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Health system governance cooperation with unrecognised health authorities: a political economy analysis in Afghanistan and Northwest Syria

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Abstract

Background The government is normally the leading actor in health system governance, yet in some conflict-affected contexts, government or equivalent health authorities are not formally recognised by the international partners who co-finance the health system. This study considers what has inhibited or facilitated cooperation between two types of non-recognised health authorities and international partners in Afghanistan from 2021 to 24 and Northwest Syria from 2013 to 19.

Methods A literature review was combined with 14 semi-structured key informant interviews, mostly with representatives (often health advisers) of donors or UN agencies. A political economy analysis (PEA) analytical framework was used, focusing on the capacities, incentives, beliefs, institutional and structural factors that influenced the behaviour of the key health system actors.

Results Although widely cited as a critical barrier, the lack of formal recognition was not the main constraint on cooperation. The in/stability of the conflict context, the likelihood of survival of de facto health authorities, the extent to which there were clashing norms between actors, and the incentives and 'ways of doing things' of both unrecognised authorities and international actors also played key roles. For example, in Afghanistan, the Taliban's approach to women's rights and education was identified as the major barrier to cooperation. In Northwest Syria, on the other hand, establishing health governance bodies that were strongly technical in focus and claimed functional independence from sanctioned ruling militias significantly boosted cooperation and protected the health system. Most interviewees felt there was more room for international actors to work with unrecognised health authorities within the "red lines" of international law and organisational mandates, using promising entry points such as supporting Human Resources for Health. There was significant agreement between authorities and international partners on the core health system strategies and priorities in these contexts. But health authorities wanted – and aid cuts suggested they should take – more control over financing and management, and they were naturally more focused than international actors on the holistic needs of the health system, beyond 'emergency' assistance.

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Conclusions International partners and de facto authorities can both take action to use more of the operational space for cooperation.

Background

Cooperation on long-term strategic goals between different stakeholders was identified as one of the key mechanisms through which health systems governance could improve health outcomes in a 2019 evidence review of Health Systems Strengthening in low and middle-income countries including fragile and conflict-affected states [1]. The government is normally the leading actor whose stewardship ensures sustainable health system development, alongside health service providers, service users, and civil society [2] as shown in Fig. 1.

There are significant risks of donor non-cooperation with governments during humanitarian response, including the creation of "parallel systems" by humanitarian health governance [5], health sector fragmentation [6], and setting back health system strengthening in the longer term. But in some conflict-affected, protracted crises, from Yemen to Syria to Afghanistan, counterpart 'government' or equivalent authorities have unrecognised or uncertain status amongst the international partners who co-finance the health system.

Unrecognised authorities are those that exist in reality, but are not recognised internationally, either as members of the UN or by other countries bilaterally. They may be non-state or secessionist actors, actors with "state-like" structures [7], or the sole actors who control the state apparatus at country or sub-national level. There are a growing number of countries where the UN, multilateral investors, and bilateral donors have to engage with unrecognised authorities, and a growing interest in understanding this type of engagement in humanitarian assistance [8]. But there is no system-wide policy for engaging with these groups [7] and different international health actors deal with different unrecognised authorities in different ways.

In theory, international health actors and unrecognised authorities share a long-term interest in cooperating, to ensure better health services and outcomes, health security, localisation of aid and health system sustainability. In practice, they often struggle to cooperate.

Aims of this study

This study explores the factors that have inhibited or allowed international cooperation with two different types of unrecognised health authorities. It asks where key international health actors and these unrecognised authorities have agreed or disagreed on health system priorities, where they could or could not cooperate, and

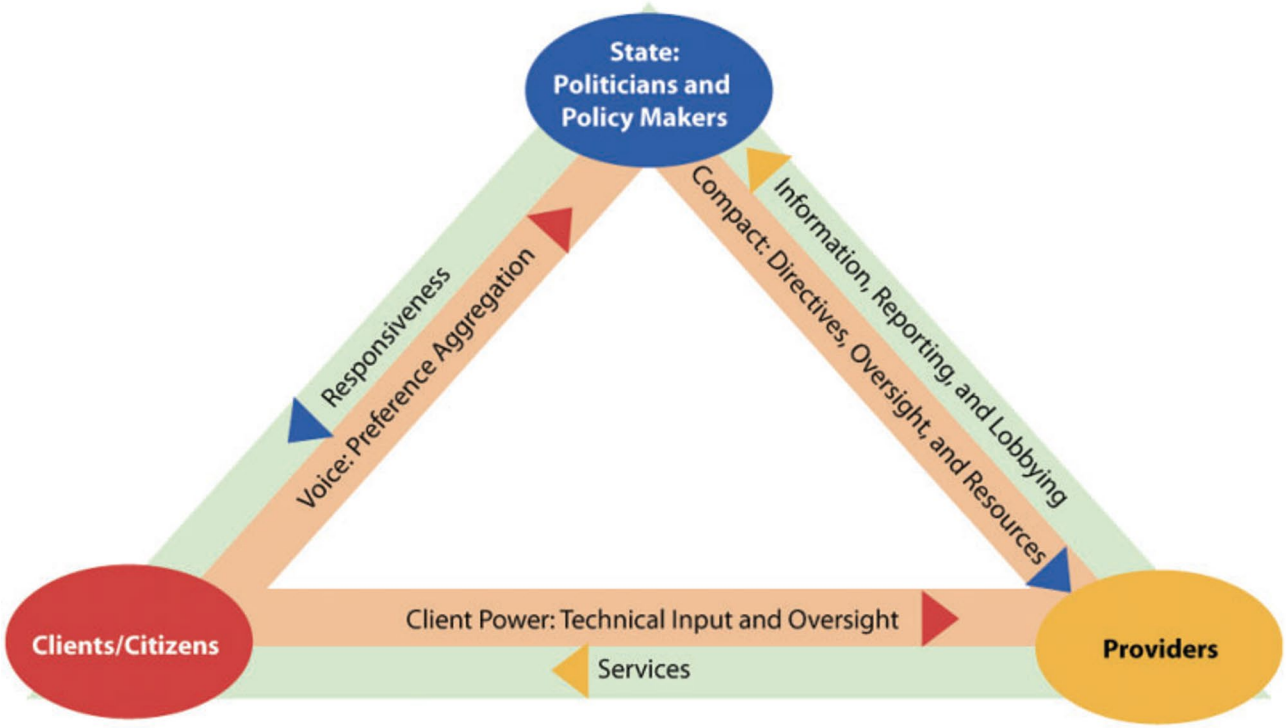

Fig. 1 Health Governance Framework. Source: Brinkerhoff & Bossaert 2008, drawn from World Development Report 2004 [3, 4]

why. It aims to provide useful findings and recommendations for health sector donors, responding agencies, and unrecognised authorities.

Methodology

Policy problems in which actors struggle to cooperate on goals which they theoretically share are well suited to Political Economy Analysis (PEA) [9]. Although there has recently been more use of PEA in health systems research, particularly on financing [10, 11] — including a WHO guide [12] — there have been calls for it to be used more widely [13]. Drawing on a long history of scholarship and debates, particularly in the field of New Institutional Economics, international development donors have widely used PEA in a more applied fashion. In the UK, for example, the Foreign, Commonwealth and Development Office encourages the use PEA in considering feasible pathways of change in aid programme design. Multiple donor-commissioned PEA guides are available. Most applied PEA frameworks consider the way policy outcomes are influenced by actors' interests, power, and beliefs, institutional laws and practices, and longer-term structural factors. They have often focused only on local actors, but here we include international actors in the analysis, since they themselves affect the political economy of aid-dependent health systems.

We have drawn on these applied PEA guides to develop a framework focused on the key actors - unrecognised authorities, donors, UN agencies, and providers of health services, asking how their room for manoeuvre and cooperation is expanded or constrained by:

a) **Structural and contextual factors**: such as the existing strength of the health system inherited or operated by de facto authorities, and the dynamics of the conflict.
b) **Formal or informal norms and practices**, **beliefs**, **and behaviours**: the formal and informal "rules of the game" or entrenched "ways of doing things" that structure the key actors and their behaviour.
c) **Actors' power and capacities**: including their control over territory and access to health service users, ability to govern, perceived legitimacy, technical capacities and access to finance and resources.
d) **Actors' interests and priorities**: including their stated health policy priorities, and the role they seek for themselves in the system. These factors also include the (sometimes conflicting) financial and organisational interests that different actors have.

This study compared two different contexts:

- ***Afghanistan 2021–2024*** after the Taliban took control. This was a country in which there was now little active conflict, and the authorities were in control almost everywhere, lacking realistic challengers;
- ***Northwest Syria 2013-19*** from the year in which the health authorities we discuss were created to the time when Assad's forces regained significant territory - the period when the health authorities of interest were most active. It was a period of significant active conflict in this region of Syria, with many contesting claims on legitimate governance, including Hayat Tahrir al-Sham (HTS), which has now taken control of Syria as a whole, and which ruled in Idlib from 2017.

These were drawn from a longlist of contexts, including Yemen, Somaliland, and Sudan, which were included in the literature search. The two contexts were selected because (i) they yielded much more literature, and more interviewees were available through author networks; (ii) they provided contrasting examples where authorities were unrecognised for different reasons, and (iii) the question of how to cooperate on health system strengthening was a 'live' one, remaining critically important for international actors and health authorities.

A broad literature review was conducted to find studies that included some mention of health systems, policy, services, programming or coordination involving unrecognised authorities internationally and in the two selected contexts. Semi-structured interviews were conducted online on Zoom or on WhatsApp in the summer of 2024 with 14 key informants - seven each on Afghanistan and Syria - identified through the authors' personal networks, and through snowballing. Four interviewees were Syrian, three were Afghan, and the remainder were from multiple countries. Ten were donor or UN representatives, two were expert researchers, one was a former member of an unrecognised authority, and one was a provider of health services. Six were women and eight were men. Interviews were recorded where permission was given, and detailed transcripts were made of each interview. Interview transcripts and the studies included in the literature review were analysed in Nvivo 14 using the same PEA framework.

Limitations

A major limitation of this study is that the voices of both unrecognised authorities and service providers have been largely excluded, with only one interviewee each in these categories. This was because of the limitations of time and resources for this short, preliminary study. As a result, the study disproportionately captures partial, donor-dominated perspectives on this issue, but we

believe these do still provide interesting insights that can inform future research.

Results

Levels of Cooperation

The Taliban authorities took over the ministries of the former Islamic Republic of Afghanistan in 2021. In 2022, bilateral and multilateral donors, together with UN and NGO representatives of the Health Sector Thematic Working Group (HST-WG) began regular meetings with the Ministry of Public Health (MoPH) according to three interviewees. However, engagement remained extremely limited, described by one study as being a "quick fix" rather than a "joint discussion on how to move forward on how to strengthen the health system" [14]. All interviewees expressed profound uncertainty about the future of the health system.

In Northwest Syria, whose governance was fragmented by the shifting control of warring factions from 2013 to 19, many functions of a Ministry of Health were taken on by other types of groups that grew out of revolutionary opposition civil society self-help organisations. These included specialist platforms such as the Syrian Board of Medical Specialties (SBOMS), created in 2015, and notably Health Directorates (HDs) — the strongest and most long-lived of which was in Idlib, created in 2013. As a former UN staff member put it:

> *" It [the Idlib HD] was a kind-of de facto entity that I suppose would be something like a Ministry of Health in a normal context."*

HDs began cooperating with the WHO and UNICEF on a vaccination campaign after the outbreak of polio in Syria in 2013, one interviewee reported. Subsequently, the HDs were regularly represented in the Syria cross-border Health Cluster in Gaziantep, Turkey. However, donor cooperation mostly stopped short of funding HDs. Interviewees felt that the development of longer-term planning and vision for the health system had been critically hampered by the dominance of external humanitarian actors. As a result,

> *"there was no governance framework to guide the newly introduced parallel system, leaving it subject to individual organizations' strategies and approaches" [15].*

This led to "*a sometimes complete dependence on NGOs, with each having its own potentially conflicting priorities*" [16].

Contextual factors: the legacies of war and health system development

Since 2001, Afghanistan had made progress in improving the delivery and coverage of primary (Basic Package of Health Services - BPHS) and secondary (Essential Package of Hospital Services - EPHS) services delivered by contractors, mostly NGOs. The contracted-out delivery of BPHS and EPHS has been praised for making the system resilient, allowing donor funding to continue in 2021 by bypassing the MoPH [17]. However, not everyone was convinced that this contracted-out structure was a beneficial inheritance in the longer term, because it had limited the development of MoPH capacities to take a larger role in running health services (one interviewee). Two interviewees mentioned that there was never a clear sustainability plan to move toward greater government financial responsibility. The system's financing remained overwhelmingly reliant on out-of-pocket payments and international aid [18].

Syria had a middle-income country health system before the war, which had been improving despite continued health inequalities. This system trained cadres of medics within Syria and in the diaspora who later took essential roles in health system governance during the conflict (two interviewees). All Syria-related KIIs confirmed that the most important influence on Health System governance was the impact and course of the conflict. Attacks on health facilities, the advance of the Assad regime with Russia's help, and the shifting control of territory by different Syrian militias created a deeply unstable situation and resulted in the death and displacement of large numbers of health-workers.

Legal and mandate-related constraints

In Afghanistan, the non-recognition of Taliban authorities was repeatedly cited as ruling out certain types of assistance. Donors have effectively suspended most development aid to focus on predominantly humanitarian aid. This excludes longer-term institution building (for example, through capacity building for staff in government departments) [19].

In Syria, a UN Security Council (UNSC) resolution stipulated that only emergency, or later—'humanitarian early recovery'— aid could be undertaken, since reconstruction aid would require a ceasefire and peace settlement. Aid mandates in Syria were deeply (geo)politicised according to two interviewees. The resolution allowing cross-border aid to Syria required a biannual vote at the UNSC — with Russia's non-objection — to be extended. Even permitting 'early recovery' aid in Syria was mired in geopolitical machinations, as the Assad regime had hoped to use this to encourage more aid to be channeled through his regime [20].

Further constraints to cooperation under international law were present in both contexts because of the presence of groups and individuals sanctioned by the UNSC [21]. But there were no sanctioned people in the Afghan MoPH leadership, according to one interviewee, and, as discussed below, some health authorities in Northwest Syria deliberately distanced themselves from sanctioned groups.

Interviewees suggested that international actors still had a lot of choice on how much cooperation they could pursue. Legally, recognition is not a decisive constraint to development cooperation, and there is considerable discretion, especially for states, in engaging with governments they do not recognise [22]. A number of interviewees felt that more system strengthening cooperation could have been possible, even within the formal legal and organisational limits they perceived. As one representative of the donor community in Syria said:

> *"We should do [health] system strengthening within the confines of our red lines, using all the operational space we have. There is a lot more operational space than we think."*

Actors' power and capacities

In both contexts, the differing power and capacities of international donors and authorities limited the scope for cooperation, but also effectively made them reliant on each other. Both health systems were dependent on international funding (and sometimes services) to function, but the health authorities had, - and in Afghanistan, strictly controlled - access to the population.

Afghan authorities lack the funds to finance the health system, but also do not prioritise it. Only 2.4% of the Taliban's 2022 budget was allocated for health, versus 40% to security and the military [23]. When the ICRC handed back the running of 25 Afghan hospitals to the MoPH in 2023, the Emirate was credited with raising some additional funds towards this, however donors continued to fund staff salaries [24]. One interviewee explained that lack of capacity prevented the Afghan MoPH from executing even the budget they did have:

> *"because they don't understand how to fully capture their budget. And for that you need to support them through capacity building which the international community doesn't have the authorizing environment to do so."*

Lack of technical capacity in the MoPH was repeatedly mentioned by all interviewees as an obstacle to cooperation. As one interviewee said:

> *"there is no capacity there to do this coordination and cooperation because they are not health people… it's difficult for them to sit in a donor meeting and talk about health and about health policy and strategy."*

But interviewees also said the Ministry had demonstrated *enough* capacity and intent to have technical conversations with international partners, and that has been seen as important by these partners in allowing cooperation. As one international interviewee working on Afghanistan put it:

> *"Since the first day it was clear the de facto authorities want to govern–they are interested–they need capacity building and training."*

In contrast, in Northwest Syria, although there were huge capacity needs in the health workforce, the HDs and associated health bodies had strong technical capacity in their leadership. The HDs showed their capacity to unify policies and guidelines across areas under different control with the support of the German Development Agency GIZ in 2016 (two interviewees). What HDs lacked was stable access to funds, and three interviewees and a number of studies suggested that they should have been better funded [16]. According to one study, HD staff had lower salaries than NGOs [16] which had received more consistent "*funds, training, and access to donors and policymakers*" [25]. By 2019, GIZ funding ended over concerns about HTS control of the areas where the HDs operated:

> *"donors started to shift their funds from the local HDs to other organizations, which resulted in weakness in the administrative capacity and roles of the directorates" [26].*

The HTS Salvation government established its own Ministry of Health, but this Ministry was described as having "no, or very limited, activity" with the HD retaining more decisive influence over health services [25]. Ultimately, however, there was always a critical question mark over the stability and longevity of the HDs, which made donors uncertain about deeper cooperation with them (three interviewees). Amidst the many competing parties in the Syrian conflict, it wasn't clear how long these bodies would survive. In the words of one international interviewee who had worked on Syria:

> *"In Syria, I think it was a little bit more complex [to support the directorates on health system planning and stewardship] because you didn't know the lifespan of these entities."*

In spite of this, some HDs, notably in Idlib, did survive after 2019.

Institutional characteristics of the authorities

Gender norms

In Afghanistan, the single most emphasised factor preventing international cooperation with the Emirate was the broader administration's approach to women's rights. Two interviewees said that each time there was a new edict restricting women's rights it struck a blow to those advocating for more cooperation. As one said:

> *"They [the Islamic Emirate administration] don't make it easy [...] the new [2024 vice and virtue] law will make it harder. We were hoping before the law was in place, that at least in the health sector, we would be able to initiate some kind of technical support and capacity building[...]But now, with this new law and not knowing how this new law will be implemented, it's very difficult to say where we will be in two years' time."*

This situation worsened after the interviews were conducted and the Taliban suspended all medical education for women in December 2024.

In Northwest Syria, one KII suggested that HDs had generally supported including women in the healthcare workforce and medical education. Around 60% of students in Idlib in 2021 under HTS rule were reportedly women [27] and former members of the Idlib HD had reflected on the barriers to more women's leadership [28].

Technical focus and independence

In Northwest Syria, the HDs and other specialist health organisations could maintain distance from the ruling militias, particularly HTS from 2017, whose past and present behaviours ruled out direct cooperation with international actors. As organisations run by medical professionals, the HDs developed an identity and behaviours defined by "*independence, autonomous structure, and technical focus*" [15]. The Idlib HD was governed by a board of representatives from health facilities, as one interviewee emphasised. Other reports have claimed that this technical focus and independence *"strongly protected the [health] system"* [25].

Key actors' interests and priorities in the health system

Areas of agreement

Interviewees emphasised the agreement of all actors on the BPHS/EPHS as the backbone of the health system in Afghanistan. Taliban Health Ministers had recently focussed on issues with which international actors agreed such as the need to increase coverage and equity and for more local procurement (two interviewees). Three interviewees reported that the 2021-24 Health Minister's new draft health policy shared many of the values and direction of the last policy, with the important omission of a previous focus on gender equity. There was also agreement between government and at least some international interlocutors on *the need* for capacity building. All Afghan interviewees said training and capacity building of MoPH staff would be a good entry point for deeper engagement, although this is not currently authorised by donor organisations.

In Northwest Syria, HDs, agencies, and donors shared a core interest in maintaining health service provision in the opposition-held areas in the most sustainable way. There was particular agreement on specific areas, such as human resources for health, seen as a good entry-point for cooperation by two of interviewees, for example through health workforce analyses, training physicians and nurses, as far as short funding cycles permitted. As a representative of the donor community said:

> *"Human Resources for Health are a good entry point[...]because they represent a sizable amount of money invested in service delivery[...]There is a lot of attention to infrastructure in Syria[...]but I also believe that without manpower it's pointless to talk about construction."*

Different priorities

In both contexts, the health authorities wanted a larger role in health system management and decision-making than international actors afforded them.

In Afghanistan, the Taliban is the only political authority but does not hold Afghanistan's seat at the United Nations. All interviewees noted that the issue of recognition was an ever-present tension in engagement. The Taliban tried to use health engagement to gain more formal recognition and legitimacy, whilst international partners were careful to avoid giving this impression in their language and presentation.

Another area of tension was the Taliban's suspicion of some NGOs awarded BPHS contracts and their reported interference in some selection processes, according to two interviewees. The MoPH had also increased its regulatory requirements for NGOs:

> *"the [MoPH] issued a letter to all governors in the provinces. If the NGO does not have the authorisation from the Ministry of Public Health, they cannot operate in the province. Close them down" [14].*

There were also reports that Taliban officials in many provinces were preventing or restricting female staff from traveling in mobile clinics [29].

The Taliban-led MoPH also brought a stronger focus on fixed infrastructure. Two interviewees noted that the Taliban MoPH had asked for the number of district hospitals to be increased significantly, which is at odds with the focus on primary health care in the donor- and UN-authored Health Sector Transition Strategy. As one donor representative said:

> *"It's not just about building, it's about managing, it's about operating costs, it's about human resources, and it's also about coverage and not every village or even every district needs to have a building because that depends on your density."*

The Taliban had also long been skeptical about mobile health facilities:

> *"UN agencies and NGOs see mobile clinics as a valuable intervention, allowing those in remote areas to access care they would otherwise have to travel long distances for. The government sees them as wasteful, drawing away resources from the stationary clinics within the government system" [30].*

The Health Minister had called for the closure of all mobile health facilities and their replacement with fixed facilities. Interviewees did not all regard this as a negative challenge. One interviewee described this as a "*good shock to everyone*", going on to explain:

> *they [the MoPH] probably knew this was unfeasible, but it did show their interest in the situation and we were able to change some mobile clinics to fixed ones, but there is a fundamental problem in that donors can't invest in development activities like fixed infrastructure while the authorities are not formally recognised.*

In North-west Syria, many differences between the HDs and international donors and agencies concerned the gap between emergency aid and broader health system needs. In the words of a donor interviewee:

> *"The leaders in charge of the directorates were having to balance basic life-saving care with maintaining specialist diabetes care so people don't go blind or lose limbs, etcetera. So it was uncomfortable for donors to say we need basic medicines and life-saving care. [...] Says who? What if it is your mother who has leukaemia and her life depends on continuing rounds of chemo?"*

The same interviewee went on to say:

> *"It's fine for a donor to sit back and have funding and say, we use our money for x and y, but not z. So vaccines or basic medicines or trauma yes, but we won't fund long term chronic issues. But it doesn't work that way. So [...] a donor funds surgery to save life, so after the life-saving surgery and amputation, who funds the rehab and the prosthesis and physio? ".*

Donors were disproportionately interested in cooperation on vaccines and global health security, one health professional with experience of working with the Health Directorates argued:

> *" We recognised from the first day that the support for the vaccine department would never stop because donors don't want polio to spread. However, in the same communities there were other problems [...] for example now more than 30% of Syrians have disabilities."*

This interviewee continued:

> *"I think there is a colonial relationship regarding funds and decision-making - you see that 90% of decisions are made on the part of donors and [international] partners."*

Different interests

Conflicting interests on cooperation were reported between and also amongst the key actors. Interviewees reported potential differences among Taliban ruling elites on the critical issue of training women health-workers. Two interviewees suggested that the MoPH agreed with donors on maintaining the pipeline of women health workers and found this hard to reconcile with the Emirate's edicts banning women's education. One interviewee reported that the previous Health Minister had considered ways of circumnavigating these edicts. The decisions restricting women's rights emanate from Kandahar, where Supreme leader, cleric Hibatullah Akhundzada, is based and are seen by some as evidence '*that the old guard of the Taliban led by the supreme leader have an upper hand in directing policy*" [31]. The Ministry in Kabul, on the other hand, is responsible for maintaining service provision–ultimately impossible without women health workers - and has more regular engagement with donors and agencies.

In Northwest Syria, two interviewees also discussed tensions between and within agencies. Tensions were reported between the two WHO offices supporting the parallel health systems run from Damascus and Gaziantep, who had no contact with each other, as well as the Whole-of-Syria coordinating office in Amman, especially when it came to compiling data for needs assessments.

The HDs in Northwest Syria also sometimes had conflicting interests with other international and Syrian health actors, notably NGOs—the dominant players in delivering health services. An assessment of health systems governance found that "*competition and the lack of unification across the health system*" and "*weak cooperation by NGOs*" were the biggest perceived challenges to the legitimacy of health system governance [26]. If 'early recovery' means more decision-making and responsibility for local coordinating institutions, this implies that implementing NGOs should cede some power. But, according to one representative of the donor community:

> *"There's an inherent incentive to keep things as they are on the part of [humanitarian] implementing partners, they have created mini-empires out of clinics.NGOs don't want to give up any of their roles.It's much easier to run a project where you control absolutely everything."*

The HDs were also treading a difficult balancing act with the range of domestic political actors fighting for power in Syria, who had an interest in controlling the governance of health services. As per one health professional with experience of working with the HDs:

> *" this [HD Health Coordination] project was under attack from all sides: from military groups because they didn't have power over it; [and] unfortunately the opposition [Syrian Interim] government [...were] saying we shouldn't compete with their official Ministry of Health ".*

This made it harder for donors to support the HDs. As a donor representative reported:

> *"[It was challenging for donors] working in a fast changing conflict setting, so due diligence [was difficult] for funding and donor reputational risk in a country where in non-government areas different factions were vying for power."*

The most dangerous enemy of the HDs during this time was the Assad regime. The very success of the HD's health systems governance and service delivery - a form of "*performing the state*" [32] - made them threatening to Assad, and the strikes on medical facilities from 2015 were seen as deliberately targeting "*areas where rebel governance is most successful*" (ibid.).

Discussion

Our findings show that in these two contexts, there was a lot of agreement between international actors and unrecognised authorities on core health sector priorities, but there were significant limits on cooperation. Although lack of political recognition was commonly described as the major constraint by international actors, other factors exerted a stronger influence than non-recognition alone. These included the uncertain fate and longevity of unrecognised authorities in the shifting Syrian conflict during the timeframe under investigation, and the normative human rights approach of Afghan authorities, which brought damaging decisions for the health system, for example, on women's medical education.

International health system actors themselves had entrenched 'ways of doing things' that inhibited cooperation. In Syria, they also inadvertently established incentives for NGO service providers that militated against shifting more power to health authorities. Their focus on emergency aid also prevented them from cooperating as much as unrecognised authorities wanted. Unrecognised authorities wanted more control in managing the health system, and they were naturally more concerned with longer-term priorities beyond the confines of 'emergency aid', yet they lacked the resources to finance these ambitions. International actors could not meet these ambitions, even though they are in line with existing humanitarian commitments to greater "independence of leadership and decision making by national actors in humanitarian action" emphasised in many definitions of localisation [33].

While international actors face and feel significant constraints on cooperation with unrecognised authorities, there may be more space for cooperation within donors' and agencies' "red lines", or limits of engagement, than has been used. Key informants suggested that support to Human Resources for Health could help address longer-term health system strengthening within donor constraints. For health authorities, these resources were a sizable proportion of the financial envelope for any health system and represented a sustainable investment. For international actors, this was an investment that was perceived as less risky.

Our findings suggest that international cooperation with unrecognised authorities may be easier where these authorities:

- are stable and unlikely to be affected by immediate challenges to their authority;
- have technically competent figureheads and advisers, or at least a willingness to engage technically;
- share enough normative ground with international actors on human rights;
- have access to, and trust among, communities, citizens, and service users.

The relationship of all health system actors, including unrecognised health authorities, to communities,

citizens, and service users (critical actors in the health governance framework shown in Fig. 1) is important to consider. In Syria, the fact that HDs and other health bodies run by health-workers themselves, reportedly had high levels of access to, and trust by, communities [26] was a strong facilitator of cooperation (reported by all Syria informants). These bodies must surely be highly relevant in designing health support to the new caretaker government.

Relationships with communities can be seen as a dimension of the 'legitimacy' of health actors - a common theme in our interviews. Key informants used the word unprompted 43 times with different implied meanings, referring both to international actors and to unrecognised authorities. Legitimacy is a much broader concept than international recognition. It is an attribute of, or a judgment on, institutions that is often most meaningfully made at the societal level. 'Legitimacy' is defined differently by different authors and disciplines. Taking just two examples, one definition sees legitimacy as

> *"the belief that a rule, institution, or leader has the right to govern" [26].*

And another as:

> *"a generalised perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed norms, values, beliefs and definitions" [34, 35].*

But both these definitions raise the question of who gets to decide on the legitimacy of health system actors. Unrecognised authorities could be seen as legitimate to different degrees by their own societies versus international actors. Yet, the huge power disparities in the international system mean that international actors' views and decisions can have the most dramatic implications for funding and governance of health systems. As one researcher working in conflict-affected settings said:

> *"I'm reflecting on the double standards – who gets to recognise this de facto authority or this government, and as a result fund projects in this area or not?"*

Recent research on legitimacy in health governance in Northwest Syria and other conflict settings [26, 34–36], including indicators to assess the legitimacy of health system actors [36], may be more broadly useful in assessing the potential for cooperation amongst health system actors.

Finally, this preliminary study could only look at two contexts at a very high level. Since non-recognised authorities are all unique, and are unrecognised for different reasons, the factors influencing cooperation are likely to be different in different places and at different times. More granular research looking at cooperation with unrecognised authorities in a broader range of contexts is merited, including in today's Syria since the fall of Assad's regime. This research should focus on the voices of unrecognised authorities, service providers, and citizens and service users, which this preliminary study has been unable to include. More research is needed at this level to understand the day-to-day political economy of these actors' interactions and decision-making in the health sector.

Conclusions

An increasing proportion of people in fragile and conflict-affected states now live in contexts where the national authorities are "politically estranged" from the international donors who often fund health systems in such contexts [37]. This means that, in order to pursue the UN Sustainable Development Goals, international actors will need to grapple with ways of working with such estranged authorities. Inadequate cooperation carries major risks of deepening health system fragmentation and preventing health authorities from taking more responsibility, which is critically needed amidst cuts to humanitarian aid. Both international partners and unrecognised authorities can change their approaches to improve the chances of cooperation. Unrecognised authorities can ensure they have technical credibility or are prepared to engage technically, prioritise responsiveness to their citizens and human rights in the health system. International actors can take the longer-term concerns of these authorities seriously and engage beyond the humanitarian-development divide.

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Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics, consent to participate, and consent to publish
This study was reviewed and given favourable opinion by the London School of Hygiene and Tropical Medicine Research Ethics Committee (ref: 30255). Informed consent was obtained from all interviewees, who also approved all the quotes used in this study.

Competing interests
The authors declare no competing interests.

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