance. For this study, though, this level of advanced planning is not possible. Instead, to facilitate this process and allow security sufficient time to check the areas, field staff send SMS messages to the supervisors when they enrol a participant informing them of their location”.

Involvement of numerous partners was seen as essential to success, but also contributed to complications in administrative agreements, coordination and timelines. For example, aligning all study partner activities on projects that were already inherently complicated by the humanitarian context often contributed to implementation delays. These delays may result in lost opportunities e.g. pre-identified staff and/or programmatic funding no longer available.

“The national government increased their enforcement of national policies to pay refugee incentive workers (our research team, and intervention facilitator team) fixed wages. Our partner has therefore altered their working policy to adhere to these national policies, which require us to change the salaries for the research team and intervention facilitators. We are currently in the process of renegotiating these contracts with the research and intervention facilitator teams so we do not exceed the legal pay rate for refugee incentive workers. This has turned out to be a protracted negotiation process, causing further delays in start of our pilot”.

Human resource availability

Difficulty in recruiting qualified staff is a hallmark of conducting research in lower and middle-income countries (LMIC). However, the unavailability of qualified staff and their turnover was particularly exacerbated by humanitarian crises. Projects teams reported having to critically rely on a very small team of researchers and no dedicated field staff. Evolving crises, for example a new refugee influx or

new natural disasters, also led to changes in priorities for technical partners over study implementation periods. This, in turn, meant a restriction on the availability of technical staff needed to work with multiple partners.

“In the immediate aftermath of the earthquake, the implementing partner accommodated a large number of earthquake related projects with various partners, creating shortage of staff and resources, resulting in delay in confirming team members and other activities. Consequently, it was necessary to hire and train additional staff, and to adapt the project timeline somewhat to the partner’s availability.”

“We found it very difficult to organise training days when all trainees are available because many have several competing commitments with other partners. In the future we need to consider potential for partial salary and time support at least to technical staff to assist in critical times during evaluation as well as engaging national level leadership from partner institutions earlier in the project to maximise commitment and accountability of national staff.”

“As we prepare for the training, we are trying to mitigate the problem that 4 or 6 matrons are illiterate. To support them, we are proposing they are accompanied by a literate health agent for the training. They will follow the workshop and assist with local language translation for key messages.”

Study teams also reported that team members could be directly affected by humanitarian crises and, in such cases, find conducting research activities potentially stressful and/or upsetting. This was particularly the case for mental health studies. In these examples some teams reported adding staff trainings to provide opportunities to reflect on experiences and to learn coping skills to use in their own work. One study also provided team members with mental health clinical support so they could debrief with a mental health professional after each intervention session.

“An additional challenge was that most staff members were themselves earthquake survivors and consequently, some suffered from earthquake-related stress and trauma reactions. Attention to this was a key component of post-earthquake project implementation. Clinical and administrative team members participated in a Service Provider training, where they were given an opportunity to reflect on their own earthquake experience and learn coping skills for use in their own work. Research team members debriefed with the Project Manager on a regular basis. Although team members shared that work was sometimes stressful and/or upsetting, no team members reported debilitating or lasting distress resulting from their work, but rather generally reported that they found work emotionally fulfilling and in fact felt that making a meaningful contribution facilitated their healing process.”

Shifts in political will

Given the fluidity of rapidly-evolving humanitarian environments, research teams have also been forced to confront periodic shifts in commitment by political actors for the approval, access, and cooperation with their projects. Changes in buy-in and support of research can often result from both active decisions taken by key political stakeholders, as well as the unintentional consequence of wider confusion and disruption to established processes caused by the humanitarian emergency.

“We have strong in-country support from the national medical board...and MOH. The National Ministry of Health has offered to host meetings. This process has stalled due to the current MOH reorganisation and countrywide health provider strike, but we hope to push this forward once the MOH is ready”.

b) Impact on the protocol and methodology

Teams reported that insecurity often **necessitated a change in the research protocol**. In such cases data collection was either cancelled, or changed to a central location in the community, instead of in participants' households, while lab testing was moved off-site.

“The situation on the ground has gotten worse, but the provider organisations continue to operate. We may have to forgo interviews with individuals inside Syria for security reasons.”

“The performance evaluation had to be completely redesigned from the original application for a number of reasons. Our inability to travel to the project site was a major factor influencing the change, in that the scope and complexity had to be significantly reduced when we had to rely entirely on our field partners to collect all the samples and manage all the logistics to ship them from the study site to a location where we were able to set up a laboratory partnership.”

Ethical and logistical concerns about the design in the context of crises also led some teams to consider modifications to the study design.

“Randomisation within the community (as required in a traditional RCT design) was neither logistically feasible nor ethically appropriate in the immediate aftermath of a natural disaster (leading to development of a) quasi experimental design”.

Living through acute or chronic humanitarian events had multiple effects on the **lives of those living in the communities where studies were being implemented**. This led study teams to reconsider methodologies and approaches of data collection. For example, in one study the team reported that the instability in the lives of participants (having recently dealt with an earthquake), as well as mistrust of research teams against a backdrop of prolific humanitarian response activities, both led to lower study participant recruitment.

“The initial lack of trust in the local research team contributed to low attendance at intervention training. This was in part related to participants giving false demographic data. Local research team members reported that participants later began to trust them and explained that the initial mistrust of researchers (reportedly provoked by negative experiences with NGOs in the past) is a common experience in the country. These behaviours shifted over time as the study team consistently fulfilled its commitments and the community came to trust and respect the team. In order to assess impact of research participation on participants, researchers and clinicians closely tracked participant willingness to participate and reactions to interview and intervention participation.”

Other study teams reported that some participants experienced distress associated with data collection itself, especially regarding difficult experiences during humanitarian crises. In one study the methodology was revised to include also a more positive measure.

“Data collection on trauma exposures was difficult. The national team advised developing more positive metrics of child wellbeing. These metrics were developed, translated, back translated and piloted.”

In one study, the lack of basic services to address primary community needs in the research community contributed to the cancellation of some activities. For example, the team reported that conducting focus group discussions on the particular study interventions was very difficult as participants felt that basic needs in the community were not being met and that those issues needed to be discussed, rather than the intervention being addressed through the study. In this case the research team chose to stop conducting focus groups discussions as it proved difficult not to address issues of primary need during these discussions.

c) Impact on programme and data quality

Instability and crisis often hampered the ability of the national programme team to deliver the health services associated with the research activities. Even when the programmes were still active, deviations from the standard treatment protocols due to lack of staff and resources, was the norm. This in turn impacted on research data quality, especially in studies that had to rely on programme records.

“Political situation led to deteriorating of quality of services in (out-patient departments) OPDs... we could observe a lack of compliance to treatment protocol, inappropriate/insufficient treatment counselling, a lack of proper recording of demographic and medical information. Security deterioration led to limited field access for data collectors...and OPD closure for nearly one month. The compliance to testing protocol has been seriously challenged, and testing could rarely be done during the window period as designed. The testing window period, which had been increased, did not allow (for) avoiding the loss of research cases. In order to improve the detection and the referral of eligible participants (due to lower than expected enrolment)... screenings were organised with community mobilisers...it (campaigns) ended when the political situation worsened. These challenges were addressed to District Public Health Office, however the political crisis led to a prolonged absence of OPD supervision...and a consequent deterioration of programmatic intervention in some OPDs, further increased by high turnover in OTP management teams”.

This also occurred in projects focusing on natural disaster.

“A period of political instability due to a new constitutional draft followed (the earth quake) during study implementation. This has created tensions between communities, loss of lives and imposed curfew in the district. This led to the closure of the research office and lack of supervision for data collectors in the field. The situation took 6 months to calm down.”

II. BARRIERS COMMON TO STUDIES IN LOW AND MEDIUM INCOME COUNTRIES (LMICs)

In addition to the range of operational implications posed by conducting health research in humanitarian contexts, additional and inter-related considerations were identified by teams as distinct to fieldwork in LMICs.

Delays in Process

Delays ranging from a few weeks to a several months were reported by the majority of study teams. These were due to several factors including:

- Delays in obtaining ethical approvals
- Changes/updates in national guidelines affecting the programmes being studied
- Unexpected partnership changes (resulting in labs closing, investigators moving or dropping out, partners withdrawing from the study) requiring new agreements and contracts.
- Delays in contracting, either with the donor or with other partners
- Emerging data from other studies or unexpected findings from baseline results sometimes necessitated a change in the protocol.

“Parallel intervention used in other study site was effective; thus, team felt ethically obligated to provide the intervention to community members in new site as quickly as resources allowed (rather than randomly assigning half the community to a wait-list control condition).”

Research staff recruitment

Low participant recruitment rates were reported due to lower than expected incidence of disease or study condition. This often meant delays and investment in community mobilisation and/or additional data collection sites.

“Due to the lower than expected births at the study health facilities, collection of exit interviews has been extended by an additional two weeks, thereby delaying analysis and dissemination.”

Currency fluctuation against the pound sterling led to budget constraints, especially in Call 3 studies being implemented after the drop in the value of the pound following the Brexit referendum.

“Recently, GBP has significantly devalued in the country, and the official exchange rate has dropped by nearly 30%, which has imposed significant pressure on the project budget. The only way project can compensate for this drop is to shift large parts of work in-house and cover them on a voluntary/non-remunerated based.”

“The financial strain (through) the decline in the grant value, approximately 20%, is requiring us to engage in the work with fewer resources. We addressed this in the only way we could, reducing the level of compensated time for our team members. As our team is committed to the project, the burden is mostly felt on a personal level. This is not a satisfactory solution, however.”

Communication and Partnership Issues

Communication between the study team members across time zones and with conflicting schedules of stakeholders was often challenging, especially where face-to-face meetings between core staff was not always possible.

A few studies noted the challenge of involving the operational NGO partner implementing the programme in the research evaluation activities of that programme. The team contended that involving staff implementing a programme in conducting acceptability evaluation would introduce bias.

“Our challenge included efforts to avoid implementing programme staff being directly involved in data collection (particularly for the acceptability evaluation), due to the bias that may introduce; however, a lack of other partners available in the field meant that this could not be completely avoided. It may be useful to engage a third party for data collection, if one were available (possibly even in another camp).”

Teams tried to deal with this by a third, non-implementing partner in research activities. In such cases, the aim was to maximise independence between the research team (e.g. local academic partner) and programmatic activities implementing partner (e.g. local NGO).

“Having a strong local academic partner, independent from the local humanitarian partner, was essential for our interaction with local communities.”

LESSONS LEARNED

In summarising the above findings, we have identified a series of preliminary observations that represent a starting point for further lessons-learning.

Partnerships

Teams reported that having a strong collaboration between academic, INGO, local NGOs and government was the main facilitator to having collaborative study design process, timely ethics approvals, and resource and capacity sharing. This, in turn, facilitated the streamlining of quality data collection even in challenging environments.

Investment in strengthening partnerships, clarifying roles and building ownership contributed to better utilisation of the strengths and experience of each partner agency. This contributed to the development intervention and research design that was both scientifically sound and contextually appropriate.

Challenges can lead to opportunities for current and future studies, for example:

- No access to study sites often created more opportunities for hiring and capacity building of local staff and facilities
- Low participant recruitment necessitated increased community engagement efforts and building of stronger trust relationships with research teams.

“Efficient negotiation between the local partner and community leaders regarding intervention and evaluation practices, that balanced humanitarian and research objectives, was a key component of post-crisis implementation”.

Significant investment at the outset in comprehensive technical and leadership training for local teams meant that expatriate investigators could focus on an unobtrusive monitoring role, allowing for a potentially more comfortable and empowering environment for data collection with participants.

“Increase the number of researchers and staff we hire in country and increase the proportion of the consultancy (transcription and translation) work to be done locally. This change was suggested by the national implementing partner as a means of increasing our project’s capacity building impact. We also think that ensuring greater involvement of local collaborators in different phases of the research project will ultimately strengthen our research”.

It is also critical to define the roles and responsibilities of each partner at the outset. This is in order to build ownership around each stakeholder’s respective role and responsibilities. Teams noted that these efforts are challenged by high rates of staff turnover in the field. Efforts to address this should focus on defining a mechanism to regularly brief local field staff on the project’s progress and inform new staff about the project to minimise setbacks and reduce interruptions in research activities.

Studies evaluating the impact of interventions should consider how to maintain independence between the implementing partner and those evaluating the impact of those activities.

Communication

Communication across time zones and with conflicting schedules of stakeholders was often challenging. Face-to-face meetings between core staff were not always possible after the first initial meeting. Suggestions to address this included:

- Budgeting for more regular (e.g. bi-annual) face-to-face meetings of the core team
- Developing creative communication ideas to address safe and ethical transfer of data and provide a way for participants to communicate with study staff.

Methodology and scope

A question that arose was whether combining development of an intervention and rigorous evaluation may be too ambitious for a relatively short-term project in a humanitarian context.

Adoption of new technologies by practitioners in humanitarian settings may be more challenging than expected. Additional time, incentives, stronger supportive supervision and integration of new technologies into existing reporting systems may improve uptake of the new technologies in humanitarian settings.

- For example, in a study of a mHealth technology, despite doctors and clinic managers seeing potential for quality of care improvement and user friendliness, there was still resistance to using the application. Use of the tool often fell to nurses, which negated the value of the decision support feature. Despite numerous updates to the application based on provider feedback, and conceptual agreement on the value of the mHealth application, adoption was more challenging than anticipated.

It is critically important to invest time in pilot testing tools and procedures, including building in time for reflection and community response to the introduction of new activities. This can be done through ensuring an adequate pilot study period using qualitative research and/or community advisory board meetings.

Integrating research activities within existing systems improved uptake and acceptance by the local community. For example, this can be partly achieved by utilising existing community groups as a means of recruitment to gain access to the study population and can result in improved group dynamics.

Moving primary custody of records to patients (common among non-displaced populations) could be useful in crisis-affected populations that are subject to frequent movement and disruption in provision of care. Having both paper-based and electronic versions of health records may improve continuity of care (especially for those with NCDs), both in persons who move around (and need to have medicines refilled or obtain treatment elsewhere) and for those that are repatriated to their home country or are resettled in another country.

Additionally, flexibility in intervention timelines around religious events (e.g. Ramadan) was necessary to ensure the feasibility of participant attendance at sessions during this time.

Capacity building

While training in research methods and clinical skills generally, and project procedures more specifically, inevitably play a role in research partnerships, future projects may benefit from making this component more explicit and comprehensive. In some cases, partner organisations might benefit from significant capacity strengthening in multiple areas of organisational development and functioning (rather than in project procedures alone) in order to provide a strong foundation for programme activities. If plans for assessing and building such capacity can be built into the project proposal and budget, it is more likely that this can be implemented in a comprehensive, systematic (rather than as-needed, sometimes haphazard) fashion. Funders could facilitate this process by more formally requesting such components in their requests for proposals.

Likewise, academic actors have much to learn from local implementing partners, with much of this learning occurring naturally in the process of co-planning and implementation. However, a more formal system for learning from partners' existing experience (e.g. through conducting a partner SWOT analysis, shadowing concurrent project implementation and/or service delivery) could be productively built into start-up procedures.

- A local research co-ordinator within the operational partner organisation – ideally a research/M&E officer – should be identified in each agency to partner with the study research coordinator. For some teams, this role proved to be critical to the success of the project.

Dissemination

- Include funder in dissemination activities
- Share experiences and expertise (beyond actual findings) with those engaged in similar activities, on the 'how' of project evaluations
- Publicise results on dedicated websites (e.g. ReliefWeb, IRIN news)

- Share methodologies, tools and short reports in English and local language with researchers who currently work in the same region with the same population
- Tailor findings in concise reports for dissemination for practitioners and policy-makers

FINDINGS FROM FOCUS GROUP DISCUSSION WITH KEY ACADEMICS, DONORS AND IMPLEMENTERS AT THE 2017 R2HC RESEARCH FORUM

During the R2HC Research Forum, 5–6 September 2017, 80 meeting delegates participated in 9 focus groups to discuss key operational challenges faced in conducting humanitarian health research and to discuss key solutions.

Table 1 presents a summary of the challenges identified in this session. Solutions to some of the same challenges were also identified by the groups, but in many instances a lack of readily-available advice for mitigating the more complex challenges indicates a clear need for further thinking and guidance development.

While these challenges are the results of a single day's discussion and are not presented as a comprehensive inventory, the exercise represented a helpful validation of the preceding discussion, as **most of the challenges identified in the group discussions mirrored those identified through progress reports that are reported above.** Most commonly these included the challenges of instability/insecurity and lack of access to the study population, and difficulties in hiring qualified staff and ensuring appropriate capacity building (both technical and operational), especially where multiple agencies/organisations are competing for the limited pool of potential staff.

Partnership challenges were also emphasised, especially in the context of situations where tensions may arise between service delivery staff and researchers due to increased pressure on staff workload and resources. Participants also highlighted the mismatch between the rapid onset and progression of timeline of humanitarian events, and that of research. This is especially considering that research activities are often further delayed by the very characteristics of the humanitarian event that necessitate rapid implementation. One theme that was highlighted more strongly in the group discussions than in the reviewed progress reports was the potential perception, either from the community or the local service delivery partners, that research is an imposition or distraction from local priorities for service delivery.

Another theme that had not been previously identified through the progress reports, was the concern from researchers that governments might not accept the findings, especially if these were sensitive or bring into question current service delivery paradigms. Equally, concerns were expressed about a potentially inherent tendency/bias towards identifying positive results in relation to the intervention being studied. Participants suggested that this could be exacerbated in projects where there is limited or no distinction between research and service delivery staff.

Other issues not previously identified related to ethical challenges, including the establishment of an appropriate control group and ensuring that ethical approvals actually reflect implementation on the ground. The challenge of translating ethical research guidelines into research operations in difficult settings was also mentioned.

Participants also put forward various suggestions for how R2HC, and potentially other donors, can support good operational practice in conducting humanitarian health research. This primarily underscored the need for the development of guidance highlighting best practice from currently funded R2HC studies.

Participants also thought it was important for donors to consider how they can work to promote the reduction of counterproductive competition between research teams in hiring limited pools of local research staff and partners. Somalia was recommended as a context where the value of such collaboration between several on-going donor initiatives is clear. Donors could also consider inviting country-expert advisers to join 'country advisory panels' to give researchers operating in the same context shared advice and guidance. The Canadian Coalition for Global Health Research has compiled country profiles, outlining aspects of the operating environment to keep in mind, and this was suggested as a useful model to consider.

In terms of community engagement, donors could prioritise studies that plan to work with grassroots organisations and using community-based research approaches, as well as those that work with or establish community advisory boards or, at the very least, demonstrate the extent of community engagement in the study development and implementation plans.

Regarding facilitating data access, donors could encourage the use of community advisory boards to enhance discussions of data ownership and access, as well as providing expert advice on data collection and sharing good practice for short listed protocols. With respect to obtaining ethical approvals, donors could lobby for global approval of IRBs for countries with no mechanism (e.g. through WHO in countries like Myanmar).

Finally, donors could play an important role in promoting rapid and appropriate dissemination by:

- Requiring engagement / presentation at the cluster level
- Dissemination conferences for humanitarian health research, such as the R2HC Research Forum, perhaps on an annual basis
- Platform to put results up quickly without peer review
- Re-calibrate academic incentives e.g. encourage/support publishing of research findings by WHO in immediate journals / ReliefWeb / MSF science days.

Table 1: Summary of group discussion feedback regarding key operational challenges and solutions in humanitarian health research:

Challenges: Recruitment	Suggested solutions:
<ul style="list-style-type: none"> • Multiple crises can result in shifting priorities and competition between agencies for a limited pool of qualified local staff, salary escalation, and an inability to compete with UN staff salary scales. These human resource issues are ultimately counter-productive to wider efforts to build a shared evidence base. • Limited technical capacity for assessing and addressing research design issues, especially in smaller NGOS. 	<ul style="list-style-type: none"> • Plan for different levels of supervision, including the possibility of hiring staff beyond the current team and local staff, and accommodate such costs in project budgets. • Having a strong local research partner, while sometimes difficult to find, can go a long way to side-stepping this point of tension. • As always, the building of local capacity to understand and contribute to research processes is critical. Participants noted that this may be an obvious point, and could be the subject of an entire field of discussion in of itself, but is nonetheless essential.
Challenges: Relationships	Suggested solutions:
<ul style="list-style-type: none"> • Maintaining positive and constructive relationships between researchers and programmatic staff in the field can be a constant challenge. This includes tensions in frontline organisations between researchers and others due to increased pressure on staff workload, and other resources (vehicles etc). • Researchers may be perceived as an imposition/distraction by on-the-ground agencies, leading to partnership breakdowns (e.g. tension between researchers and their programmatic partners organisations could arise from resentment of additional workload 'imposed' by external academics). • This issue is linked to the challenge of presenting the immediate value of longer-term research that might be apparent at an NGO HQ level, but not to NGOs at country/local level. 	<ul style="list-style-type: none"> • Gaining trust and buy-in from partners by being able to demonstrate good results from previous research projects. • R2HC seed funding supports research teams to come together in person with a view to exploring specific roles and responsibilities during the full proposal development stage. • R2HC experience has shown that longer-standing partnerships demonstrate higher success in attaining funding and lower risks from partnership working during research implementation. • For academics, better recognition that implementers do not have to be 'researchers', and that there will always be two sets of priorities between the two groups. • R2HC offers partnership management training to PIs at the outset of their research, to help raise awareness of challenges associated with leading partnerships and to help build understanding and core skills around partnership management.

	<ul style="list-style-type: none"> • Engage a member of the NGOs' technical unit at country office level as well as HQ. • Hire a dedicated on-site research coordinator, ideally from a local research institution, as a means to reduce burden on NGO partners and provide a 'round the clock' presence to strengthen the partnership. • Share working documents that clearly outline job descriptions and responsibilities. Work together to recruit staff. Discuss and clearly articulate expectations and budget parameters from the research outset. • A checklist covering everything needing to be considered when planning a research project, including costs, is helpful. It would also be useful to have a systematic way to address risks. R2HC offer facilitated partnership workshops for applicants using seed funding to meet as a full research team, looking at roles and responsibilities within the partnership as well as stakeholder engagement and risk mapping. • Having a 3rd party mechanism to resolve conflicts between research and programmatic staff would be useful. This is support R2HC offers.
Challenges: Community engagement	Suggested solutions:
<ul style="list-style-type: none"> • Without clear communications and dedicated engagement from researchers, communities can easily perceive that the research is not a local priority. 	<ul style="list-style-type: none"> • Community engagement should be held as a priority throughout the research process, and a significant body of good practice already exists for guiding researchers. • The R2HC Ethics Tool provides a series of questions for consideration about engaging with local communities during development, implementation and post-research.
Challenges: Security / access	Suggested solutions:
<ul style="list-style-type: none"> • Instability/insecurity and lack of access to the study population can result in delayed 	<ul style="list-style-type: none"> • Greater focus on contingency planning and thinking through 'worst case' scenarios prior

timelines, inability to train local staff and increased pressure on local staff to do more.	<p>to implementation can help mitigate instability.</p> <ul style="list-style-type: none"> • Invest in careful selection of quality local staff who can provide continuity through the life cycle of the intervention and afterwards, and invest more deliberately in their training. • Participants noted and appreciated R2HC's 'unique flexibility' in permitting budget reallocations in the face of unforeseen events, which was 'absolutely essential but quite rare' for a humanitarian research grant.
Challenges: Funding	Suggested solutions:
<ul style="list-style-type: none"> • Discrepancy of timelines, in that research does not operate in the same timelines as humanitarian events. Nonetheless, once funded there is a tension between the need for rapid implementation of research projects vs. on-the-ground constraints in operating environment. • Funding modalities are not optimised for the humanitarian context. For example, donors typically fund 1–2 years with extensions, limiting the types of (particularly longitudinal) research that can be conducted. 	<ul style="list-style-type: none"> • Alternative coordination • Documentation of progress • Consider alternative research designs that use innovative methods and challenge orthodoxy • Strengthen project M&E to justify project delays and no-cost extension requests. • Lobby donors to align humanitarian response funding with research funding, so as to maximise opportunities for increasing the evidence base.
Challenges: Political Sensitivities	Suggested solutions:
<ul style="list-style-type: none"> • Concerns about acceptance of results by government and jeopardising relationships with authorities due to sensitive findings. • There is a potentially inherent bias towards 'positive' results in validating/supporting the operating partner. This is especially evident where the research and service delivery time are not independent, or are the same – this can increase likelihood of conflict of interest between researchers & designers. • Researchers often face what participants called a 'culture of fear' in humanitarian 	<ul style="list-style-type: none"> • The ability to demonstrate/refer to results from similar studies can increase buy-in within organisations • Budget and plan to hire outside of government or implementation partner (e.g. better use of local researchers) • Ensure institutional separation between those implementing the intervention and those evaluating it, so as to avoid conflict of interest.

environments, particularly complex emergencies, in which both local authorities and affected community members are highly distrusting of outside investigations and reluctant to speak candidly about sensitive topics.	<ul style="list-style-type: none"> • Consultation with affected communities and community engagement can help mitigate mistrust. From an ethical perspective it may be necessary to delay the research or to select an alternative study site if local concerns cannot be alleviated.
Challenges: Ethical Concerns	Suggested solutions:
<ul style="list-style-type: none"> • There remains a need to translate ethical research guidelines – e.g. informed consent – into operational practice. • Respondent research fatigue. 	<ul style="list-style-type: none"> • Utilise mechanisms for assessing research fatigue. • Establish appropriate control groups. • Ensure that ethical approval reflects what actually occurs and/or is to be implemented.
Challenges: Data Quality	Suggested solutions:
<ul style="list-style-type: none"> • Compromised data quality due to limited capacity of national staff; assessment fatigue; security /access issues. 	<ul style="list-style-type: none"> • Ensure allocation of training of sufficient length. • Engage data owners / collectors (local / national data owners). • Partner with local/regional research institutions that have the capacity to provide quality supervision, understand local contexts and can mediate with authorities for access.
Challenges: Administrative issues	Suggested solutions:
<ul style="list-style-type: none"> • Contingency planning for exchange rate changes 	<ul style="list-style-type: none"> • Development of a checklist/approach for establishing new collaborations (e.g. costing considerations, HR considerations). • Develop strong contingency planning for methodologies and budgeting; identify criteria for when a project might need to be stopped altogether.

CONCLUSION

This report reflects a preliminary exploration of some of the most common operational challenges identified by R2HC-funded research projects and the academics, donors, and implementers of humanitarian health research who attended the R2HC 2017 Research Forum. In identifying a series of overlapping challenges stemming from conducting research in both humanitarian and LMIC contexts, a wide range of issues surfaced in relation to implementation plans, research protocols and methodology, programme and data quality, process delays, staff recruitment, communication, and partnership. At the same time, respondents also identified a series of constructive and valuable lessons-learned for mitigating many of these challenges. These findings provide the R2HC with a foundation for exploration and development of future guidance for aiding its grantees and the wider humanitarian health research community in navigating similar operational challenges in research projects.

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