

Greater than the sum of its parts: Releasing synergies by integrating health and disaster risk reduction



A case study of the Honduran Red Cross
and Swiss Red Cross

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*In memoriam:
Claudio Stauffer, the SRC's deeply committed
country coordinator in Honduras
for 20 years and a pioneer of
community-based DRR programming.*



Acronyms

CODEL	Local emergency committee
DRM	Disaster risk management
DRR	Disaster risk reduction
HRC	Honduran Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
OECD/DAC	Organisation for Economic Co-operation and Development / Development Assistance Committee
SRC	Swiss Red Cross
UNEP	United Nations Environment Programme
UNISDR	United Nations Office for Disaster Risk Reduction
WHO	World Health Organization

Executive Summary

Health and DRR programmes share certain concepts like the perception of risk, vulnerability, resilience, community engagement or capacity building, which constitutes an important potential for synergies. The SRC Strategy 2020 defines health and DRM as the core spheres of its international cooperation activities. Since 2012, the SRC has applied an integrated approach in Honduras, bringing local DRR and health agents together in its efforts to support communities and local authorities in three areas of intervention (Olancho, Valle and Choluteca Departments).

The case study explores the potential of integrated health and DRR programming to release synergies. It aims to understand how health and DRR agents perceive collaboration; what factors influence collaboration between stakeholders at the community and municipal levels, between project teams and communities, and within project teams (health and DRR subteams); what exactly is the added value of an integrated approach; and whether that added value serves to counter international criticism that integrated projects are neither efficient nor result-oriented.

A literature review provided the basis for the development of the conceptual framework and of an interview guide. The conceptual framework identifies the factors and processes at play when DRR and health agents collaborate and how they translate into synergies. Qualitative data were collected in semi-structured interviews with key informants and focus group discussions. They were subsequently analysed using a combination of grounded theory and content analysis. The study population included local health professionals, teachers, authorities, community members, and HRC staff and volunteers.

A range of factors facilitated collaboration between health and DRR agents, both within teams and in the community context. The key supporting factors coincided with those identified in the literature and included reliability and trust, frequent and open communication, a shared vision, leadership, increased human and social capital, and a sense of ownership among all stakeholders in both the process and its outcome. Synergies were released at different levels. Human, financial and logistical resources were better used within project teams and at community and municipal levels. Local entities adopted a more integrated and prevention-oriented perspective on risks and community development, including mutual support and shared responsibility between different community groups. Health and DRR agents were increasingly integrated both vertically and horizontally. Project teams cited shared responsibility for the project as a whole, better planning and harmonization within the team, and heightened visibility as major synergy outcomes.

The study showed that collaboration and releasing synergies were possible even in fragmented systems and resource-poor settings. The lessons learned can be summarised as follows:

- A combined bottom-up and top-down approach facilitates collaboration.
- Stakeholders' ownership of the process and outcome is crucial for successful collaboration.
- Successful collaboration is a prerequisite for achieving synergy.
- Synergy in turn creates an enabling environment for sustainable collaboration.
- Synergy has a high replication potential.

1. Introduction

1.1 Health and DRR

It has long been recognized that the environment, climate and health all influence each other; Hippocrates (460–370 BC) was among the first to note the connection (WHO, 2003). The relationship between disasters and health is inversely proportional. Poor health-care systems exacerbate the magnitude of disasters, and disasters, climate and environmental changes have negative effects on health (WHO, 2003; UNEP, 2005; Bocchino and Burroughs, 2013). In recent years, “health” has been explicitly recognized as both a determinant and an outcome of the human dimension of DRR (Chan and Shi, 2017). At the same time, DRR and health interventions are directly proportional: the more one is implemented in a given area, the more the other will benefit and be strengthened (Bocchino and Burroughs, 2013). Ardalan et al. (2013) have proven that DRR activities administered through primary health-care systems can effectively and sustainably improve disaster awareness and preparedness at the community level.

Health and DRR programmes share a number of concepts – the perception of risk, vulnerability, resilience, community engagement and capacity building – that constitute an important potential for synergies (Bocchino and Borroughs, 2013). Despite the evidence, the DRR and health sectors are very fragmented at all levels (local, regional, national, international), and past policy inconsistencies have hindered collaboration between DRR and health agents (Costello et al., 2009). In keeping with the shift in international frameworks towards more global policy coherence,¹ the two sectors are called on to break down silos and collaborate more closely in order to tackle complex societal and environmental challenges.

The Sendai Framework for Disaster Risk Reduction 2015–2030 highlights concerns about human health and well-being that are also relevant to DRR, climate change and sustainable development. It is a strong advocate for health resilience, making explicit references to health in its targets and proposed actions (UNISDR, 2015). It aims not only to mainstream and integrate DRR within and across all sectors, including the health sector, but also to evaluate the health outcomes of DRR implementation (Aitsi-Selmi et al., 2015).

1.2 Health and DRR in the International Red Cross and Red Crescent Movement

Health and DRR play a crucial role in the strategy of the International Red Cross and Red Crescent Movement. In its Strategy 2020, “Saving lives, changing minds” (IFRC, 2010), the IFRC defined three strategic aims:

- Strategic aim 1: Save lives, protect livelihoods, and strengthen recovery from disasters and crises
- Strategic aim 2: Enable healthy and safe living
- Strategic aim 3: Promote social inclusion and a culture of non-violence and peace

¹ For instance, the Sustainable Development Goals, the Sendai Framework for Disaster Risk Reduction and the Paris Climate Agreement.

The first two aims in particular make explicit reference to the links between health and DRR. Strategic aim 1 encompasses bolstering disaster and crisis preparedness and response, reducing the number of deaths, losses and damages, and accelerating the restoration of community and healthcare functions after disasters. Strategic aim 2 refers to community resilience, the goal being to improve personal and community health, ensure more inclusive public health systems, reduce exposure and vulnerability to natural and man-made hazards, and promote the adoption of environmentally sustainable ways of life.

The SRC refers in its work to the IFRC Strategy 2020. Its own Strategy 2020 for International Cooperation (2013) defines health and DRM as the core spheres of SRC international cooperation activity, in line with the mission to “foster healthy living and improved disaster risk management capacities among particularly vulnerable people and communities” (see Figure 1). In over 30 countries worldwide, the SRC supports the efforts of vulnerable people and communities to build their capacities in the areas of health and disaster risk management, which it considers key to development and poverty reduction.

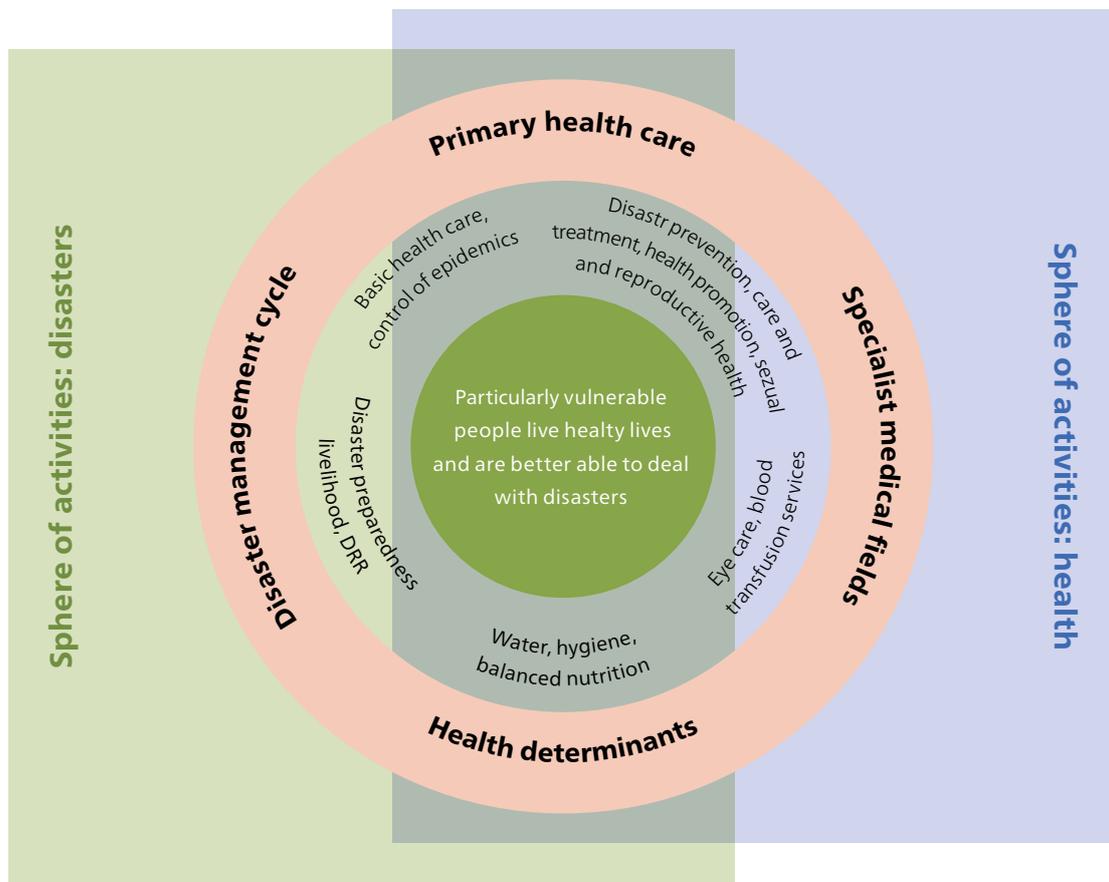


Figure 1: SRC spheres of activity

1.3 Project context

In 1998, in the wake of Hurricane Mitch in Honduras, the SRC provided humanitarian aid and implemented reconstruction projects in cooperation with the HRC and local partner organisations. Since then, the SRC's permanent delegation in the country has engaged in small-scale emergency response and launched development projects in the eastern (Olancho Department) and southern parts (Valle and Choluteca Departments, or the Zona Sur) of the country (see Figure 2).

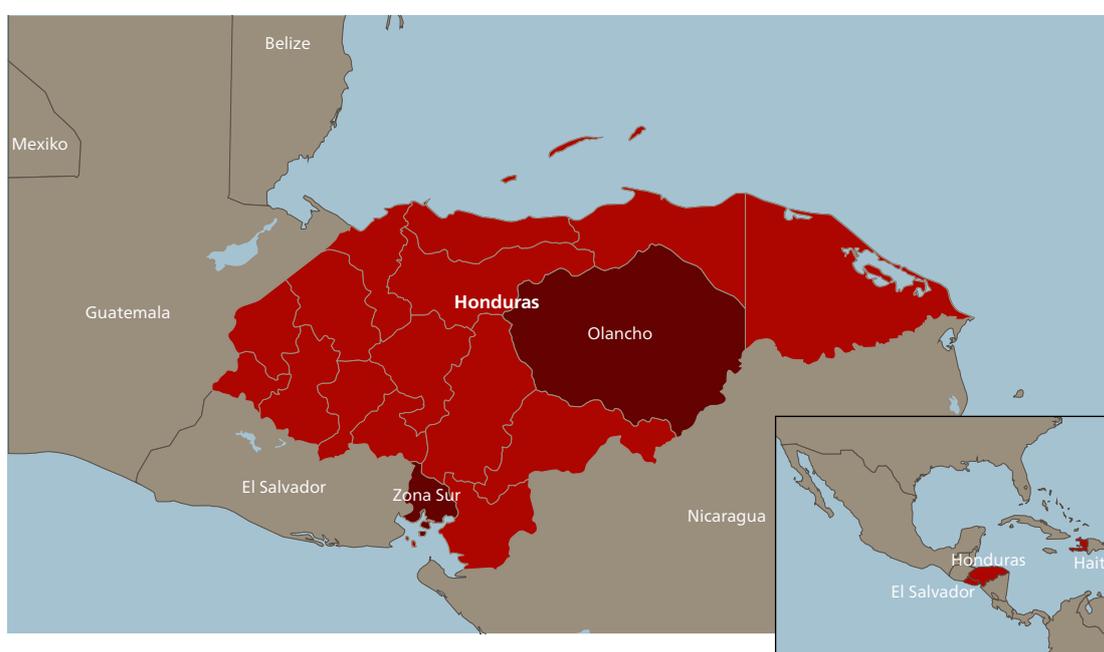


Figure 2: Project intervention areas

The economies of the three project municipalities in Olancho Department (San Esteban, Dulce Nombre de Culmí and Catacamas) are based on animal husbandry, agriculture (corn, beans and coffee, among others) and forestry (principally pine). The department consists mostly of protected rainforest areas that are nonetheless chronically affected by human activity, such as deforestation, over-exploitation of forests, slash and burn agriculture, and inappropriate use of soil on slopes for crops and grazing. It is frequently buffeted by tropical storms and hurricanes originating in the Atlantic. The main natural hazards identified in these municipalities are floods, landslides and debris flows. Health issues include malnutrition, substandard healthcare provision and the worrisome proliferation of vector-borne (e.g. dengue, chikungunya, Zika) and respiratory diseases (e.g. pneumonia, bronchitis, asthma). The project in Olancho initially focused on DRR. Health components were subsequently added based on experience and the lessons learned from the project implemented in the Zona Sur.

The three project municipalities in the Zona Sur (Aramecina in Valle Department, Pespiré and San José in Choluteca Department) are located in the “corredor seco”, an area affected by desertification owing to high temperatures and a lack of rainfall. Severe droughts followed by heavy rains and floods, along with recurrent invasions of pests and outbreaks of disease, hamper the capacity of local farmers to produce sufficient food. Malnutrition and water pollution are two of the main threats to human health. Apart from these health issues, the region has a higher-than-average teenage pregnancy rate and land tenure is insecure. The result is a high migration rate. The project in the Zona Sur initially focused on health, with DRR components being added based on experience and lessons learned from the project implemented in Olancho.

In 2012, both projects embarked on a new phase in which DRR and health were for the first time combined in a single project, albeit as separate components, and existing local DRR and health agents were brought together. Community and municipal DRR and health committees, beneficiaries and HRC volunteers and staff were trained in both DRR and health. In the process, both teams helped each other build capacities in the area in which they had already developed expertise. In 2015, both projects entered into a further phase, with a similar focus, but a different project design, reflecting the ongoing process of integration of health and DRR. The sectors were no longer treated as separate project components; instead, joint targets were set at local, municipal and institutional level.²

Both projects focused on strengthening capacities and developing skills in DRR and health at the local level, including community structures and municipalities, and linking them to the sub-national level. The aim was to increase the resilience of vulnerable people, population groups and communities to risks related to health, climate change and natural hazards. Project outcomes comprised reduced damage after natural hazardous events and epidemics, more efficient disaster response at the local level, enhanced community capacities to manage local risks autonomously and strengthened official capacities as reflected, for example, in increasingly risk-oriented planning and budgeting.

1.4 Study rationale

While implementing the new phase and applying a more integrated approach, the project teams noted benefits at different levels compared to (single) sector programming. Those benefits went beyond the project outputs and outcomes and were similar to those observed in the project area in El Salvador, where the SRC had adopted a similar approach. The question thus arose whether an integrated project approach released synergies and increased efficiency and/or effectiveness, and if so, how. At the institutional level, the questions were oriented more towards obtaining evidence of whether integrated projects had added value, so as to counter international criticism that they were not efficient or result-oriented.

² Before 2015, outcomes typically read as follows: “Communities use increased capacities to prevent, prepare for and respond to disasters and impacts of climate change” or “Communities have increased access to preventive health services and knowledge”. After 2015, they read: “Local capacities at the individual, household and community levels for health protection, risk reduction and adaptation to climate change are strengthened.”

In 2015, the SRC started a learning process to understand how DRR and health agents perceived collaboration, what factors influenced collaboration, and whether an integrated DRR and health approach released synergies and increased efficiency and effectiveness. This report presents the results of a study conducted in the context of this learning process. It focuses on Honduras, as in El Salvador – where a study visit with similar data collection methods was carried out – the number of interviews was considered insufficient to draw conclusions. In general, however, the findings in El Salvador bear out the findings in Honduras presented here.



Joint community campaigning

2. Concepts of collaboration and synergy

There is no universally accepted definition of the term “collaboration”, which is often used synonymously with cooperation and coordination. McNamara (2012) describes cooperation, coordination and collaboration as falling along a continuum.

- **Cooperation:** an interaction between participants with capabilities to accomplish organizational goals, but who choose to work together, within existing structures and policies, to serve individual interests, stands at one end.
- **Coordination:** an interaction between participants in which formal linkages are mobilised because some assistance from others is needed to achieve organizational goals, stands in the middle.
- **Collaboration:** an interaction between participants who work together to pursue complex goals based on shared interests and a collective responsibility for interconnected tasks which cannot be accomplished individually, stands on the other end of the continuum.

Collaboration is complex and influenced by various factors (Patel et al., 2012). Several studies have identified elements that are essential for successful collaboration. According to Mayer and Kenter (2015), collaboration is characterised by nine key components: communication, consensus decision-making, diverse stakeholders, goals, leadership, shared resources, a shared vision, social capital and trust. Based on a literature review, Mattessich and Moseny (1992) identified a total of 19 factors that influence collaboration. Among the most frequently cited are mutual respect, understanding and trust, an appropriate cross-section of members, members sharing a stake in both process and outcome, multiple layers of decision-making, open and frequent communication, and a history of collaboration or cooperation in the community.

The aspect of mutual dependency between stakeholders to achieve a shared goal is also present in Corwin’s definition of collaboration as “individual partners desiring to work together towards a common aim, to achieve an output beyond the reach of partners’ individual efforts” (Corwin et al., 2012). This definition builds on the concept of **synergy**, which is defined as the combined effects resulting from the interaction of two or more organisations or agents that are greater than the sum of their separate effects (Oxford English Dictionary, 2018). Autonomous stakeholders collaborate in order to produce synergy.

The Bergen Model of Collaborative Functioning (see Figure 3) is based on research on collaboration in the health promotion sector (Corbin, 2006; Corbin and Mittelmark, 2008) and offers a systems model of understanding collaborative interactions. It describes the inputs (e.g. partner resources, financial resources, a shared mission), the collaboration itself (influenced by leadership, communication, roles and structure within the collaboration), the outputs, and the interactions between those components.

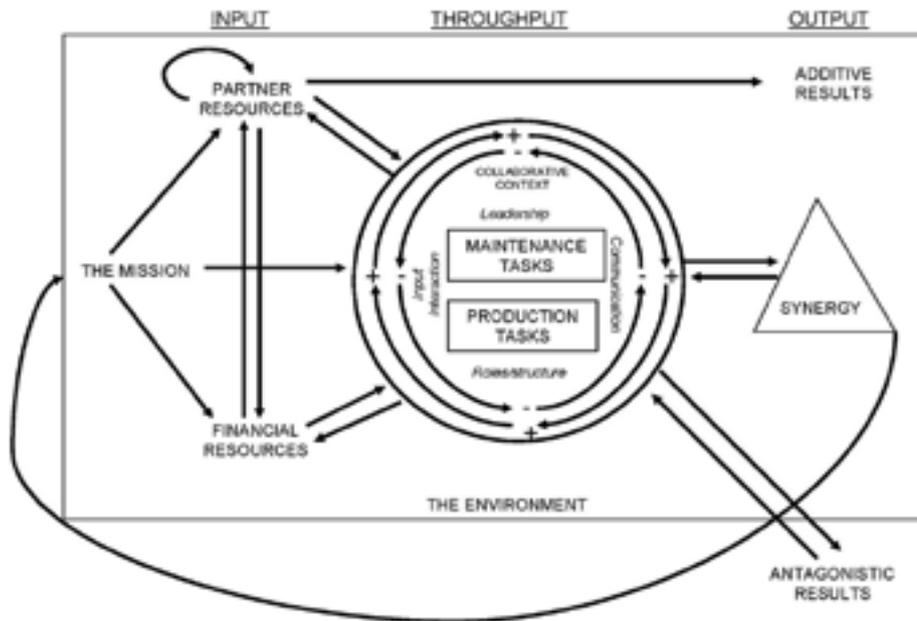


Figure 3: Bergen Model of Collaborative Functioning

Three different types of output are possible:

1. The collaborative context has no impact at all and partners accomplish no more than they would have on their own – the output is additive.
2. The collaboration does not accomplish its goals; time, energy and money were wasted – the results are antagonistic.
3. The collaboration is successful in combining partner and financial resources for a common goal to create something that was otherwise not possible – synergy is achieved.

3. Methodology

The methodology comprised three phases (see Figure 4), each with several steps, described in the sections below.

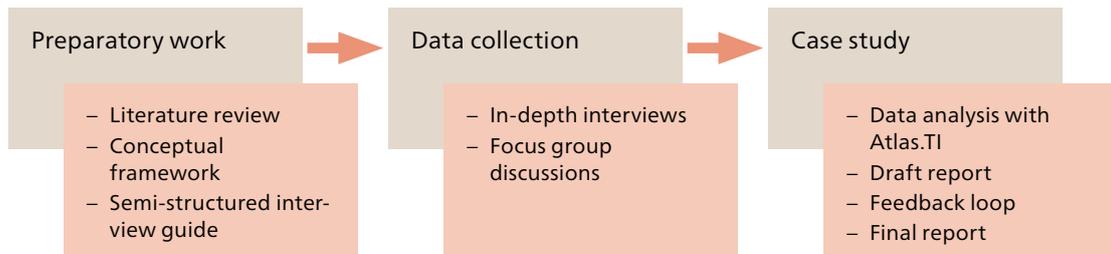


Figure 4: Case study methodology

3.1 Conceptual framework

For this case study, the authors used a simplified Bergen Model of Collaborative Functioning and adapted it to the local project context, producing a conceptual framework (see Figure 5) whereby collaboration occurs within the project teams (health and DRR subteams), within the local and municipal community context (health and DRR committees, other stakeholders), and between the project teams and communities. Synergies are thus released both at community and team level. As the results reached through synergy go beyond the additive outputs of each stakeholder, it is assumed that synergy increases efficiency³ and/or effectiveness⁴. The outcome of the collaboration in turn affects the functioning and future inputs thereof.

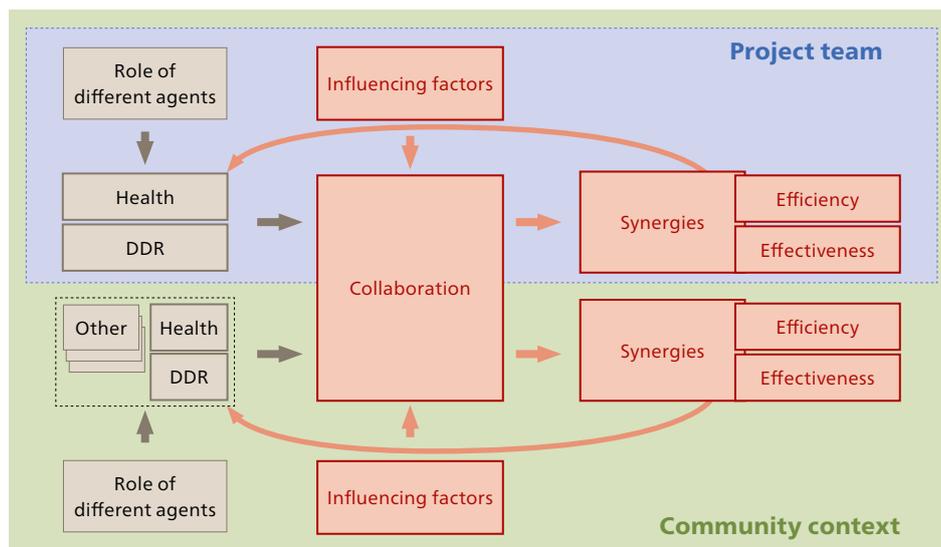


Figure 5: Conceptual framework

³ "A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results". (OECD, 2019).

⁴ "The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance". (OECD, 2019).

3.2 Data collection

The authors conducted a literature review encompassing project documents and scientific literature on collaboration and synergies in general, and in the areas of health and DRR in particular, before developing the conceptual framework and a semi-structured interview guide.

Qualitative data were collected in semi-structured interviews with key respondents and in focus group discussions. The semi-structured interviews covered pre-defined topics and gave respondents the opportunity to provide information they perceived as important. Once they had completed their fieldwork, the authors verified their preliminary findings with the project teams.

The interviews lasted between one and two hours. They were conducted in Spanish and recorded. Before starting the interviews, the authors informed the participants about the aim of the study and obtained oral permission for recording and filming. All user information was treated confidentially. Only the authors had access to the results. Participants had to state whether they agreed that anonymous quotes and the video material could be published and all gave their consent.

A second feedback loop with the SRC project teams took place after the results had been analysed. The draft report was translated into Spanish, giving the teams the possibility to reflect on the results and incorporate important aspects regarding collaboration and synergies that had emerged only after the data collection period.

3.3 Study population

The study population consisted of local health professionals, teachers, health and DRR authorities at the local level, community members, and HRC volunteers and staff. The authors used purposive sampling and selected individuals based on their knowledge and experience.

Fourteen focus group discussions were held with 99 participants (45 female/54 male), five in-depth interviews were held with seven SRC project managers (2 female/5 male) and two group discussions were conducted with SRC project team members (11 female/10 male). One of the focus group discussions was not included in the analysis due to a recording error. The result is a total of 20 interviews/groups. For reasons of readability, the term interviewees is used here to refer to both respondents in in-depth interviews and focus groups (1 focus group = 1 interviewee).

3.4 Data analysis

The authors transcribed all taped interviews and entered them into ATLAS.ti 7 for analysis and coding. All interviews were analysed in Spanish and only the results translated into English.

The data were analysed using a combination of grounded theory and content analysis. In grounded theory, researchers look for patterns and categories in the text and link them to theories, while in content analysis they look for themes and patterns that will confirm a hypothesis (Bernard, 2000).

3.5 Methodological constraints

The study had several limitations. Purposive sampling may have excluded some interest groups. The fact that the interviews were conducted by SRC personnel may have produced a certain bias in the interviewees. Owing to time constraints, only a limited number of interviews and focus group discussions were organized and data triangulation was not possible. As interviews and site visits were conducted mostly in communities where experiences had been successful, information on factors that hindered collaboration in less advanced or non-targeted communities is missing. Hence, the findings may be person- and/or context-specific.

Classes in nature



4. Findings

The findings are aligned with the conceptual framework (see Figure 6). Sections 4.1 and 4.2 below describe the factors that facilitated or hindered collaboration on integrating the DRR and health sectors. Sections 4.3 and 4.4 analyse the synergies produced by the collaboration, focusing on effectiveness and efficiency, and the challenges to synergy. The influencing factors and synergies produced could not always be clearly differentiated, however, as they were closely interrelated in an iterative circle and mutually influenced each other.

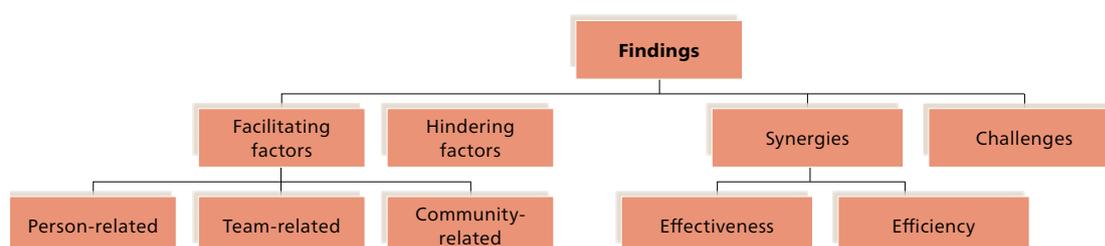


Figure 6: Alignment of the findings

4.1 Factors facilitating collaboration

Collaboration between health and DRR agents, both within teams and in the community context, was facilitated by diverse factors, the most frequently mentioned being person-related factors, followed by team- and community-related factors.

4.1.1 Person-related factors

All stakeholder groups referred to the following factors. A majority of interviewees highlighted the **willingness to reproduce and share the knowledge** gained in training with others as an important prerequisite for successful collaboration. Knowledge was thus transferred from the team to the community, between community members, within the team and to other people such as HRC volunteers, health staff and teachers. Knowledge transfer was also predicated on the willingness of persons to accept new knowledge, which was strongly influenced by the relationship of trust created between the project team and the communities. **Trust** was therefore cited as an important factor by many interviewees, in line with those who considered the **reliability of the Red Cross** as a partner as a major reason for successful collaboration.

Leaders that have improved capacities and that are working together can organize and guide people. When a person is perceived to do things well, and he or she fulfils his or her responsibilities, people trust in that person.

Community focus group, Olancho

Some interviewees mentioned **working for the benefit of the community** as their motivation for working with others. Some had a **personal interest** in a topic or in the region they lived and/or worked in, and had the feeling that networks and coordination helped them to advance the issue at stake (development in general, DRR and public health in particular). Others had an **urge to learn** and to develop their capacities to advance their economic situation or to become a respected member of the team. Volunteers and team members felt that they had a certain **responsibility** as Red Cross members, while some community members identified with the project and felt a certain responsibility towards the Red Cross.

4.1.2 Team-related factors

For the project teams, the most important factor facilitating collaboration was that the projects themselves were **designed with integration in mind**, meaning that the integration of DRR and health was reflected in the project logical frameworks.

We changed our logical framework. The synergies reflected in the design are because we start from combined expected outcomes. At a glance, we see that in one outcome we focus on community strengthening, health, and disaster risk issues. That in itself says we must address [these issues] in a comprehensive manner.

Red Cross staff, Olancho

This conceptual integration was community-driven and resulted from a bottom-up project planning approach; it was therefore partly based on problematic experiences – coordination difficulties, logistical concerns (i.e. difficult conditions of access to remote places), the time burden, particularly for community promoters – from the previous project phase, when the two topics were treated separately. The interviewees also stated that their supervisors – up to headquarters level – played an important role in promoting an integrated project approach.

Capacity building across sectors for team members not only improved coordination within the team, it helped to create a shared vision enabling the team to come up with more integral and sustainable solutions. It also helped to transfer this spirit of collaboration to the communities. A couple of interviewees considered that **collaboration reduced conflicts** within the teams, which was a further source of motivation to work in an integrated manner. Some also mentioned that **new technologies**, such as smartphones, facilitated team communication and project monitoring.

4.1.3 Community-related factors

An important factor facilitating collaboration within the community was that community members received **joint training** in DRR and health, bringing together different community structures at the capacity-building stage. This was well perceived, especially by small communities



with limited human resources for leadership. For small communities, the integrated approach was particularly welcome, and the prospect of achieving a **higher impact**⁵ was an important incentive for collaboration. Several interviewees said that DRR and health committee members often already had other commitments in the community and assumed some form of leadership role (e.g. teacher, priest, pastor). One focus group mentioned that a crucial characteristic of committee members was the **willingness to contribute and share their knowledge** with the community, and that they were elected on the assumption that they would use their position for the benefit of the whole community.

[The membership of people in several committees] has not created a problem, but it is part of the willingness to participate in everything, they are not there to receive a personal economic benefit, you see the participation and the collaboration, and the community is aware of the benefits you have with this management. For the organisation, leaders are sought because they motivate the communities, but also people outside the committees are involved.

Red Cross staff, Olancho

Many interviewees stressed that **supportive local authorities** facilitated collaboration. Some explained that the authorities were supportive because institutional players had agreed on what the area's problems were. Others stated that the municipal authorities had previous experience coordinating work with other stakeholders. According to interviewees from the Zona Sur, the establishment of **crosssectoral roundtables** involving governmental and non-governmental entities at the regional level considerably facilitated collaboration.

Interestingly, although it was mostly community agents at local and municipal level who felt the need for closer collaboration between the health and DRR sectors, it was the project that drove the momentum therefor. According to team members, authorities and HRC volunteers, **the two projects** significantly stimulated coordination between health and DRR agents and the objective to work in a more integrated manner in the communities.

⁵ E.g. community empowerment, increased ownership, behaviour change, joint solutions etc. (see Section 4.3.1 below).

A few interviewees stated that, for them, **the tangible results** of the project activities were a particular motivation for working collaboratively. Particularly for the authorities, **working with scenarios**, e.g. on the possible epidemiological situation in the municipality, was helpful to motivate people to collaborate.

Other supporting factors included the possibility to **work jointly** on a politically uncontentious issue, which was said to help reduce conflicts in the community, and radio communications, which greatly facilitated coordination with others.

Many stakeholders recognized the value of joint planning to encourage a **joint vision** for the area. This shared vision, expressed in a language shared by both DRR and health agents, helped to spread knowledge and, together with the factors mentioned above, to create trust. This in turn positively influenced collaboration. The successful experience of collaboration had a big impact on the motivation of all stakeholders.

Working together is better because people are more responsive and comply better with the recommendations.

Community focus group, Olancho

4.2 Factors hindering collaboration

Not surprisingly, most of the stated factors hindering collaboration concerned the absence of the abovementioned facilitating factors – **lack of trust, no means of communication, or silo thinking**. Four interviewees identified the fragmentation between different sectors such as health, DRR or education, across all administrative levels and, in the past, within project teams, as a major cause of faulty coordination and exchange of information. While interviewees saw the authorities as important for collaboration, they also saw them as major obstacles (in cases where decisions were taken top-down) and as a hindering factor; e.g. **high political turnover** meant a huge investment in building up knowledge and confidence at regular intervals with new representatives.

Another hindering factor identified was the **differing level of relevance** that communities attributed to DRR and health: not all communities are equally exposed to natural hazards or vulnerable to health problems.

According to one interviewee, the new way of working also created scepticism or fear in the team, and joint planning, exchange of information within the team and reporting to a supervisor could create conflicts. That fear, however, was a distraction rather than a hindering factor.

Finally, but importantly, some interviewees stated that the overall **socio-political context** of a region had a major influence on how a project evolved. In the Zona Sur, DRR and health sector

agents, together with other stakeholders, acted more **paternalistically** than in Olancho. They were more likely to make donations rather than increase community capacities and tackle structural problems, meaning that they were more likely to remain within their sector.

4.3 Synergies

Synergies express themselves as either increased effectiveness or greater efficiency. Increased effectiveness may be visible in a community, team or individual, or be object-related. Many of the aspects of synergy discussed in this section are not only the result of collaboration, they are themselves important supporting factors for collaboration.

4.3.1 Effectiveness

One effect of collaboration mentioned by a majority of respondents was the **increased horizontal integration** of community structures through joint training and activities. DRR and health committees, but also other local organisations such as education and water committees, had previously worked as separate entities. After attending joint training in DRR, health, environmental issues and management of a community organisation, they started collaborating closely on planning and implementing joint activities. Fewer, but still a majority, also noted that **vertical integration**, i.e. the linkage of community structures to municipal or higher structures, had improved. A majority of all stakeholders mentioned that more information was exchanged as a result of the horizontal and vertical integration, and of the shared objectives.

According to a majority of respondents, all stakeholders **addressed human and environmental health more holistically** and no longer as separate topics. This had an impact at different levels (personal, community, team and object) and was a crucial prerequisite for behaviour change. People gave concrete examples of situations in which DRR and health converged, such as preparedness and response to epidemics and disasters, education, resilience, or protection of health facilities from natural hazards.

A few respondents said that the **Red Cross gained legitimacy** in the communities through the successful experience of collaboration.

At community level

According to the majority of interviewees, the most important outcomes of collaboration were **community empowerment and behaviour change** in terms of how to address risks related to health, climate and natural hazards. Through collaboration, communities strengthened their structures. Not only were health and DRR committees more committed to the community in their respective field of expertise, they also stepped up their **joint efforts** and **included other community structures**, such as water committees and the education system, in order to have a higher impact in the community. It was now common to see all community structures working

jointly on relevant health, environmental or DRR issues. Accordingly, those structures had become more assertive, had a greater impact on community members and authorities, and were important agents of change.

Before as CODEL, we had to carry out reforestation campaigns on our own, but now that has changed because we are united as CODEL, Health Committee, Water Board, Youth Committee and School DM Committee – it is nice to know that we are not alone in this effort and it is nice to work together for the benefit of our environment.

CODEL member, Olancho

Now [community members] do not seek you anymore as a Red Cross technician to tell them that their house is in a risk zone, but rather they turn to the DRR committees. You can see the empowerment of these people; they know that there is a committee in the community that assumes this role. The DRR committees ask us for advice, which is motivating, because they are aware that the project at one point can end, but they already have the qualifications and the will to work for the community.

Red Cross focus group, Olancho

A majority of interviewees observed that the different committees developed a sense of **ownership** and that their activities went from being **responsive to preventive**. Communities and authorities became more aware of the negative impact, for example, of uncontrolled slash-and-burn techniques, deforestation or the use of agrochemicals. They were acting more sensitively in terms of the interrelation between health, environmental issues, climate and natural hazard risks and the need for more sustainable resource management, including the protection of micro watersheds, increased use of agroforestry systems and ecological orchards. Interviewees believed that the incidence of vector-borne, water-borne or respiratory diseases had fallen and that the environment overall had improved. In some cases, holistic thinking advanced to a degree where one committee implemented the tasks of the other and vice versa.

For us as a municipality, to have the Red Cross visualizing the range of situations that generate risk and vulnerability in the population, training us, and raising awareness through reforestation programmes, is very helpful. The local emergency committees have been carefully monitoring fires, observing the protection of watersheds, reforestation, what has to be done in specific cases where water is polluted through livestock or coffee cultivation.

Community focus group, Olancho



Various interviewees highlighted that community members, committees and communities were giving each other **greater mutual support**. In addition, one community member affirmed that working together had increased the committees' credibility in the communities, and a few stated that collaboration had contributed to **conflict resolution** in the communities.

Not only community players, but also municipalities and HRC volunteers felt empowered, and both groups said that collaboration enabled them to **access additional funding**.

At team level

Like the communities, the teams said that collaboration had added to the effectiveness of project interventions and that **mutual support** among team members had increased. They felt a shared responsibility for the project as a whole and not only for one component of it. Thus, they also valued the development of capacities in both DRR and health.

Within the project, we are coordinated. [The community members and Red Cross volunteers] can come to me even if I am not from the DRR team, and ask me a question, and I can help. This integration makes us stronger as a team, we support each other, and this makes us more trustworthy as a team. When we see situations in the field that concern DRR we give indications on how to do the follow up, and then we inform our colleagues from the DRR team what we identified. We do not behave like islands, we work together.

Red Cross health staff, Zona Sur

Before, in the family visits, I focused only on the risks by landslides and floods that a family could have. Now I feel also confident to discuss other issues with the families, e.g. if there are breeding grounds of vectors, if they manage to keep their house clean, if they practice the measures of self-care, if they take care of the water. Well, we exchange on everything related to the health and environment and the visits become more pleasant for us and for them.

Red Cross DRR staff, Olancho

Interdisciplinary cooperation often resulted in a joint presence in the communities. In a fragile and conflict-affected context, as was the case particularly in Olancho Department, this led to **increased security**, which was perceived by the team members as a very positive secondary effect.

Team members from the Zona Sur considered **better planning** and **increased harmonization** within the team as important outcomes. They also said that collaboration had made their work **more visible** to other stakeholders, which may be an important factor when it comes to scaling up the collaborative approach.

New and established team members had to be open to learning new methods, tools and ways of working. Several members noted that integration of the components into one project had led to **improved achievement of results**. The integrated approach helped the project teams to be more result- rather than activity-oriented. Several team members observed that the teams started looking increasingly for synergies when planning and implementing activities. Thanks to the internal learning process fostered by the integrated project approach, team members not only broadened their capacities, they also deepened their professional skills in their respective area.

At object level

Many interviewees cited activities that led to several outcomes, often in both the DRR and the health spheres, as important synergy effects. Among the examples they mentioned were the **cleaning campaigns**, which improved surface water runoff and thereby reduced the risks of flooding and of vector proliferation, and the improved biomass **cooking stoves** that reduced the number of trees chopped for firewood and the prevalence of respiratory diseases, particularly among children. Those activities were often spontaneously replicated by other community members who were not involved in the projects.

The most frequently replicated activity involved **soil bioengineering** for slope stabilisation and soil retention to protect homesteads. Over time, those measures were combined with a family garden and the recovered spaces used to grow fruit trees, medicinal plants and vegetables for consumption or sale. This had a positive impact on DRR and health, and also generated economic opportunities.



Converting zones at risk into areas of opportunity

With the soil bioengineering measures, we have more nutrition because the stabilised slopes are used as family gardens, which contributes to our health. Before we could see many cases of malnourished children. Now, with the approach to use these measures as a means to maintain health, to keep children nourished, you can see the change in communities, you do not see so many malnourished children anymore.

Red Cross staff, Olancho

The authorities recognized that new, more environmentally friendly production systems such as ecological agriculture and agroforestry could contribute significantly to development in their jurisdictions. They also recognized the added value of working collaboratively and engaging in networks in order to address their challenges.

In one way or another, the above-mentioned effects often also came into play at the **individual level**. A majority of interviewees from all stakeholder groups stated that they had increased their individual **capacities** related to DRR and health, and that this had **changed their behaviour** and led to similar behaviour changes in other members of the communities/teams.

For many interviewees, the knowledge gained in the course of the project was not only beneficial but also **motivating**. Several interviewees confirmed that they were more aware of the complex factors contributing to vulnerability. A few interviewees (team members and HRC volunteers) stated that recognition of one's work by others was a significant reward and a major motivating factor prompting them to continue working for the benefit of the community.

4.3.2 Efficiency

There were several statements indicating that collaboration had increased efficiency.

For the teams, this meant mostly that they were able to make **better use of the available human and financial resources and logistical means**, thanks to cross-sectoral capacity building. A team member with knowledge of both health and DRR could provide training in both areas

and would be able to identify possible problems in the communities and report back to the other team members. This reduced travel costs and opened opportunities to increase coverage.

Communities perceived joint training as **reducing pressure on community human and time resources**. This was particularly the case in smaller communities, where the same people were often engaged in both DRR and health committees. It was observed mostly by team members, but was confirmed by authorities and HRC volunteers.

According to various interviewees, coordination and cooperation expanded the reach of Red Cross and municipal interventions. Several interviewees said that working together constituted a means of **overcoming logistical and financial problems**. The authorities said that collaboration with the Red Cross and other stakeholders allowed them to **increase their outreach** with the available funding. Some community representatives pointed to the greater efficiency resulting particularly from increased community health capacities compared to the long waiting times previously typical for health centres.

4.4 Challenges

Only very few interviewees indicated aspects they believed showed how non-collaborative work translated into results that were merely additive or even antagonistic, or where they saw limits to the concept of synergies. Before DRR and health were integrated at project level, exchanges with team members were limited to those working on the same topic, and knowledge about what the other team members were planning and doing and the general exchange of information were reduced. This even led to a kind of competition between DRR and health teams, with each team striving to conduct more activities than the other, without taking into account the needs of the communities.

Some respondents stated that, although most team members now had knowledge of both DRR and health work, it was misleading to think that everyone could do everything. The idea was not that a DRR team member could completely replace a health team member and vice versa, but rather that they could generally work together while addressing tasks requiring highly specialized knowledge in a separate and complementary manner. In addition, one person, noting that team leaders had a fairly heavy workload, said that while collaboration could improve efficiency in planning and implementation, it could also increase the pressure on individuals who had to bear more aspects in mind.

Some team members noted that, while greater collaboration had a positive impact at community level, articulating and aligning emergency plans and the wider prevention agenda within all the community structures involved (and subsequently at the municipal level and with other strategic partners) was a challenging task for those involved and needed greater impetus from the project team. Furthermore, consolidating the synergies released at the municipal level and

4. Findings

with strategic partners, neither of which had necessarily gone through the same process of changing from a reactive to a preventive approach, still required constant and further input from the communities and project teams alike.

According to some team members, community expectations had increased with respect to the thematic focus of the projects: if integrating DRR and health (including water, sanitation and hygiene activities) worked so well, why not add other important sectors such as education, agriculture and economic support? In fact, working collaboratively allowed community agents and the project teams to look at the processes more holistically. They perceived the need to search for integral and more sustainable solutions and to create the new structures needed to strengthen the process. While encouraging the communities to act and mobilise on any of these issues, the project teams could not provide direct support, and acting as facilitators did not yield immediate results owing to the lack of appropriate agents in these remote areas.



Lesson learning at different levels

5. Lessons learned

A combined bottom-up and top-down approach facilitates collaboration.

The integrated programme approach responds to local realities and needs and must be supported by institutional leadership. This creates the enabling environment for project teams to develop cross-sector capacities and increase their personal and professional flexibility. Project teams and communities are interconnected through a shared vision (e.g. strengthened resilience of communities) to which both contribute. Project teams help key individuals improve cross-sectoral collaboration between community groups and committees so that they can assume the role of community leaders and become major agents of change.

Stakeholder ownership of process and outcome is crucial for successful collaboration.

For different agents from various sectors to feel committed to collaboration, they need an enabling environment. A shared vision, a common language, and open and frequent communication are key to the trust-building process. If everyone contributes to the process and has a stake in the outcome, they will in turn develop a strong sense of ownership. Development cooperation programmes can further this process by taking the time to identify supportive leaders and applying a participative and inclusive approach and capacity-building process.

Successful collaboration is a prerequisite for achieving synergy.

The findings of the case study largely confirm the literature with regard to the concepts of collaboration and synergy. Frequent and open communication, clear roles and structures, formal and informal leadership combined with trust and social capital are decisive for a synergetic outcome of collaboration.

Synergy itself creates an enabling environment for sustainable collaboration.

All stakeholders in the study area perceived the synergies achieved through collaboration as positive, successful and huge sources of motivation to continue working collaboratively. This expands the scope for sustained action. Development cooperation programmes can foster this by promoting measures that create direct and multiple benefits across sectors (e.g. improved cooking stoves, soil bioengineering). These are “low hanging fruits” that offer a good entry point for stimulating collaboration.

Synergy has a high replication potential.

The findings of the case study reveal that community members and communities that were not part of the project spontaneously replicated many of the measures providing multisector benefits, in particular the conversion of critical sites into areas of opportunity through soil bioengineering combined with family gardening. Even neighbouring municipalities started to replicate the integrated approach. Development cooperation programmes should keep this in mind and ensure such measures are highly visible at the regional level.

6. Conclusion

The study shows that, even in fragmented systems with scarce resources (in terms of finance, but not of time invested in the integration process), collaboration is possible. It also shows that successful collaboration can release synergies, resulting in improved community and team effectiveness and efficiency, and in better use of human, financial and logistical resources. Mutual support and shared responsibility across project subteams led to a more results-oriented way of working, and the focus of team members shifted to potential synergies. Communities were empowered. Community DRR and health committees became proactive agents of change in the face of risk, moving from responsive to preventive behaviour.

Development agents can support and should promote an integrated DRR and health approach bearing in mind the key facilitating factors.



Agents of change in the community

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