Social Sciences & Humanities Open 10 (2024) 101064

Contents lists available at ScienceDirect

Social Sciences & Humanities Open

journal homepage: www.sciencedirect.com/journal/social-sciences-and-humanities-open

Regular Article

Integrating research evidence in humanitarian health responses: Analysing power and knowledge negotiation using the adapted Extended Normalization Process Theory

Enrica Leresche [a,*], Neha Singh [b], Carl May [c], Maria Livia de Rubeis [d], Umberto Pellecchia [e], Syed Yasir Kazmi [f], Marco Albertini [g], Bishara Abdullahi Suleiman [h], Mazeda Hossain [i]

[a] Department of Global Health and Development, London School of Hygiene and Tropical Medicine, United Kingdom
[b] Department of Global Health and Development, London School of Hygiene and Tropical Medicine, United Kingdom
[c] Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine, United Kingdom
[d] Mèdecins Sans Frontières Operational Centre Brussels, Luxembourg
[e] LuxOR, MSF Luxembourg Operational Centre Brussels, Luxembourg
[f] Mèdecins Sans Frontières Operational Centre Brussels, Belgium
[g] International Committee of the Red Cross, Geneva, Switzerland
[h] McKing Humanitarian Engagement Consultant, Kenya
[i] Nottingham Trent University, Department of Global Health and Development, London School of Hygiene and Tropical Medicine, United Kingdom

ARTICLE INFO

Keywords:
Implementation
Operational research
Humanitarian
Evidence-based
Knowledge
Normalization process theory
Public health
Conflict

ABSTRACT

Background: People living in settings affected by conflicts face insecurity and live in fragmented social systems. Conducting research in these settings is essential, however integrating results into practices is complex. Implementation science tools are not used often in such environments. In this paper we explore how a convenience sample of interviewees experienced implementation in these settings, through the lens of the adapted Extended Normalization Process Theory (a-ENPT).

Methods: We conducted in-depth interviews with 26 participants (donors, academics, and humanitarian actors). We assessed what key issues interviewees met and how they negotiated them. We combined an inductive thematic analysis to identify implementation issues, and we applied the a-ENPT deductively to question power imbalances, engaging a group of humanitarian actors as co-authors along the way.

Results: The main challenges met by interviewees related to a) engaging frontline actors to produce knowledge; b) discussing the results critically; c) integrating research results in constrained learning spaces; and d) managing contextual instabilities in settings affected by conflicts. Interviewees negotiated these constraints through an early involvement of frontline actors, an institutional support, a meaningful engagement of communities, and balanced partnerships. Based on these findings we propose a tool to anticipate the power imbalances embedded in the implementation of research results in settings affected by conflicts, rooted in the a-ENPT constructs.

Conclusion: We identified mechanisms that allowed for the negotiation of important challenges and power imbalances, through an implementation science tool. Further research should focus on the perspectives of communities affected themselves.

1. Introduction

People living in areas affected by conflict face insecurity and threats in systems that are shattered socially and fragmented politically (DeJong et al., 2017; El Achi et al., 2020; Fouad et al., 2017; Lokot et al., 2022; Martineau et al., 2017). Half of the poorest people on earth are expected to be living in such environments by end of 2030 (Corral, Irwin, Krishnan, Mahler, & Vishwanath, 2020). Conducting research of relevance for people living in these settings is an ethical imperative as resources are distributed unevenly (Bowsher et al., 2019; Kohrt, Mistry,

* Corresponding author. 166, La Canebière, 13001, Marseille, France
E-mail addresses: enrica.leresche@lshtm.ac.uk (E. Leresche), neha.singh@lshtm.ac.uk (N. Singh), carl.may@lshtm.ac.uk (C. May), maria.livia.de-rubeis@luxembourg.msf.org (M.L. de Rubeis), umberto.pellecchia@brussels.msf.org (U. Pellecchia), yasirkazmi05@hotmail.com (S.Y. Kazmi), malbertini@icrc.org (M. Albertini), bsuleiman1986@gmail.com (B.A. Suleiman), mazeda.hossain@ntu.ac.uk (M. Hossain).

https://doi.org/10.1016/j.ssaho.2024.101064
Received 15 November 2023; Received in revised form 21 July 2024; Accepted 31 July 2024
Available online 17 August 2024

Anand, Beecroft, & Nuwayhid, 2019; Sibai et al., 2019). However, conducting research in conflict-affected settings is also fraught with political, social, academic, and economic power imbalance (Leresche et al., 2020; Lokot, 2019; Sibai et al., 2019). This is why it is crucial to understand whether research efforts lead to revised practices in such contexts.

Over the past two decades, implementation science scholars developed theoretical tools for a better understanding of why and how new knowledge may be implemented in practice (Nilsen, 2015; Peters, Adam, Alonge, Agyepong, & Tran, 2013). Such tools allow one to conceive implementation as a dynamic interplay between the actors, the intervention, and the context (Durlak & DuPre, 2008; Eccles & Mittman, 2006; Nilsen, 2015; Wandersman et al., 2008). In settings affected by conflicts, theoretical implementation tools are rarely used (Leresche et al., 2023; Norton & Tappis, 2024) and an academic understanding of how frontline actors experience implementation is scarce (Lokot, 2021; Rass et al., 2020), which is an issue as power imbalances are known (Ataullahjan, Gaffey, Sami, et al., 2020; Blanchet, Fouad, & Pherali, 2016; Hynes, 2003; Mistry, Kohrt, Beecroft, Anand, & Nuwayhid, 2021).

This paper contributes to developing a better understanding of how frontline actors may revise practices based on research in settings affected by conflicts (Ataullahjan, Gaffey, Sami, et al., 2020; Leresche et al., 2023; Norton & Tappis, 2024). To focus our work, we decided to study implementation within organizations sharing a similar (Dunantist) history, such as the International Committee of the Red Cross (ICRC) and Médecins Sans Frontières (MSF) (Palmieri, 2012). To account for frontline actors' capacity to act – to which we refer as 'agency' throughout this paper – we chose to apply an implementation theory allowing one to anticipate how frontline actors integrate complex interventions in routine practices collectively, considering their structural capacity, the capabilities offered by the intervention itself, and the potential of actors to act: the Extended Normalization Process Theory (ENPT)(May 2013; May et al., 2016, 2018). The ENPT also offers a potential of prediction (May 2013).

In earlier work, we found that the ENPT was useful to understand how humanitarian frontline actors discussed new knowledge, compensated for high staff turnover, shifted resources, or created cohesive groups to implement research recommendations (Leresche et al., 2022, 2023). Based on these findings, we proposed an adapted ENPT (a-ENPT) in which frontline actors may influence the effects of contextual instabilities, negotiate adapted recommendations, engage communities, or compensate for limited resources faced by humanitarian organizations (Fig. 1). A description of the development of the ENPT and of the adaptation proposed in settings affected by conflicts is available in Appendix 1.

This paper is part of a research project aiming at understanding what mechanisms influence the implementation of operational research recommendations in settings affected by conflicts using and adapting the ENTP along the way. Following one field study within the ICRC (Leresche et al., 2022) and a scoping review of the literature (Leresche et al., 2023), this paper contributes to assess how a broader set of actors perceive, experience and solve implementation issues through the lens of the a-ENPT, focusing on power imbalances.

2. Methods

The overall research project was conducted with MSF Luxembourg Operational Research (LuxOR), MSF Operational Centre Belgium (OCB), and with the ICRC. Interviewees were identified through a literature review (Leresche et al., 2023), one case study within the ICRC (Leresche et al., 2022) and another case study within MSF (*forthcoming paper*). We used qualitative methods to explore how a convenience sample of academics, humanitarians and donors, understood and worked to integrate research results in practice. We asked each interviewee the following questions: What issues have they experienced in relation to implementation? Who negotiated these tensions and how? And then, we explored how our findings related to the a-ENPT and the potential to anticipate power imbalances brought by this theoretical lens. The

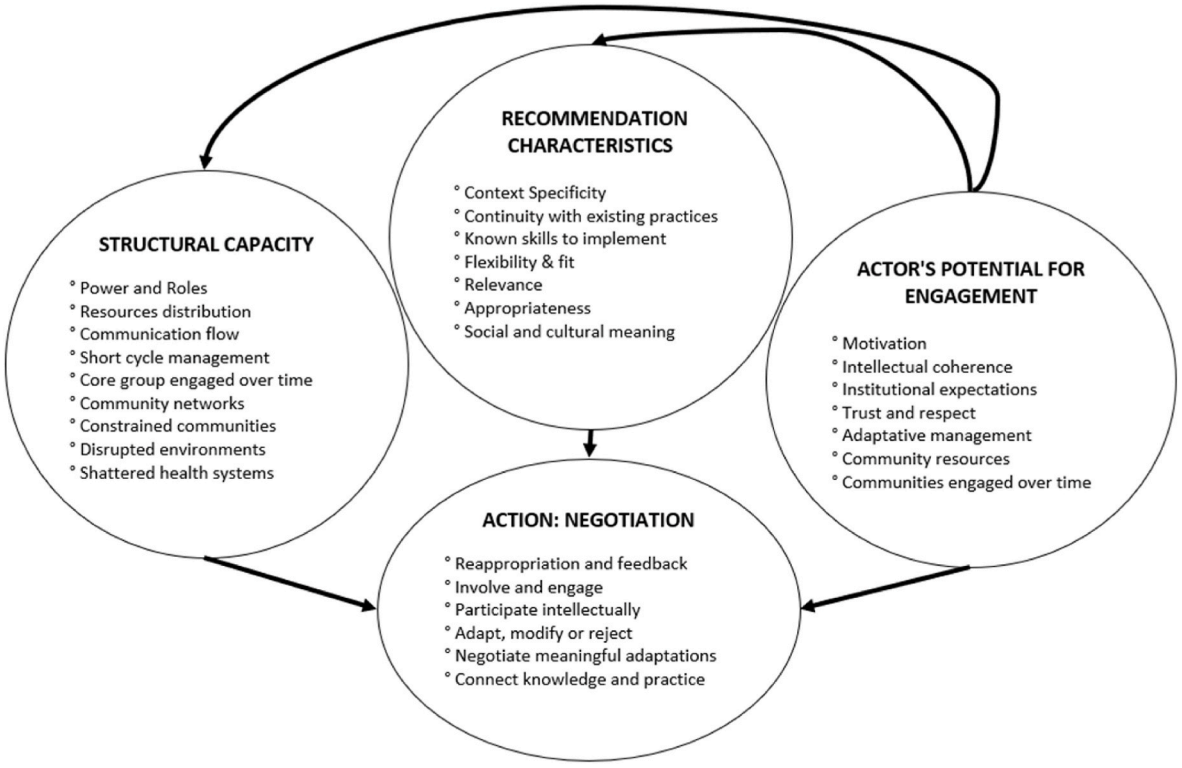

Fig. 1. The adapted Extended Normalisation Process Theory (a-ENPT) for the implementation of operational research results by frontline actors working in conflict-affected settings shows how actors may engage to negotiate contextual constraints (structural capacity) and OR recommendations (characteristics).

Table 1
Definitions used in this paper.

	Citation (s) that the definition is based on
Agency is 'the things that people do to make something happen and the ways that they work with different components of a complex intervention'.	(May, 2013)
People living in **conflict-affected areas** means that they live 'within 60 km of 25 or more battle-related deaths in the year in question'.	Corral et al. (2020)
Implementation science studies the mechanisms by which evidence-based interventions can be taken up systematically and integrated in usual activities.	(Nilsen & Birken, 2020; Peters et al., 2013)
Frontline actor are individuals and groups that encounter each other to implement research recommendations, including health staff, community health workers or lay healthcare providers.	(May et al., 2007, 2009)
An **Implementation theory** is a conceptual tool that allows one to explain and anticipate key implementation mechanisms at play.	(May et al., 2009; Nilsen, 2015)
Operational research allows one to produce new knowledge through qualitative or quantitative scientific methods, useful for decision-makers and practitioners to improve the quality of the programme, increase its coverage or enhance its effectiveness.	Zachariah et al. (2009)

definitions used in this paper are presented in Table 1.

Sampling strategy: Participants were sampled purposively within MSF, the ICRC, academic institutions, Non-Governmental Organizations (NGOs), United Nations (UN) or donor agencies, and had to lead, support or study the implementation of research results in settings affected by conflicts for more than 5 years. The sampling strategy was built with co-authors (NS, MH, MLR, UP) in order to include:

- o Academic authors of peer-reviewed papers focusing on the implementation of research results in humanitarian settings based on a scoping review of the literature (n = 8) (Leresche et al., 2023);
- o MSF (n = 8) and ICRC (n = 8) field and/or headquarters staff engaged in producing, using, sharing, or implementing operational research results in the field (total n = 16)
- o Donors supporting research or implementation efforts in settings affected by conflicts (n = 5)
- o NGO/United Nations (UN) staff (n = 8) engaged in policy-to-practice or implementation efforts

Access was obtained at headquarters level for MSF and for the ICRC, and individually for academics, NGOs, UN, or donor staff. A total of 37 interviewees were contacted anonymously by EL, and 26 responded within the time frame (6 months). Each interviewee received a detailed information sheet (Appendix 2) and signed a written informed consent (Appendix 3). The sample is described in Table 2.

Interviews: A semi-structured questionnaire was used (Appendix 4). EL conducted, recorded (using an autonomous Sony recorder), transcribed verbatim, anonymized, and analysed thematically the interviews. While introducing themselves, interviewees shared different roles and nationalities. The mean age was 49.5 years. There were 12 women and 14 men. Interviews took place between February and October 2022 in English. Because of the effects of the COVID-19 pandemic, interviews were conducted remotely (via Zoom or MS Teams).

Analysis: Anonymized transcriptions were imported in NVivo 12 Plus (NVivo12, 2021). EL discussed the coding index with co-authors (NS, MH, CM) who shared critical insights based on their academic experiences. EL analysed the results in two steps. First, an inductive analysis allowed EL to identify main themes within participant's accounts in relation to the key research questions (Braun & Clarke, 2006). Second, EL explored the data deductively, to understand how initial themes related to a-ENPT constructs. Early results were shared with co-authors who provided critical insights based on their academic and field experience. EL then used the results to develop a tool to question power imbalances while implementing operational research recommendations in conflict-affected settings. In Table 3, we present a coding Index showing the relationship between the themes identified inductively (based on our key research questions), and our deductive work (based on the a-ENPT) (May, 2013).

This research project was approved ethically end of 2021 by the LSHTM (*Ref.26482*), the ICRC ethics committee (*2118_Nov DP_DIR 21/* 00031 CGB*/bap*), and by MSF Belgium ethics review board (*ID 2177*) in April 2022.

3. Results

An overview of the main results is presented in Appendix 5. Interviewees described current roles within MSF (n = 6); the ICRC (n = 6); donor agencies (n = 4); universities (n = 6); UN (n = 2) or NGOs (n = 2). Most were mid-level staff with long experiences in humanitarian settings (>10 years). Several interviewees had experience across categories (n = 13) or were from communities affected by conflicts (n = 8). The results are presented along the research questions: 1) What issues did interviewees experience? 2) How were these negotiated? 3) What do the findings mean for the a-ENPT?

3.1. What challenges did interviewees experience?

Interviewees experienced challenges to engage frontline actors to conduct research, to disseminate the results, to manage organizational constraints, and to manage contextual instabilities.

The first challenge *was to engage frontline actors* to produce knowledge. External researchers were perceived to lack understanding of what results mean practically, including by academics. Most interviewees said that someone needed to translate findings into applicable recommendations, connecting new knowledge to local conditions. Research produced locally was also more likely to be trusted and appropriate.

> *'I think that the researchers sometimes are good at putting our understanding in recommendations, but the researchers may not be sufficiently operational in nature. So, I think that you still need someone to bridge that gap between research and operations'* (§12, Humanitarian & Academic).

Engaging frontline actors to conduct research was constrained by resources. While humanitarian actors perceived the cost of conducting research to be relatively low compared to overall operational costs, the constraints involved the type of research designs easily funded, and the control over the choice of designs by rich countries. Donor's capacities to engage with complex research processes was thought to be insufficient by humanitarians. Donors also perceived implementation to be less resourced compared to funds available to conduct research.

> *'Anyway, there's far more resources spent in producing research than there is to use and applying it'* (§13, Donor).

More specifically, time was a constraint. External researchers felt that a sustained field presence was not valued academically, and that national academics were not engaged over longer periods of time. Donors' efforts were recognized but seen as incomplete within short funding cycles. Then, time to engage communities was essential to build trust, develop buy-in, and establish accountability. However, the quality of the engagement varied. Who was involved in research, how and for how long? Responding to these questions was perceived to be difficult.

> *'Because yes, it is in every protocol, submitted to the ethics committee, but what is really happening in the ground, what do people really feel? Do people feel that they are really part of it?'* (§ 19, Humanitarian practitioner).

Table 2
Summary of the characteristics of the 26 interviewees included.

Main current role described	Location (nationality by region)							Interviewees with past or present roles across categories	Interviewees from within communities affected
	Europe	North America	Africa	Middle East	Asia	Australia	Total		
Donor	Non-disclosable						**4**	0	0
MSF	4		1		1		**6**	6 *(Humanitarian & academic)*	2
ICRC	1	1	3		1		**6**	2 *(Humanitarian & academic)*	2
NGO			1	1			**2**		1
UN	Non-disclosable						**2**		0
Academia	3	1		1	1		**6**	5 *(Academic & humanitarian)*	3
Total							**26**	**13**	**8**

The second challenge *was the ability to discuss the meaning of the results* and debate whose expertise counts. Humanitarian actors mentioned that practical knowledge could lead to override initial recommendations if results were unreliable, weak, or partial. Trust or mistrust in the results related to concerns that experts might be confined to narrow perspectives, which is why research could not be trusted as the only guide for operational responses. Sometimes important results were ignored if not transmitted via the right channels. For many, expertise meant situated knowledge, advancing that non-randomized studies and local experiences should be considered. Some academics declared that studies ignoring communities should not be trusted at all.

'*The most important thing is this division between us and the population that we work with, who actually have kind of firsthand knowledge on their situations, but they also probably bring expertise on things that we are doing, and we probably don't acknowledge that enough or we don't recognize that enough*' (§ 14 Humanitarian & Academic).

Most interviewees mentioned the importance of discussing results among different types of experts. Building a community of practice and getting space to appraise findings critically in organizations was perceived to be lacking.

'*You have to present the information; you have to be ready. They will challenge you and you have to have strong knowledge of what you want to do and why*.' (§22 Humanitarian & Academic).

The third challenge *was to navigate the organizational learning space*. Overall, research was perceived to have become more integrated in humanitarian organizations today. Persisting issues related to the capacity to modify thinking processes. Humanitarians mentioned that the ability to absorb new things was limited. Pressure stemmed from new priorities arising constantly, while routine procedures enhanced ownership and fluid learning mechanism. Despite efforts to improve leadership and accountability, organizational learning spaces were perceived to be narrow, lacking transparency and constrained by turnover and competition.

'*It is of course anti-intellectual. And it is anti-self-reflection. And I think the field itself hasn't mounted great resistance to that, but on the other hand I think that the nature of the funding system and the delivery of sessions, and the focus on the practical, and it is almost the cow-boy manifestation, that is the core stereotype, all that is counter to critical thinking. And very counter to absorption of new knowledge and very counter to the passive business of reflecting and learning*' (§ 23, Humanitarian practitioner).

However, the capacity to engage with what went wrong seemed to emerge slowly. Humanitarian actors at lower hierarchical levels could bring change when they had trusted affiliations to specific networks. In organizations such as MSF and the ICRC, the chain of command was perceived to be complex involving high number of staff. While national organizations were perceived to be more flexible, bigger organizations allowed one to be anchored across level, which motivated staff to introduce changes. More complex organizations allowed for a slower but steadier adjustment to the intricate humanitarian landscape across populations affected, national authorities, international bodies, and donors.

'*I mean the complexity of introducing or changing the way that we do thing is just easier said than done. When do we change this, how do we change this, who would change this, what would be the value if we did it differently, how would that affect our budget and affect our staffing, and what are the sort of effects?* (§ 14, Humanitarian & academic).

Sometimes, existing hierarchies were perceived barriers to implementing innovative recommendations. For instance, the distance between headquarters and people affected was strongly felt by humanitarians. Academic and humanitarian actors shared a sense that headquarters staff might be closer to institutional issues.

'*So, I think that the medical hierarchy, for humanitarian health related disasters and the for the emergency response mechanisms, are both very hierarchical. And it is very difficult to change that*' (§ 11, Academic).

The fourth challenge *related to managing contextual instabilities*, such as the limitations of academia, the humanitarian system, and volatile settings.

The necessity for academics to go beyond their field of expertise was voiced by many, including academics, sharing experiences of a rigid system, vested in commercial interests and far from the field. The need to engage locally and the issue of academic work ending with publications were raised. Resistances to consider other forms of knowledge within the academic circles was also mentioned by many, as knowledge, power, and resources were thought to be distributed unevenly.

'*There is certainly the fact that academia is too removed from 'astringencies' and difficult and austere environment that the frontline actors have to work in*' (§25, Humanitarian & Academic).

Interviewees met contextual challenges stemming from a) the humanitarian system competitiveness, fragmentation, and weak coordination; b) short term funding mechanisms deterring longer term implementation processes; and c) the legacies from military medicine thought to perpetuate old power imbalances or colonial heritages. External factors included violence, insecurity, and disruptions. In conflict settings, local power imbalances could sometimes amplify global power asymmetries. For populations affected this meant disrupted networks, shattered social supports, and increased vulnerability. The notion that communities were not 'one' and presented a degree of fragmentation was also discussed, while corruption and abuses were thought to be underestimated by humanitarian interviewees.

3.2. What could be negotiated and how?

In this section we present what interviewees said was negotiated.

Table 3
Coding Index of the research questions, thematic codes developed, and the a-ENPT constructs used in our qualitative analysis. This table presents the relationship between the main a-ENPT dimensions, the research questions, and the thematic codes used to analyse the data.

		What challenges did actors meet?				Who negotiated and how?			
		Produce new knowledge	**Discuss Research results**	**Understand Organizational factors**	**Identify External challenges**	**Engage frontline actors**	**Engage communities**	**Integrate cross-cutting issues**	**Negotiate Trade-offs**
a-ENPT constructs	**Actors' potential to engage**								
	Actors' capacities in relation in disrupted environments								
	Actors capabilities in relation to operational research								
	Actors' contributions to negotiations								

First, negotiate the engagement of frontline actors as connectors between new knowledge and practices. Frontline actors could trigger collective dynamics provided they were related to someone that had leverage within the organization, had established trustful relationships, possibly coupled with their position in the organizational hierarchy, and were aware of internal rules. Such connectors were often operational or middle level managers with a capacity to counter heavy bureaucracies, creative, and embedded in steady networks of trusted colleagues.

> *'I think that there's a couple of things that kind of hang on, which are, who's going to do these changes, who is it specifically, that will do these, that will implement changes or bring in this new knowledge? Because those people, and there might be many of them, if the first they hear about this is you coming to them with 'this is what you should do' you've missed everything else before. Even if you are a mirror enlightened from behind*. (§ 14 Academic & Humanitarian).

Frontline actors could also motivate others, as they were perceived to be competent and wanting to understand nuances. The motivation to implement research recommendations increased when influent leaders were backed by global research initiatives, when researchers stayed longer in the field and when leadership was stable. Research initiatives aligned with field priorities were thought to create ownership. Humanitarians perceived that if research was led by a field team, frontline actors adapted to shifts in priorities. But that privileged position made them also more likely to be demotivated when research processes were exclusive or rigid.

> '*Those (frontline actors) are the people that you need to have onboard, and you might not have them onboard from the beginning because you might not know what the research is going to come up with. But bringing them in as soon as you begin to see that these things are relevant to them. Because people won't do what they don't understand is relevant to them. And if I just say, this is relevant to you …. Knowing that something is relevant to you is a process, you don't just take my word for it, you have to know that yourself. (§ 14)*

Alternatively, frontline actors could resist the implementation process, to safeguard stability in stressful situations, to counter fatigue (from monitoring, research, and changes), or to prioritize. Academic and humanitarian interviewees explained that resistance also stemmed from power imbalances embedded into medical, military, emergency, humanitarian, or government hierarchies, emerging when practical knowledge was ignored, for instance if recommendations were not appropriate in terms of timing or resources. Or, when the change introduced was not compensated for: when staff remained alone, underpaid and far away. Inappropriate guidance could trigger strong resistances. Some interviewees mentioned that donors could also be hesitant to introduce change. Lastly, resistance could be tied to unmet community needs.

> 'This (example) is a specific operational research project, the 'raison d'être' of this project is really operational research. So, there you feel that the drive really comes from the field staff, from the coordination where they want to go further, they want to do side research, they kind of pressure the organization, to go quicker and take extra steps. And there you feel that it is them driving the implementation and even going beyond the initial plan and really taking the advantage that they have to demonstrate certain things.' (§ 20 Humanitarian)

Second, negotiate the involvement of communities. Most interviewees mentioned that communities needed to be engaged beyond a ticking-the-box exercise.

> *'And so, you make it more of a conversation. Again, you've got to break down all that power hierarchy and you've got to break down the slightly neo-colonial attitude about the 'what are they going to know, why should we change practices based on what some ignorant villager is going to tell us' ….and then, you mutually negotiate'* (§ 11 Academic).

Challenges included late engagement, the absence of a community stakeholders' map or lack of meaningful exchanges. Not being able to understand the intricacies of who is present, what type of interactions or power dynamics exist, and what imbalances are involved, was an issue. However, many interviewees shared examples of activist groups, peer-led support, non-specialist driven programs, or civil society group engaging communities to implement research recommendations. What these networks had in common was the involvement of lay actors from within communities. Patients themselves were also involved, for example people living with chronic diseases. Such experiences included patient organizations active to counter gaps in the existing health system, patient-driven healthcare models, activists defending people's rights, or telephone feedback centres.

> '*Now why, why does it work? I believe it is because it is non-specialist driven, it is a capacity building program, so it inherently builds local capacities, and it is successful because it is engaging and empowering. Training local actors, who customize the intervention to their own socio-cultural needs, so I was thinking bio-psycho-social needs, right? So, and*

who knows more about the local context, than the local actors?' (§6 Humanitarian & Academic).

Third, negotiate balanced partnerships, power, and time to increase the space to find solutions.

Interviewees agreed that building *balanced partnerships* to learn was crucial. Beyond co-production, thinking together about what results mean for practice was key. The main challenges included: a) the capacity of academics (or lack thereof) to engage with frontline actors; b) getting something on the agenda while keeping communities and governments autonomous; c) small partnerships easier to manage bring small-scale effects, while higher level partnerships bring bigger scale effects but involve bureaucracy; and d) the competition between organizations or donors when organizations need to learn collectively from mistakes. Building balanced partnerships considering these tensions was thought to be necessary by all.

'*Having better partnerships, where the researcher understands the challenges of response and then where the humanitarian organization can understand the benefits of the research, I think that there is a wide gap, and this is the biggest challenge'* (§7 Donor).

Then, interviewees mentioned the unequal distribution of power in relation to) global economies and colonial legacies; b) bureaucracies and de-centralized decision-making; c) academic knowledge perceived to be structured along a bio-medical hierarchy, including perverse gate-keeping; d) donors priorities possibly aligned with, or constrained by national political agendas and security considerations; and e) communities and the socio-economic or political hierarchies being reinforced in crises situations. Two dimensions of power were strongly felt by interviewees: first, the type of knowledge (academic, practical, tacit, informal) considered as legitimate to conduct research, share results, or implement recommendations; and second, the power of money and its flow in humanitarian settings.

'*Because although we can localize, and nationalize the response, the money is still going to be very centralized. And that gives a lot of power to do things' (§ 10 Donor)*.

And lastly, work and funding cycles differed between academics and humanitarians, making it difficult to measure longer term changes. Time was needed to produce research and for frontline actors to discuss what they mean, especially if communities were on move and insecure.

'*On one had you need to integrate people, and make sure that you can get buy in, but by the time you do that you are one step behind'* (§17, Humanitarian & Academic)

Fourth, negotiate trade-offs while implementing

Negotiating trade-offs included providing feedback and adjusting, recognizing that measuring impact in humanitarian settings is complex because causality was not (understood to be) simply linear. Sustainability for instance, was perceived to be constrained by the ability to follow-up, the timing of the humanitarian response, and the need to differentiate immediate and longer term changes.

'*How were you feeling before, how are you feeling after, can we show a change? Yes, we can. Okay. But beyond that? Who is not improving? Who is improving? How can we make the ones that are not improving improve? I feel like it should be our responsibility but maybe time will show that it will be the donors who will make the difference. But I feel that it is a failure on our part*' (§3, Humanitarian practitioner).

The following trade-offs needed to be solved collectively: How can frontline actors negotiate long term issues when time is limited to deal with uncertainties? How can actors listen to each other to find a middle ground when decision-making is quick? How can actors adapt, re-frame or customize recommendations when fidelity to the initial recommendations is expected? How can organizations capture and reward audacious people when institutional coherence is valued? How can organizations change things quickly enough to learn while avoiding risks? How can individuals or groups challenge existing organizational or social norms while fostering one strong organizational identity?

'So then, perhaps in this setting, I will accept that I will do this step one and not the step three. And this has to be understood and accepted'(§ 18 Humanitarian & Academic)

3.3. How do our results relate to the a-ENPT?

Based on our results, we summarize below the mechanisms described by interviewees to manage challenges and power imbalances that they experienced.

- Actors' potential for engagement

Interviewees perceived that frontline actor struggled with late engagement, narrow expert perspectives, organizational spaces to reflect critically, and uneven distribution of knowledge. Negotiating these issues meant discussing different types of knowledge, through flexible research initiatives and timely engagement. Power imbalances related to the legitimacy of practical knowledge, inclusive engagement, and to the capacity of frontline actors to activate local networks.

- Actors' structural capacities in relation to the internal/external context

Interviewees perceived that frontline actor struggled with imbalanced resources for implementation, inadequate field presence to develop situated knowledge, high turnover and competition, and complex bureaucracies. Negotiating these issues meant creating small partnerships, distributing resources evenly, providing institutional support, or resisting implementation. Power imbalances that interviewees related to the distribution of resources and to global and historical legacies.

- Actors' capabilities tied to the research recommendations

Interviewees perceived that the type of research funded by rich countries, mistrust in the results, the lack of integration of community needs, and rigid biomedical hierarchies were challenges. Negotiating them meant aligning research initiatives with field questions, giving the lead to field teams, integrating practical knowledge. Power imbalances that interviewees identified related to the academic understanding of causality, the different types of knowledge recognized, and the capacity to adapt recommendations (or the lack thereof).

- Action and negotiation

Interviewees perceived that frontline actors struggled to translate new findings into applicable recommendations, build a community of practice, discuss results with different experts, be affiliated to trusted networks, and consider a diverse community. Negotiating such issues meant safeguarding autonomy, thinking together about what results mean for communities, or resisting implementation to safeguard stability. Power imbalances experienced included the capacity to decide what type of expertise was recognized or the power to pertain to trusted networks.

As a result, the a-ENPT lens was used to propose a tool allowing for the prospective identification of power imbalances embedded in each a-ENPT dimension of the implementation process (Table 4)

4. Discussion

We found that 26 interviewees experienced challenges to: implement research results in settings affected by conflicts; engage practitioners and communities in a balanced way; discuss the meaning of new

Table 4
Relationship between the a-ENPT constructs and potential questions to be used to identify issues or power imbalances, using our results.

a-ENPT CONSTRUCTS	What issues did interviewees experience?				Who negotiated these issues and how?			
	Produce new knowledge	Discuss research results	Understand Organizational factors	Identify external challenges	Integrate cross-cutting issues	Engage practitioners	Engage communities	Negotiate
Actors' potential to engage	◦*Did frontline actors conduct the research?*	◦*Did frontline actors discuss the results?*	◦*Is there a safe space for actors to discuss failure?*	◦*Has practical knowledge been discussed?*	◦*Can frontline actors decide who is involved?*	◦*Can frontline actors be autonomous to implement?*	◦*Can communities discuss the meaning of the results?*	◦*Can frontline actors negotiate the adaptation of recommendations?*
Actors' structural capacities in relation to the internal/ external context	◦*Are there resources available to engage frontline actors in research?* ◦*Where frontline actors skills used to conduct research?*	◦*Where the results shared by frontline actors?* ◦*Are frontline actors that are expected to implement involved in the discussions?*	◦*Is high human resources turnover going to be compensated for?* ◦*Is there an institutional space to learn?* ◦*Are recommendations part of actors' usual roles?* ◦*Are there actors involved who can counter heavy bureaucracies?*	◦*Are existing resources sufficient in the long term?* ◦*Can frontline actors counter existing medical or academic hierarchies?* ◦*Can health system fragmentations be compensated for by frontline actors?*	◦*Can frontline actors decide how the resources to implement are distributed?* ◦*Are frontline actors engaged in a relatively small and balanced partnership?* ◦*Are expected long term changes realistic for frontline actors?*	◦*Are frontline actors supported institutionally?* ◦*Is there a stable leadership in place to support?* ◦*Is it feasible for frontline workers to implement now?*	◦*Are the resources from the communities taken into account?* ◦*Can communities counter the gaps of the health system?* ◦*Are the recommendations aligned with social norms or roles?*	◦*Can frontline actors take risks?* ◦*Can frontline actors propose a different measure of impact?* ◦*Can frontline actors challenge assumptions over time?*
Actors capabilities tied to research recommendations (the object)	◦*Does the research relate to usual practices?*	◦*Are the results trusted by frontline actors*	◦*Can recommendations be integrated in existing practices?*	◦*Can frontline actors bring knowledge that is not academic to shape the recommendations?*	◦*Can frontline actors decide whether recommendations can be adapted?*	◦*Can practitioners propose to adapt recommendations?*	◦*Can communities provide feedback on the recommendations?*	◦*Can frontline actors discuss the expected outcome?*
What actors do to implement (their contribution)	◦*Are the results related to what frontline actors already known?* ◦*Can frontline actors translate the findings into applicable recommendations?*	◦*Do results relate to existing operational knowledge?*	◦*Are results aligned with organizational priorities?* ◦*Are research results shared with actors that are embedded in a supportive network?* ◦*Are results integrated in monitoring tools?*	◦*Is there a diverse sample from the community engaged in a way that is safe for them?*	◦*Can frontline actors have an input on whether recommendations are relevant or culturally meaningful?*	◦*Do the recommendations relate to an issue on which practitioners have leverage?*	◦*Can community knowledge, experience and skills be factored in?*	◦*Can frontline actors discuss and negotiate longer term issues and potential solutions?*

*The questions in this table show how the a-ENPT dimensions could be used as a tool by researchers, donors, and humanitarian actors to identify issues and then possible manage power imbalances embedded in the research implementation processes.

knowledge critically; create organizational learning spaces in bureaucratic and busy humanitarian organization; and manage uncertainties. We found that frontline actors negotiated such issues by creating collective dynamics, engaging with communities meaningfully, building balanced partnerships, and balancing trade-offs.

Our results present the experiences of a relatively small sample of interviewees who manage, guide, support, fund or study the implementation of research results in settings affected by conflicts. While recent research efforts assessed the challenges encountered by frontline actors in a variety of settings affected by conflict (Ataullahjan, Gaffey, Sami, et al., 2020; Mistry et al., 2021), our work uniquely combines the perspectives of actors working with the ICRC, MSF, UN, NGO, academic and donor agencies.

We used the a-ENPT lens to focus on the agency of frontline actors. In settings affected by conflicts, implementation science frameworks are used to scale up effective interventions (Bennett, Mahmood, Edward, Tetui, & Ekirapa-Kiracho, 2017), build theories of change (Fuhr, Acarturk, Sijbrandij, et al., 2020; Fuhr, Acarturk, Uygun, et al., 2020; Truppa et al., 2023), or study implementation processes (Norton & Tappis, 2024; Shahabuddin et al., 2020), while scholars used the ENPT to assess feasibility or process evaluation in such settings (May et al., 2018; Willey et al., 2018). In our work, the a-ENPT lens allows one to analyse the questions of agency, negotiations mechanisms and power imbalances – which are often recognized but not necessarily approached through an implementation science lens in the literature (Lokot, 2019, 2021; Lokot & Wake, 2022; Rass et al., 2020; Singh et al., 2021).

Our results echo documented findings: to implement research results frontline actors face insecurity, cultural barriers, social inequities, poverty, destroyed services, or unreliable data (Ahmed et al., 2020; Akik et al., 2020; Altare et al., 2020; Ataullahjan, Gaffey, Tounkara, et al., 2020; Das et al., 2020; Mirzazada et al., 2020; Ramos Jaraba et al., 2020; Sami et al., 2020; Tyndall et al., 2020); organizational constraints include human resources turnover, fragmented governance, irregular financial flow, lack of support to task shifting, or insufficient engagement with traditional forms of care (Ahmed et al., 2020; Akik et al., 2020; Altare et al., 2020; Ataullahjan, Gaffey, Tounkara, et al., 2020; Das et al., 2020; Mirzazada et al., 2020; Ramos Jaraba et al., 2020; Sami et al., 2020; Tyndall et al., 2020); Difficulties to engage frontline actors include grievances over resources, political and economic interests, or inadequate policies (Ahmed et al., 2020; Akik et al., 2020; Altare et al., 2020; Ataullahjan, Gaffey, Tounkara, et al., 2020; Das et al., 2020; Ramos Jaraba et al., 2020; Tyndall et al., 2020). The specific contribution of our work is to shed light on how frontline actors address these challenges, and to propose a tool for the anticipation of issues by applying key questions throughout the research process.

We examined the agency of frontline actors, which means building balanced and ethical research processes. Scholars examining research co-production and ethics in settings affected by conflicts, showed that accountability, long term engagement and power imbalances need attention (Ford, Mills, Zachariah, & Upshur, 2009; Goodhand, 2000; Leaning, 2001; Rass et al., 2020). Co-production has received increased consideration recently (Filipe, Renedo, & Marston, 2017; Oliver, Kothari, & Mays, 2019) and is complex in humanitarian settings (Bennett et al., 2017; Elmusharaf, Byrne, Manandhar, Hemmings, & O'Donovan, 2017; Lokot & Wake, 2022; Shahabuddin et al., 2020). Our results show that beyond producing research collaboratively and ethically, the need for time, trust and space to debate the findings and to negotiate implementation is crucial.

We found that frontline actors bring practical knowledge. Philosophically, separating scientific knowledge from practices can be traced back to Plato's myth of the Cavern: some people would know (the truth) while others ignore it, the first ones being responsible to enlighten the second (Latour, 2000, 2004). Challenging that myth means re-introducing a debate between those inside and outside the cavern (Latour, 2004). This is what we propose in Table 4: power issues shape how knowledge is conceived, and debates may allow frontline actors to connect scientific knowledge to practical experiences.

Some may also argue that improved leadership, change management and system thinking are needed in humanitarian organizations for frontline actors to implement research recommendations (Blanchet, de Savigny, & Adam, 2017). Improved leadership may increase motivation and collective engagements (Lee, Gillespie, Mann, & Wearing, 2010). Change management models provide insights on how beliefs, attitudes, values and behaviours can be influenced within human networks (Coghlan, 2021). System thinking bring increased understanding of the complexity of systems, especially in fragile settings (Truppa et al., 2024). The a-ENPT allows for these perspectives to be considered as possibly embedded in the structural capacity that actors have. The added value of the a-ENPT is to question the power relations with regards to knowledge, resources, and practices in complex situations. We did not find another theoretical approach that proposed that sort of specific examination in conflict-affected settings (Leresche et al., 2023; May et al., 2018; Norton & Tappis, 2024).

Implementation may be a space where different forms of knowledge need to be articulated, piloted, challenged, adapted, and eventually integrated into practices. In order to do that, flexibility and time are needed. Two characteristics that are utterly missing in humanitarian settings and organizations. These challenges might be addressed through discussions, partnerships and possibly even politics. If implementation means negotiating, using the a-ENPT lens in humanitarian settings may allow for the anticipation of how people negotiate power imbalances, individually or collectively, within disrupted systems and relatively transitory humanitarian responses.

4.1. *Strengths and limitations*

This paper has several strengths. First, it shows how frontline actors negotiate known implementation constraints in settings affected by conflicts. Second, we used an implementation science tool to identify the power imbalances that frontline actors face, and we propose a practical approach to anticipate them. Third, we engaged a unique sample of interviewees holding different roles and from distinct geographies from ICRC, MSF, NGO, academics as well as donors. Our results also confirm findings from preliminary work (Leresche et al., 2020, 2022, 2023). Lastly, the critical review of these results by field actors and academics from countries affected is also a strength.

The main limitation of this work includes the absence of representatives from the communities that do not work for a humanitarian or academic institution, and the fact that local frontline actors are not strongly represented. Including local communities would have been crucial but was challenging as this would have meant obtaining ethical approval from local authorities from a variety of settings. A double site case study conducted within MSF is going to fill in that gap (*forthcoming paper*). The results presented therefore lack a comprehensive understanding of what communities affected do when they engage with new knowledge in settings affected by conflicts, possibly under-estimating the challenges met by communities themselves.

5. Conclusion

This study has allowed us to identify issues of power, trust, organizational bureaucracy, and contextual disruptions experienced by a small sample of interviewees while supporting the implementation of empirical research results in conflict affected settings. We found that negotiating trade-offs and addressing power imbalances was crucial. We also proposed a tool for humanitarian organizations conducting research in settings affected by conflict to anticipate implementation issues related to power imbalances, to be tested in the field engaging communities affected themselves.

6. Funding declaration

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. The publication fees were supported by MSF-Luxembourg. MSF-Luxembourg had no role in the study design, data collection, analysis, and interpretation of data. Enrica Leresche had full access to all of the data in the study and had final responsibility for the decision to submit for publication.

CRediT authorship contribution statement

Enrica Leresche: Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Neha Singh:** Writing – review & editing, Validation, Supervision, Methodology, Conceptualization. **Carl May:** Writing – review & editing, Validation, Methodology, Conceptualization. **Maria Livia de Rubeis:** Writing – review & editing, Validation, Methodology, Conceptualization. **Umberto Pellecchia:** Writing – review & editing, Validation, Methodology, Conceptualization. **Syed Yasir Kazmi:** Writing – review & editing, Conceptualization. **Marco Albertini:** Writing – review & editing. **Bishara Abdullahi Suleiman:** Writing – review & editing. **Mazeda Hossain:** Writing – review & editing, Validation, Supervision, Methodology, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

We thank all interviewees for their time, interests, and rich insights. We thank the reviewers for their thorough and rich feedback.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssaho.2024.101064.

References

Ahmed, Z., Ataullahjan, A., Gaffey, M. F., Osman, M., Umutoni, C., Bhutta, Z. A., et al. (2020). Understanding the factors affecting the humanitarian health and nutrition response for women and children in Somalia since 2000: A case study. *Conflict and Health, 14*(1), 35. https://doi.org/10.1186/s13031-019-0241-x

Akik, C., Semaan, A., Shaker-Berbari, L., Jamaluddine, Z., Saad, G. E., Lopes, K., et al. (2020). Responding to health needs of women, children and adolescents within Syria during conflict: Intervention coverage, challenges and adaptations. *Conflict and Health, 14*(1), 37. https://doi.org/10.1186/s13031-020-00263-3

Altare, C., Malembaka, E. B., Tosha, M., Hook, C., Ba, H., Bikoro, S. M., et al. (2020). Health services for women, children and adolescents in conflict affected settings: Experience from north and south kivu, democratic republic of Congo. *Conflict and Health, 14*(1), 31. https://doi.org/10.1186/s13031-020-00265-1

Ataullahjan, A., Gaffey, M. F., Sami, S., Singh, N. S., Tappis, H., Black, R. E., et al. (2020). Investigating the delivery of health and nutrition interventions for women and children in conflict settings: A collection of case studies from the BRANCH consortium. *Conflict and Health, 14*(1), 29. https://doi.org/10.1186/s13031-020-00276-y

Ataullahjan, A., Gaffey, M. F., Tounkara, M., Diarra, S., Doumbia, S., Bhutta, Z. A., et al. (2020). C'est vraiment compliqué: A case study on the delivery of maternal and child health and nutrition interventions in the conflict-affected regions of Mali. *Conflict and Health, 14*(1), 36. https://doi.org/10.1186/s13031-020-0253-6

Bennett, S., Mahmood, S. S., Edward, A., Tetui, M., & Ekirapa-Kiracho, E. (2017). Strengthening scaling up through learning from implementation: Comparing experiences from Afghanistan, Bangladesh and Uganda. *Health Res Policy Syst, 15* (Suppl 2), 108. https://doi.org/10.1186/s12961-017-0270-0

Blanchet, K., de Savigny, D., & Adam, T. (2017). *Applied systems thinking for health systems research: A methodological handbook*.

Blanchet, K., Fouad, F. M., & Pherali, T. (2016). Syrian refugees in Lebanon: The search for universal health coverage. *Conflict and Health, 10*, 12. https://doi.org/10.1186/s13031-016-0079-4, 12.

Bowsher, G., Papamichail, A., El Achi, N., Ekzayez, A., Roberts, B., Sullivan, R., et al. (2019). A narrative review of health research capacity strengthening in low and middle-income countries: Lessons for conflict-affected areas. *Global Health, 15*(1), 23. https://doi.org/10.1186/s12992-019-0465-y

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. https://doi.org/10.1191/1478088706qp063oa

Coghlan, D. (2021). Edgar schein on change: Insights into the creation of a model. *The Journal of Applied Behavioral Science, 57*(1), 11–19. https://doi.org/10.1177/0021886320924029

Corral, P., Irwin, A., Krishnan, N., Mahler, D. G., & Vishwanath, T. (2020). *Fragility and Conflict. On the front lines of the fight against poverty*. World Bank Group, 2020 International Bank for Reconstruction and Development/The World Bank.

Das, J. K., Padhani, Z. A., Jabeen, S., Rizvi, A., Ansari, U., Fatima, M., et al. (2020). Impact of conflict on maternal and child health service delivery – how and how not: A country case study of conflict affected areas of Pakistan. *Conflict and Health, 14*(1), 32. https://doi.org/10.1186/s13031-020-00271-3

DeJong, J., Ghattas, H., Bashour, H., Mourtada, R., Akik, C., & Reese-Masterson, A. (2017). Reproductive, maternal, neonatal and child health in conflict: A case study on Syria using countdown indicators [10.1136/bmjgh-2017-000302]. *BMJ Global Health, 2*(3). http://gh.bmj.com/content/2/3/e000302.abstract.

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*(3–4), 327. https://doi.org/10.1007/s10464-008-9165-0

Eccles, M. P., & Mittman, B. S. (2006). Welcome to implementation science. *Implementation Science, 1*(1), 1. https://doi.org/10.1186/1748-5908-1-1

El Achi, N., Menassa, M., Sullivan, R., Patel, P., Giacaman, R., & Abu-Sittah, G. S. (2020). Ecology of war, health research and knowledge subjugation: Insights from the Middle East and north africa region. *Ann Glob Health, 86*(1), 120. https://doi.org/10.5334/aogh.3015

Elmusharaf, K., Byrne, E., Manandhar, M., Hemmings, J., & O'Donovan, D. (2017). Participatory ethnographic evaluation and research: Reflections on the research approach used to understand the complexity of maternal health issues in south Sudan. *Qualitative Health Research, 27*(9), 1345–1358. https://doi.org/10.1177/1049732316673975

Filipe, A., Renedo, A., & Marston, C. (2017). The co-production of what? Knowledge, values, and social relations in health care. *PLoS Biology, 15*(5), Article e2001403. https://doi.org/10.1371/journal.pbio.2001403

Ford, N., Mills, E. J., Zachariah, R., & Upshur, R. (2009). Ethics of conducting research in conflict settings. *Conflict and Health, 3*(1), 7. https://doi.org/10.1186/1752-1505-3-7

Fouad, F. M., Sparrow, A., Tarakji, A., Alameddine, M., El-Jardali, F., Coutts, A. P., et al. (2017). Health workers and the weaponisation of health care in Syria: A preliminary inquiry for the lancet American university of beirut commission on Syria. *The Lancet, 390*(10111), 2516–2526. https://doi.org/10.1016/S0140-6736(17)30741-9

Fuhr, D. C., Acarturk, C., Sijbrandij, M., Brown, F. L., Jordans, M. J. D., Woodward, A., et al. (2020). Planning the scale up of brief psychological interventions using theory of change. *BMC Health Services Research, 20*(1), 801. https://doi.org/10.1186/s12913-020-05677-6

Fuhr, D. C., Acarturk, C., Uygun, E., McGrath, M., Ilkkursun, Z., Kaykha, S., et al. (2020). Pathways towards scaling up problem management Plus in Turkey: A theory of change workshop. *Confl Health, 14*, 22. https://doi.org/10.1186/s13031-020-00278-w

Goodhand, J. (2000). Research in conflict zones: Ethics and accountability. *Journal of Forced Migration, Review, 8*.

Hynes, T. (2003). *The issue of 'trust' or 'mistrust' in research with refugees: Choices, caveats and considerations for researchers*.

Kohrt, B. A., Mistry, A. S., Anand, N., Beecroft, B., & Nuwayhid, I. (2019). Health research in humanitarian crises: An urgent global imperative. *BMJ Global Health, 4* (6), Article e001870. https://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=pmnm4&AN=31798999.

Latour, B. (2000). *Pandora's hope: Essays on the reality of science studies*.

Latour, B. (2004). *Politics of Nature-How to bring the sciences into democracy*.

Leaning, J. (2001). Ethics of research in refugee populations. *The Lancet, 357*(9266), 1432–1433. https://doi.org/10.1016/S0140-6736(00)04572-4

Lee, P., Gillespie, N., Mann, L., & Wearing, A. (2010). Leadership and trust: Their effect on knowledge sharing and team performance. *Management Learning, 41*(4), 473–491. https://doi.org/10.1177/1350507610362036

Leresche, E., Hossain, M., De Rubeis, M. L., Hermans, V., Burtscher, D., Rossi, R., et al. (2023). How is the implementation of empirical research results documented in conflict-affected settings? Findings from a scoping review of peer-reviewed literature. *Conflict and Health, 17*(1), 39. https://doi.org/10.1186/s13031-023-00534-9

Leresche, E., Hossain, M., Rossi, R., Truppa, C., Barth, C. A., Mactaggart, I., et al. (2022). Do we really want to know? The journey to implement empirical research recommendations in the ICRC's responses in Myanmar and Lebanon. *Disasters*. https://doi.org/10.1111/disa.12549

Leresche, E., Truppa, C., Martin, C., Marnicio, A., Rossi, R., Zmeter, C., et al. (2020). Conducting operational research in humanitarian settings: Is there a shared path for humanitarians, national public health authorities and academics? *Conflict and Health, 14*, 25. https://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=pmnm&AN=32435274.

Lokot, M. (2019). The space between us: Feminist values and humanitarian power dynamics in research with refugees. *Gender and Development, 27*, 467–484.

Lokot, M. (2021). Whose voices? Whose knowledge? A feminist analysis of the value of key informant interviews. *International Journal of Qualitative Methods, 20*, Article 1609406920948775. https://doi.org/10.1177/1609406920948775

Lokot, M., Bou-Orm, I., Zreik, T., Kik, N., Fuhr, D., El Masri, R., et al. (2022). Health system governance in settings with conflict-affected populations: A systematic review. *Health Policy and Planning*. https://doi.org/10.1093/heapol/czac027

Lokot, M., & Wake, C. (2022). NGO-academia research co-production in humanitarian settings: Opportunities and challenges. *Disasters*. https://doi.org/10.1111/disa.12556

May, C. (2013). Towards a general theory of implementation [journal article]. J Implementation Science, 8(1), 18. https://doi.org/10.1186/1748-5908-8-18.

Martineau, T., McPake, B., Theobald, S., Raven, J., Ensor, T., Fustukian, S., et al. (2017). Leaving no one behind: Lessons on rebuilding health systems in conflict- and crisis-affected states. *BMJ Global Health, 2*(2), Article e000327. https://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=pmnm4&AN=29082000.

May, C. R., Cummings, A., Girling, M., Bracher, M., Mair, F. S., May, C. M., et al. (2018). Using normalization process theory in feasibility studies and process evaluations of complex healthcare interventions: A systematic review. *Implementation Science, 13*(1), 80. https://doi.org/10.1186/s13012-018-0758-1

May, C., Finch, T., Mair, F., Ballini, L., Dowrick, C., Eccles, M., et al. (2007). Understanding the implementation of complex interventions in health care: The normalization process model. *BMC Health Services Research, 7*(1), 148. https://doi.org/10.1186/1472-6963-7-148

May, C. R., Johnson, M., & Finch, T. (2016). Implementation, context and complexity. *Implementation Science, 11*(1), 141. https://doi.org/10.1186/s13012-016-0506-3

May, C. R., Mair, F., Finch, T., MacFarlane, A., Dowrick, C., Treweek, S., et al. (2009). Development of a theory of implementation and integration: Normalization process theory. *Implementation Science, 4*(1), 29. https://doi.org/10.1186/1748-5908-4-29

Mirzazada, S., Padhani, Z. A., Jabeen, S., Fatima, M., Rizvi, A., Ansari, U., et al. (2020). Impact of conflict on maternal and child health service delivery: A country case study of Afghanistan. *Conflict and Health, 14*(1), 38. https://doi.org/10.1186/s13031-020-00285-x

Mistry, A. S., Kohrt, B. A., Beecroft, B., Anand, N., & Nuwayhid, I. (2021). Introduction to collection: Confronting the challenges of health research in humanitarian crises. *Conflict and Health, 15*(1), 38. https://doi.org/10.1186/s13031-021-00371-8

Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science, 10*(1), 53. https://doi.org/10.1186/s13012-015-0242-0

Nilsen, P., & Birken, S. A. (2020). Prologue. In P. Nielsen, & S. A. Birken (Eds.), *Handbook on implementation science*. Edward Elgar.

Norton, A., & Tappis, H. (2024). Sexual and reproductive health implementation research in humanitarian contexts: A scoping review. *Reproductive Health, 21*(1), 64. https://doi.org/10.1186/s12978-024-01793-2

NVivo12. (2021). *QSR.International pty ltd. NVivo (Version 12 Plus)*.

Oliver, K., Kothari, A., & Mays, N. (2019). The dark side of coproduction: Do the costs outweigh the benefits for health research? *Health Research Policy and Systems, 17*(1), 33. https://doi.org/10.1186/s12961-019-0432-3

Palmieri, D. (2012). An institution standing the test of time? A review of 150 years of the history of the international committe of the red Cross. *International Review of the Red Cross, 94*. file:///C:/Users/monpe/OneDrive/Documents/LSHTM%20backup%20documents/LSH258500/ULMO/Assignement/background%20articles/irrc-888-palmieri%20(1).pdf.

Peters, D. H., Adam, T., Alonge, O., Agyepong, I. A., & Tran, N. (2013). Implementation research: What it is and how to do it. *BMJ British Medical Journal, 347*, f6753. https://doi.org/10.1136/bmj.f6753

Ramos Jaraba, S. M., Quiceno Toro, N., Ochoa Sierra, M., Ruiz Sánchez, L., García Jiménez, M. A., Salazar-Barrientos, M. Y., et al. (2020). Health in conflict and post-conflict settings: Reproductive, maternal and child health in Colombia. *Conflict and Health, 14*(1), 33. https://doi.org/10.1186/s13031-020-00273-1

Rass, E., Lokot, M., Brown, F., Fuhr, D., Kosremelli Asmar, M., Smith, J., et al. (2020). Participation by conflict-affected and forcibly displaced communities in humanitarian healthcare responses: A systematic review. *Journal of Migration and Health, 1*.

Sami, S., Mayai, A., Sheehy, G., Lightman, N., Boerma, T., Wild, H., et al. (2020). Maternal and child health service delivery in conflict-affected settings: A case study example from upper nile and unity states, south Sudan. *Conflict and Health, 14*(1), 34. https://doi.org/10.1186/s13031-020-00272-2

Shahabuddin, A. S. M., Sharkey, A. B., Jackson, D., Rutter, P., Hasman, A., & Sarker, M. (2020). Carrying out embedded implementation research in humanitarian settings: A qualitative study in cox's bazar, Bangladesh. *PLoS Medicine, 17*(7), Article e1003148. https://doi.org/10.1371/journal.pmed.1003148

Sibai, A., Rizk, A., Coutts, A., Monzer, G., Daoud, A., Sullivan, R., et al. (2019). North–South inequities in research collaboration in humanitarian and conflict contexts. *The Lancet, 394*, 1597–1600. https://doi.org/10.1016/S0140-6736(19)32482-1

Singh, N., Lokot, M., Undie, C.-C., Onyango, M., Morgan, R., Harmer, A., et al. (2021). Research in forced displacement: Guidance for a feminist and decolonial approach. *The Lancet, 397*, 560–562. https://doi.org/10.1016/S0140-6736(21)00024-6

Truppa, C., Ansbro, É., Willis, R., Zmeter, C., El Khatib, A., Roberts, B., et al. (2023). Developing an integrated model of care for vulnerable populations living with non-communicable diseases in Lebanon: An online theory of change workshop. *Conflict and Health, 17*(1), 35. https://doi.org/10.1186/s13031-023-00532-x

Truppa, C., Yaacoub, S., Valente, M., Celentano, G., Ragazzoni, L., & Saulnier, D. (2024). Health systems resilience in fragile and conflict-affected settings: A systematic scoping review. *Conflict and Health, 18*(1), 2. https://doi.org/10.1186/s13031-023-00560-7

Tyndall, J. A., Ndiaye, K., Weli, C., Dejene, E., Ume, N., Inyang, V., et al. (2020). The relationship between armed conflict and reproductive, maternal, newborn and child health and nutrition status and services in northeastern Nigeria: A mixed-methods case study. *Conflict and Health, 14*(1), 75. https://doi.org/10.1186/s13031-020-00318-5

Wandersman, A., Duffy, J., Flaspohler, P., Noonan, R., Lubell, K., Stillman, L., et al. (2008). Bridging the gap between prevention research and practice: The interactive systems framework for dissemination and implementation. *American Journal of Community Psychology, 41*(3), 171–181. https://doi.org/10.1007/s10464-008-9174-z

Willey, S., Gibson-Helm, M., Finch, T., East, C., Khan, N., Boyd, L., et al. (2018). Implementing innovative evidence-based perinatal mental health screening for refugee women. *Women and Birth, 31*(Supplement 1), S8. https://doi.org/10.1016/j.wombi.2018.08.033. The Australian College of Midwives 2018 "Coming of Age" 21st National Conference. Australia.

Zachariah, R., Harries, A. D., Ishikawa, N., Rieder, H. L., Bissell, K., Laserson, K., et al. (2009). Operational research in low-income countries: What, why, and how? *The Lancet Infectious Diseases, 9*(11), 711–717. https://doi.org/10.1016/S1473-3099(09)70229-4