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Resilience Without Foundation? Interrogating Health System Governance in Shaping Health System Resilience in Haiti – A Qualitative Study of Stakeholders' Perceptions

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Abstract

Background: Health system resilience (HSR) is a priority in Haiti, one of the world's most fragile and poorly governed countries. It depends on the capacity of communities, institutions, and actors to anticipate, absorb, and adapt to shocks. Health system governance (HSG) – policy processes, institutional arrangements, and stakeholder relations – is a core determinant of HSR. This study examines how health system stakeholders in Haiti understand HSR and the role of HSG in shaping it.

Methods: We conducted an exploratory qualitative study using semi-structured interviews with 15 strategic decision-makers, senior and operational managers, and healthcare providers in July 2023 in Port-au-Prince and Southern Haiti. Participants were recruited through purposive and snowball sampling. Data were analysed thematically, combining deductive codes from HSR frameworks, with inductive identification of emerging HSG themes. Social contract constructs identified in participants' accounts informed the application of a social contract lens as an *ex post* interpretive framework for discussion.

Results: Participants framed HSR as a collective political commitment to health systems strengthening (HSS) and advancement of an integrated health and development approach, rejecting interpretations that shift responsibility onto communities. HSG was considered foundational to HSR, with three interdependent dimensions emerging from analysis: organisational-structural, politico-institutional, and ethical-citizen. Weaknesses across dimensions—including weak planning capacity, constitutional ambiguities, budget opacity, donor-driven power asymmetries, inequitable access, limited accountability, and legitimacy gaps—were mutually reinforcing. Trust emerged as a cross-cutting determinant.

Conclusion: From a social contract perspective, coherence across HSG dimensions rather than adherence to isolated principles appears to be a key condition for HSR in Haiti. Strengthening institutional capacity, credible planning, and legitimacy require simultaneous actions across these dimensions. Provider-community trust constitutes an HSG resource on which to build. Despite the small sample and absence of community perspectives, the study offers a basis for further exploration in countries facing similar HSG challenges.

Keywords: Haiti, Caribbean Region, Health System Governance, Health System Resilience, Fragile States, Contact

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Background

Countries exposed to overlapping acute and chronic shocks urgently need resilient health systems. However, the structural vulnerabilities inherent to these contexts hamper health systems strengthening (HSS) efforts and undermine progress towards resilience.[1,2] Health system resilience (HSR) refers to "populations, institutions and actors' capacity to foresee and respond to shocks while preserving essential functions, adapting or, when necessary, transforming themselves when faced with crisis."[2] This conception extends beyond service continuity to decision-making and organisational processes that shape health systems in both routine and crisis conditions. It encompasses policy choices, institutional arrangements, and actors' interactions, positioning health system governance (HSG) at the core of HSR.[3-5] HSG is understood here as the process through which governments and social organisations interact with citizens, formulate policies, and deliver services in an increasingly complex and interdependent environment.[4,5]

A growing body of literature highlights the interdependence between HSG and HSR. Effective HSG enables coherent decision-making, resource mobilisation, and collective action on which HSR depends.[6,7] This interdependence becomes especially salient in fragile and conflict-affected states (FCAS),

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Key Messages

Implications for policy makers

- Strengthen national institutional foundations and regulatory authority: Constitutional ambiguities and budgetary opacity that undermine the Ministry of Public Health and Population (MoPHP) authority require action beyond the health sector. The MoPHP should clarify mandates, adopt merit-based appointment processes, and strengthen its engagement with citizens and local stakeholders.
- Realign planning with institutional capacity: Health planning should be aligned with available capacities and resources to reduce inefficiencies, aid dependency, and power asymmetries, while strengthening financing autonomy.
- Advance decentralisation: Functions and resources should be devolved to subnational levels to strengthen participation in the departmental and municipal health systems during routine operations and emergency responses.
- Align donor practices and move from rhetoric to action: Donors should recognise aid dependency and short-term approaches as constraints on effective health system governance (HSG) and align their funding with ministerial priorities under the coordination of the MoPHP, while ensuring predictable, long-term financing commitments.
- Implement an integrated approach to HSG: Governments and development partners should adopt an integrated approach to HSG that encompasses organisational-structural, politico-institutional, and ethical-citizen dimensions in order to restore legitimacy and trust and repair breaches in the social contract.

Implications for the public

In Haiti, a fragile and conflict-affected states (FCAS), weaknesses in health system governance (HSG) make it harder for the health system to protect communities during crises. Inadequate planning, lack of budget transparency, and power asymmetries between donors and national institutions reduce its ability to respond effectively when shocks occur. This study drew on the perspectives of health professionals, managers, and decision-makers across the country to understand how governance shapes resilience. The study shows that resilience is not only about communities finding ways to cope, but also about building trustworthy institutions that plan responsibly, use resources transparently, and serve people fairly. Stronger governance – where citizens' voices matter, leaders act responsibly, and resources are distributed equitably – can support a health system that protects everyone, especially those most at risk. By identifying governance gaps and proposing integrated actions, this study offers a pathway towards a resilient health system that people can trust even in difficult times.

where political instability, recurrent shocks and chronic institutional weaknesses,[8-10] fragment systems, disrupt service provision, and erode trust.[1,11-13]

Haiti offers a compelling case for examining the interplay between HSG and HSR. It remains the only country in the Caribbean and the Americas consistently ranked among the world's most fragile States.[14] In 2024, Haiti recorded very low scores for anti-corruption and government effectiveness according to the Worldwide Governance Indicators (16.68 and 12.15 out of 100, respectively).[15] Amid protracted political instability, pervasive insecurity, recurrent abductions of health personnel, and extreme poverty affecting over half the population, Haiti's already fragile health system teeters on the brink of collapse.[16-18] In this context, understanding HSG processes that foster or hinder HSR proves crucial.

Key dimensions of effective HSG include strategic vision, coordination, transparency, accountability, and legitimacy.[4,19] However, standardised governance indicators often fail to capture the informal negotiations, relational practices, and power dynamics that hold particular relevance in FCAS.[20-22] Growing consensus holds that resilience-building and HSG are inherently political, shaped by asymmetrical power relations, aid dependence and global-local dynamics.[23] Yet, much of the HSR literature relies on models derived from relatively stable settings, whilst HSG research tends to assess governance against capacities or principles that health systems are expected to demonstrate. Both offer limited insight into how HSG is enacted and shapes HSR amid protracted instability and violence, as in Haiti.[4,7,24]

This study addresses this gap. It examines how stakeholders in Haiti understand HSR and the role of HSG in shaping it. Drawing on qualitative data, it contributes to debates on HSG in FCAS by proposing a three-dimensional approach to HSG comprising organisational-structural, politico-institutional, and ethical-citizen dimensions. It emphasises the need for coherence within and across these dimensions to foster HSR.

Materials and Methods

Study Design

The study adopts an exploratory qualitative design with an analytical and interpretive focus grounded in a processual and contextual understanding of HSG. HSG is examined through stakeholders' experiences, practices, and interactions within the health system in a fragile and conflict-affected context.[4,5,25,26] The study follows a reflexive thematic approach and adheres to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.[27-29]

Contextual Background and Study Sites

Since Haiti's last elected President, Jovenel Moïse, was assassinated on July 7, 2021, the country has entered a period of prolonged political and institutional instability. The expansion of armed groups and weakening of state institutions have disrupted mobility, public services, and access to healthcare.[30-32] National health policy recognises health as a fundamental human right and a State priority, with the Ministry of Public Health and Population (MoPHP) responsible for health system oversight. The health system comprises a three-tier pyramid of about 1061 public, private, and mixed facilities of which fewer than half provide standard-level care. Primary tier relies heavily on multi-skilled community health workers who sustain outreach and basic services. Marked inequities persist in the distribution of facilities and resources with Port-au-Prince concentrating most services and many rural areas remaining underserved.[33-36]

At the time of data collection (July 3-21, 2023), escalating

violence had caused mass displacement, worsened food insecurity, and forced the closure of Haiti's largest tertiary hospital, the State University Hospital. Violence and recurrent abductions of health personnel also intensified brain drain.[16,18,32,37] Table 1 provides an overview of Haiti's contextual and health system indicators.[38-40]

The study sites (Figure 1) were purposefully selected to document HSG at different levels of the health system under these circumstances. Port-au-Prince metropolitan area was chosen at the strategic level because it hosts central institutions and a large concentration of national and international decision-makers. The South and Nippes Departments were selected at the operational level due to their recent exposure to a major natural hazard, namely the 7.2-magnitude earthquake of August 15, 2021.[41] These selections also minimised memory bias. The municipalities of Les Cayes and Torbeck were selected for practical reasons and feasibility.

Sampling

We applied a reasoned, purposeful sampling approach, complemented by snowball principle. Participants were recruited through the first author's professional networks via email and follow-up calls with additional referrals. Selection was based on position, experience within the health system, and involvement in emergency management, ensuring diverse and relevant perspectives. After three unsuccessful contact attempts, non-respondents (n = 5) were replaced by participants with similar profiles where possible. This explains, for instance, the absence of civil society representatives in the sample. Efforts were made to include stakeholders from both urban and rural settings to enhance the credibility and scope of the findings. The sample comprised strategic decision-makers, senior managers, operational managers, and healthcare providers.

Data Collection

Data were gathered through semi-structured interviews, using a guide based on Kruk and colleagues' HSR index, World Health Organization (WHO) frameworks for HSS and emergency preparedness, organised around pre-,during and post-shock phases (Supplementary file 1).[2,3,42] The interview guide was elaborated in French and subsequently translated into Haitian Creole by the first author. It was piloted in both languages with a stakeholder who did not participate in the study. Interviews were conducted by the first author at locations chosen by participants, taking security constraints into account. Responses were paraphrased during interviews to confirm understanding and validate interpretations. Interviews were audio recorded following participants' and transcribed verbatim prior to analysis. Creole recordings were transcribed directly into French. For presentation of the findings, governance related verbatim were translated into

Table 1. Haiti's Contextual and Health System Indicators

Dimension	World Bank Income Level	Lower-Middle Income		
	Indicator	Figure	R/W Average[a]	Year[b]
Socio-economic; poverty and inequality	Population	11 637 398		2023
	GDP annual growth as %	−4.17		2024
	GDP per capita (PPP)	3193.7	21 961.2 (R)[c]	2024
	Personal remittances received as % of GDP	16.3		2024
	Gini index	41.1		2024
	Poverty head count ratio $3.00 PPP/day	40.4		2024
	Multidimensional Poverty head count ratio (% population)	53.2		2024
	Prevalence of severe food insecurity in the population (%)	45.4		2023
	Number of fatalities due to violence	>3137		2025
	IDP	1 037 000.0	73 467 201 (W)	2024
Health system; health outcomes and financing	Density of MD/10 000 population	2.9		2022
	Density of nurses/ 10 000 population	7.3		2022
	Under-five mortality rate/1000 live births	55.1	13	2023
	Maternal mortality ratio/100 000 live birth	328	<70	2023
	Hospital beds/1000 population	4.9		2023
	Life expectancy at birth	62.5	71.4/74.1	2021
	GGHE-D as % of GDP	0.30	3.99	2025
	GGHE-D as % GGE	4.2		2021
	CHE per capita in US$	54.41	1309.97 (R)	2023
	EXT as % of CHE	31.56		2025
	OOP as CHE	52.40		2023
	CHE as % of GDP	3.48		2021

Abbreviations: R/W, regional/world average; MD, medical doctor; GGHE-D, domestic general government health expenditure; IDP, internally displaced people; GDP, gross domestic product; GGE, general government expenditure; EXT, external health expenditure as % of; CHE, current health expenditure; OOP, out-of-pocket expenditure; PPP, purchasing power parity.

Source: Authors based on World Bank,[35] World Health Organization,[36] the United Nation News.[37]

[a] If available; [b] Latest available data; [c] Excluding high income countries.

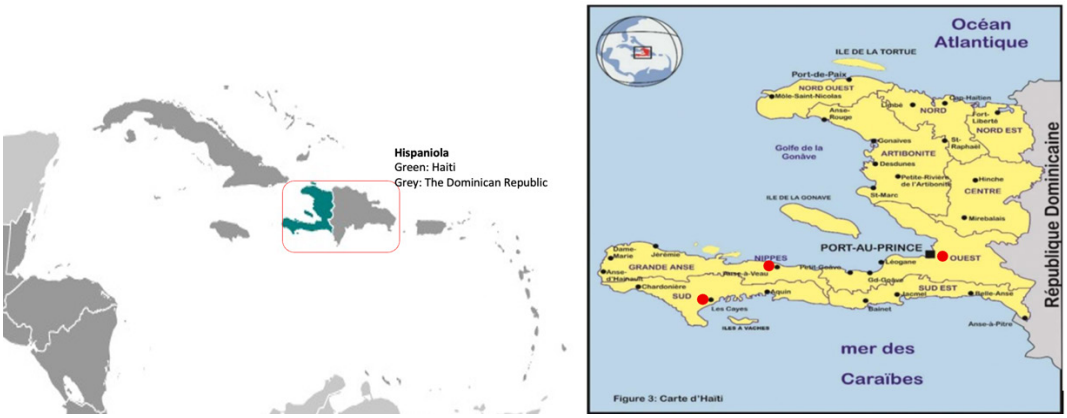


Figure 1. Haiti's Geography and Study Departments. Sources: Central Intelligence Agency, The World Factbook, Human Resources Development Strategic Plan 2018-2022.

English using a double translation procedure with DeepL 26.6.14 to enhance consistency.

Data Analysis

Data were analysed thematically in NVivo (version 15.5.0) using a deductive-inductive approach. Initial coding was deductive and guided by thematics derived from the interview guide (Table 2, Supplementary file 1).

A second coding cycle applied Siddiqi and colleagues' governance principles to governance-related excerpts identified inductively: strategic vision, participation, transparency, responsiveness, equity and inclusion,

Table 2. Interview Guide Thematics and Corresponding Deductive Codes

Thematics	Key Points Covered
	Across pre-shock (preparedness), during-shock (response), and post-shock (recovery and transformation) phases
(A) Participants background: Examine participants' work experience, role, motivation	1. Previous experience with emergencies 2. Training history including in EPR 3. Institutional, self-role and responsibilities (before, during and after event) 4. Decision-making involvement 5. Changes in role after event 6. Motivation and reflections on experience
(B) Health system context: Examine services/users' profiles before, during, and after an event; partnership and participation processes as well as existing laws, protocols and plans	7. Health system structure, coordination and leadership at municipal, departmental, central/national levels 8. Partnership, collaboration mechanisms 9. Plans and legal framework including for EPR 10. Institutional adjustments mechanisms and/or policy revisions 11. Service organisation or reorganization and utilisation 12. Resource mobilisation and/or reallocation
(C) Emergency preparedness and response EPR: Explore processes and action for preparation, response, adaptation, reactivity, recovery and transformation	13. Preparedness plans and protocols 14. Staff readiness and simulations 15. Coordination mechanisms and plans' activation of plans 16. Crisis management actions and adaptation to population needs 17. Implementation challenges 18. Evaluation of response, impact on staff and services 19. Lessons learned and system transformation
(D) Definition and characteristics of HSR: Informed/aware, self-regulated/ autonomous, integrated, diverse, evolving/transformed	20. HSR: Definition characteristics and their meaning for the country's health system 21. Health system flexibility, autonomy and ability to maintain essential services 22. Awareness and integration mechanisms 23. HSR strengthening measures (institutional, local or nation-wide) 24. Self-assessment of system resilience and justification 25. Needed improvements (resources, skills, training, opportunities)
(E) Health system building blocks and values for HSR: To understand health system functions in line with HSR; conducts system self-assessment/ evaluation of the building blocks	26. Governance and leadership effectiveness 27. Financing arrangements and emergency funding use 28. Workforce capacity, redistribution and retention 29. Regulatory framework (regulations and laws; participation process; supervision and control) 30. Service accessibility, acceptability, affordability quality and safety 31. Supply readiness 32. System's core value (inclusiveness, solidarity, transparency, trust)

Abbreviations: EPR, emergency preparedness and response; HSR, health system resilience.
Source: Adapted from Kruk et al[2] and the WHO.[3,42]

effectiveness, accountability, surveillance and information, and ethics[4] (Table 3).

Patterns and interconnections in participants' accounts and codes were examined, leading to the regrouping of HSG principles into three sub-domains, that formed contextually adapted HSG dimensions. This analytical structure informed the organisation and presentation of the results (Supplementary file 2, Figure 2). Thematic saturation was assessed through informational redundancy, as described by Braun and Clarke (2007, 2019), and supported by the depth

Table 3. Reference Framework for Health System Governance

Principles of Governance – Definition	Sub-domain
(1) Strategic vision: Forward-looking and holistic approach to health; consideration of social determinants; rooted in cultural and social realities; guarantee of sustainability	The country's constitution and human rights/health as a priority and role in development
	Clear policy – well defined health system objectives
	Policy that takes health determinants into account
	Actions considering health determinants and improving human capital
	Reform and actions to improve human resource management and
	Reform and actions to improve HSS/EPR and HSR funding
	Coherent and fundable health plan and policies
	Holistic approach (promoting economic, social and human growth)
(2) Participation and consensus: Inclusive decision-making; safeguarding majority interests; genuine expression of individual or representative voices	The interest and sensitivity of donors/stakeholders, what matters
	Inclusion, participation of all in health decisions
	Discussion platform for plan development and decision-making
	Culture of accountability
	Engagement of the private sector, civil society and the community
	Decentralisation
(3) Rule of law: Alignment of laws on fundamental rights; consistency in their application; regulation, accreditation and licensing of health-related activities	Health as a human right – Consistence in constitution and laws
	Regulation of professional training
	Capacity to regulate medicines and equipment
	Safety of services – justice for healthcare consumers
	The Ministry of health and the enactment of laws affecting health
	The Ministry of Health and its role in healthcare provision
(4) Transparency: Timely, public and accessible information on decision-makers, budgets, allocation of funds, and control structures	Corruption/transparency regarding appointments and allocation of funds
	Control structure to oversee appointments and use of funds
(5) Accountability: Clear rules, regular oversight and effective judicial systems; accountability and reporting at all levels	Responsibility of the Ministry of Health (including in ensuring emergency preparedness)
	National health accounts ensuring compliance with administrative and financial regulations
	Role of the media and NGOs – international organisation
	Control structure – known or unknown evaluators
	Judicial system – (Negligence)
(6) Responsiveness: Response to current and emerging health needs; consideration of community satisfaction with the quality of services	Assessment of needs and responses to the needs of the population
	Quality of services
	Community satisfaction
(7) Equity: Equitable access and financial protection regardless of gender, ethnicity or socio-economic status; equitable distribution of resources	Affordability, financial protection (out-of-pocket expenditure)
	Achieving societal balance
	Geographical barriers
	Equitable distribution of human and financial resources (decentralisation)
	Consideration for vulnerable/disadvantaged people
(8) Effectiveness and efficiency: Sound management, skilled workforce, optimal use of resources, long-term sustainability of services	Sound management: qualified personnel in the right positions
	Defined health leadership
	Human resources control and conflict of interest management (public-private)
	Administrative prioritisation procedure (effective leadership and management and timely release of funds)
	Culture of organisational resilience
	Public health awareness/training for staff
	Technical capacity of the MoPHP for planning, management and internal communication
(9) Monitoring and information: Reliable data collection, analysis and dissemination to guide evidence-based policies and decisions	Health information system – Reliable data
	Research
	Culture of informed decision-making
(10) Ethics: Adherence to ethical standards in care, research and professional conduct; prioritisation of dignity, rights and equity	Institutional ethics standards and mechanisms – professional conduct
	Promotion of bioethical principles in research and care

Abbreviations: EPR, emergency preparedness and response; HSS, health systems strengthening; HSR, health system resilience; MoPHP, Ministry of Public Health and Population; NGOs, non-governmental organisations.
Source: Adapted from Siddiqi et al[4] governance principles.

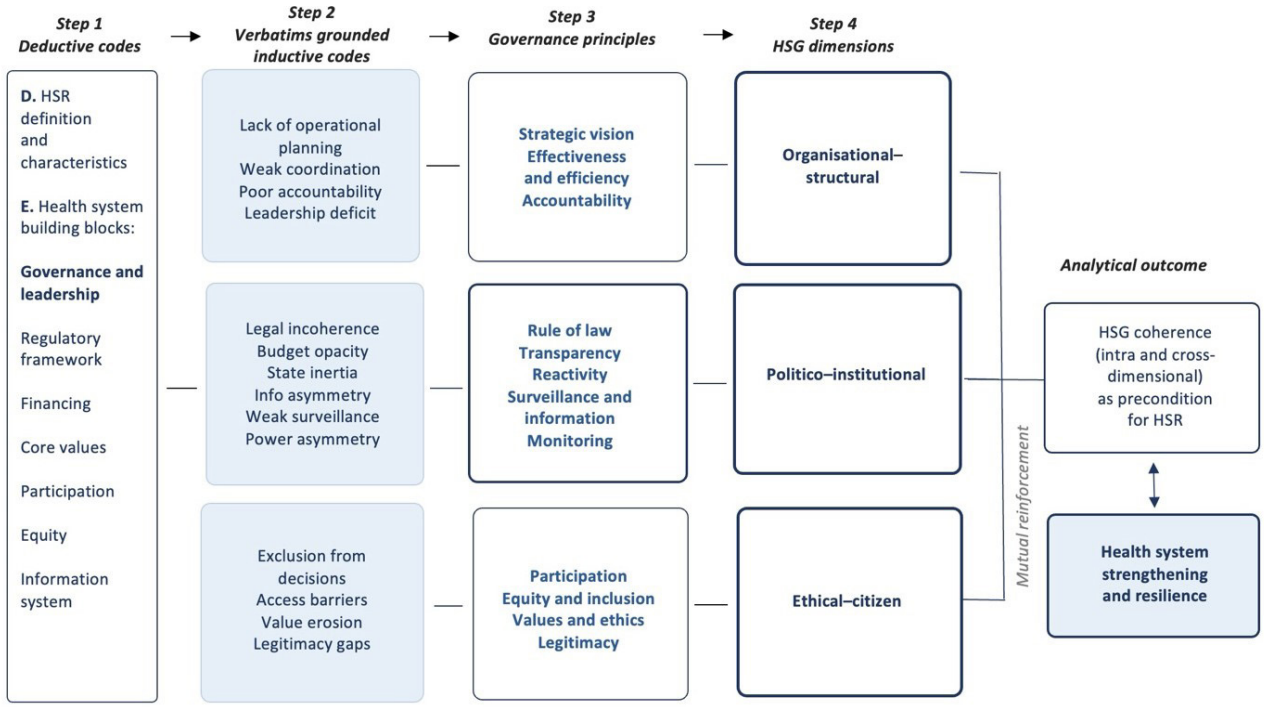


Figure 2. Thematic Recategorisation and Analytical Regrouping Logic. Abbreviations: HSR, health system resilience; HSG, health system governance.

and consistency of the data.[43-45] Negative and deviant cases were used to refine and qualify the dominant patterns and support interpretative claims. They also provided examples of successful HSG practices. These cases did not generate additional codes or patterns, but contributed to the validation and interpretation of the findings.[45] Finally, analysis of participants' accounts revealed constructs relevant to social contract theory. Although these constructs did not guide coding, they subsequently informed the *ex post* interpretive framework applied in the Discussion.

Results

The findings are organised into five sections. The first describes participants' profiles. The second presents their contextual understanding of HSR, which led to the identification of HSG as a key precondition. The third examines HSG in Haiti in greater depth. Drawing on participants' perceptions, it moves beyond adherence to HSG principles to identify three interdependent dimensions. The coherence within and across these dimensions was identified as shaping HSS and HSR processes. The fourth provides examples of promising local actions whereas the fifth presents social contract constructs that emerged from the data and were subsequently used as an *ex post* interpretive lens for the Discussion.

Participants' Professional and Socio-demographic Profiles

Fifteen interviews were conducted with key health system actors involved in health and climate emergency preparedness, public financing, and service delivery. To preserve anonymity, exact professional titles are not reported. Participants held strategic (central/national) and operational (departmental or municipal) positions in Port-au-Prince and the Southern departments, respectively. Five interviews were conducted in Creole resulting in richer discussions. Since the first author is a native Creole-speaker, information bias arising from linguistic interpretation was minimised. Interviews lasted an average of 60 minutes long, and participants averaged nine years of professional experience (Table 4).

Description and Definition of Health System Resilience in Haiti

The participants emphasised the importance of clarifying the concept of HSR before discussing its relevance or implementation. Such clarification was deemed vital in Haiti to avoid rhetorical use and decontextualised applications of the concept (Table 5). HSR was commonly described as the health system's ability to absorb shocks, adapt, and remain operational. However, participants rejected the growing tendency, especially since the 2010 earthquake, to equate

Table 4. Participants' Profile

Interview Length Mean (Min-Max)	Gender (n)	Age Group (n)	Education Level (n)	Work Experience Mean (Min-Max)[a]	Site – (n)
60 (27-112)	M (11)	30-34 (3)	Vocational qualification (1)	9 (2-18)	Port-au-Prince (8)
	F (4)	40-44 (6)	Bachelor's degree (1)		South – (Torbeck, Paillant, Les Cayes) (7)
		45-49 (1)	Master's degree (8)		
		50-54 (2)	PhD (5)		
		55-59 (3)			

[a] Two participants had been in their position for only 2 years.

Table 5. Participants' Definition of Health System Resilience and Discarded Alternatives

HSR (Is)	Verbatim	HSR (Is Not)	Verbatim
Builds over time, enabling self-sufficiency	*"When the system (previously reinforced) is stretched beyond its limits, how should we respond? [...] Now, if support is needed, we can seek help. Because, in fact, external support should start coming in once one's own capacity is exceeded, at which point one can call for help"* (S7). *"Fewer emergencies and more reinforcement of underlying systems? [...] But now we need to have that flexibility ... How can we achieve it? How do we capitalise on it?"* (S6).	Is neither a quick fix, nor an overnight emergence	*"Because building takes time. In emergencies, one cannot build. Therefore, if we want to develop a resilient health system, we ought to establish a system that ensures smooth day-to-day operations"* (S7).
Reflects a willingness for programmatic reorientation, grounded in local and sustainable investments	*"That we have the will to do so. Do we have the capacity, the political will? I would even say. Do you believe that the national and international communities are interested in sustainable solutions? We must consider sustainability. [...] Unless we achieve this, we will always be in a state of emergency. And the system will ultimately collapse [...]"* (S6). *"We must, in Haiti we must invest (in health and locally)..."* (S7).	Should not be reduced to large-scale, sporadic and costly emergency interventions	*"[…] a resilient system for Haiti, ie, regardless how many shocks occurs, is how to ensure that the health system keeps providing services without resorting to massive interventions"* (S6). *"I think, given the amount of money spent, they could have simply reinforced the Cayes public hospital (local hospitals), thereby creating a much more lasting impact. Instead, they come, set up mobile clinics, take photos, and then leave after a month or two"* (O5).
Equips the health system that in return, equip the population to cope	*"Resilience is the ability to reduce the impact of incidents, catastrophes and disasters on the population [...] Therefore, it is also about the population's ability to cope with such incidents and disasters"* (S8).	Is not incumbent on citizens or healthcare providers alone	*"Resilience [...] We use it increasingly. But I've noticed [...] a difference. Quite often when we talk about resilience. Yes, we need to have resilient health systems. But contrarily to some people's opinion, Haitians are resilient. I oppose these ideas; citizens should not be expected to be resilient, it is the system that should be resilient, not the population. The population deserves to enjoy all that is good, fair and pleasant"* (S2).
Enables to withstand shocks and quickly recover	*"'Nou se wozo, nou pliye n pa kase' (a Haitian saying literally meaning: 'We are reeds, we bend yet we do not break'). So, that means [...] it's the ability to weather a shock and be flexible enough to adapt to the new reality and get back to work as quickly as possible [...]"* (S7). *"It's the system's ability to cope with different shocks [...] to organise and reorganise itself in order to respond"* (S2).	Is not this overused concept, too often reduced to mere individual or sectoral survival in such a context.	*"Now the term itself, unfortunately, has been overused and misinterpreted over time, particularly after the earthquake of 12 January (2010)"* (S8).

Abbreviation: HSR, health system resilience.

population's endurance with HSR.

"Now the term itself, unfortunately, has been overused and misinterpreted over time, particularly after the earthquake of 12 January (2010)" (S8).

"I oppose these ideas; populations should not be expected to be resilient, the system should be resilient, not the population. The population deserves to enjoy all that is good, fair and pleasant" (S2).

Participants further argued that one-off emergency interventions do not amount to resilience-building. HSR cannot be developed under emergency conditions. Instead, a resilient system is one whose foundations have been laid in advance. It can maintain routine functioning and resort to external assistance when its own capacities are exceeded (Table 5).

"Because building takes time. In emergencies, one cannot build" (S7).

HSR was associated with sustainable development. Participants stressed that HSR will remain wishful thinking unless investment priorities shift towards sustainable measures. Effective change requires reframing the debate from a short-term emergency response mindset to a long-term strategic vision supported by sustained political commitment across all levels of HSG.

"If we don't change this narrative in terms of investment, we won't enter this period of development. Nothing much will change. We will not be able to strengthen the system. We will not have resilience… But do we have this political will" (S6).

"*We must... In Haiti, we must invest (in health and locally)..."* (S7).

While some participants questioned the meaning of HSR in the Haitian context, others described it as non-existent or still evolving. Frontline healthcare providers were either unfamiliar with the concept or did not perceive it in practice. These perspectives suggest that the understanding and operationalisation of HSR remain uneven, highlighting the need for greater conceptual clarity and broader dissemination of the concept among frontline providers.

"… the health system in Haiti is not (resilient), it is not really equipped" (O1).

"I would not say that it is resilient. It exhibits certain characteristics" and "they are working on it" (O4).

"There is a lot of effort still to be made …and trust in the government, absent" (O6).

"I am used to hearing this word, resilience, but, I had no idea what it meant in relation to the health system" (O4).

"What? Resilience? No [I have never heard of it]" (O2).

Health System Resilience in Haiti – a Collective and Political Commitment to Health Systems Strengthening

Drawing on participants' clarifications in Table 5, HSR can be defined as: "*a collective political commitment of stakeholders, sectors, and institutions to strengthen the health system, promote transitions towards an integrated approach to health and development, shoulder their respective and shared responsibilities, and apply lessons learned to optimise adaptation, organisation, planning, and preparedness for future shocks, while effectively addressing population health needs.*"

Having established this contextual definition of HSR, participants highlighted several preconditions (Supplementary file 3), with HSG emerging as a key one.

Preconditions for Health System Resilience in Haiti – Health System Governance as a Cornerstone

Participants acknowledged HSR as a relevant concept for Haiti while stressing that its development depends on essential preconditions. They emphasised intersectoral integration, financial autonomy and a conducive investment environment. Beyond these broader conditions (Supplementary file 3), their reflections converged on HSG as the pivotal precondition and cornerstone of resilience-building efforts.

"*There is a constellation of factors, I might say. However, we are talking about a country with a serious governance problem. That is the starting point...*" (S2).

Rethinking Health System Governance in Haiti – Three Interdependent Dimensions

The following sections present stakeholders' perspectives on HSG and its links with HSR. Participants' discourse showed that governance principles cannot be approached as independent checklist items. Rather, their weaknesses emerged as interconnected, overlapping and mutually reinforcing. This insight informed the identification of three interdependent dimensions for understanding HSG in Haiti: organisational-structural, politico-institutional and ethical-citizen (Supplementary file 2).

Health System Governance Organisational-Structural Dimension

Participants outlined organisational weaknesses in planning, coordination, and resource allocation that hinder HSG, resulting in reactive and fragmented responses to population health needs. Planning gaps were linked to non-operational, unfunded, and context-blind plans. They also described insufficient coordination, particularly during emergencies, and inadequate central regulation, both associated with duplicated activities.

"When resources are not allocated according to set objectives, there is a serious problem of adequacy" (S2).

"A plan that cannot be financed is merely a draft" (S4).

"X came on Monday; Y comes back on Tuesday for the same conditions […] in the same area…" (O5).

Alongside these challenges, participants highlighted limited accountability, stemming from weak oversight mechanisms. This was described as fostering impunity, demotivation and inefficiency.

"We let things slide... (but) if we cultivate this culture of accountability, we will change governance" (S6).

In contexts of insecurity, operational constraints generate inefficiencies that shape resources use and divert them towards unsustainable actions.

"We were granted a humanitarian corridor [...]. Yet, we still had to travel 300 kilometres to deliver goods 10 kilometres from Port-au-Prince. Here are concrete examples of how this (the security context) directly impacts our effectiveness. We are forced to deploy more resources to logistics than to the

response itself" (S8).

"It turned out that almost everyone was offering the same service. Every responder involved was distributing pills, applying bandages, whereas community members needed other or additional services or care" (O7).

Participants also reported limited strategic autonomy linked to dependence on external financial support. This reduced national regulatory capacity and created power asymmetries that shaped HSG's organisational-structural dimension.

"It's as if the State, the MoPHP, is not really the regulatory body. NGOs [non-governmental organisations] are the ones providing the money […] The donors are the ones who decide what they want and how to do it. 'He who pays the piper calls the tune.' The donor dictates because they are the ones giving the money; they are the 'boss'" (O7).

Health System Governance Politico-institutional Dimension

The politico-institutional dimension shapes the environment in which organisational-structural processes unfold. Participants described a landscape marred by regulatory uncertainty, a dysfunctional judicial system and restricted budgetary transparency. Together, these factors were seen as weakening the MoPHP's authority. Constitutional ambiguities, particularly around presidential and prime ministerial roles, alongside outdated legal frameworks ill-suited to current health system needs, were reported to blur responsibilities and compromise policy continuity amid political instability and frequent government reshuffles.

"There are governance's issues raised within the constitution itself – notably the ambiguity between the roles of the President and the Prime Minister. […] If I take the organic law of the MoPHP, it is not adapted to the reality of the MoPHP to be able to manage its system. The health emergency management unit (…) that we put in place and that works is not in the organic law. That means it was created by a ministerial circular, because it was something important that we wanted. So, the law needs to be revised" (S7).

These conditions were described as further eroding the MoPHP capacity and authority to fulfil its role. In that context, participants also highlighted a gap between institutional practices and social and civic values compounded by judicial dysfunction. This was seen as undermining institutional credibility and limiting regulatory capacity.

"It is love of the country … that is what builds a country. The work for the health system must be done at the highest level. It means practicing good governance, having the right person in the right place, supported by strong justice systems. There must also be a strong justice system, because there is a great waste of money, a lot of corruption. This happens because there is so much impunity" (O5).

Financial resource management was perceived as lacking transparency, notably regarding post-disaster reconstruction funds. Limited budgetary predictability was seen to hinder strategic planning and reinforce mistrust between donors and the State. Existing transparency mechanisms, which are often externally driven, remain partial.

"Earthquake rehabilitation funds were managed through opaque structures outside government oversight, with large amounts of donor funding never passing through the public treasury. (…) While there is a management structure in place, there is no upward flow of information that would allow visibility into effective management... So, the information does the ministry in a timely manner. (…) This allows donors more freedom to act outside State control, which is why their funding is not included in the national budget" (S5).

Interview excerpts on donor relations also revealed structural power asymmetries, as donors and aid agencies can intervene outside State channels at their own discretion.

"Donors operate outside State control, and due to mistrust in State institutions, they prefer working with NGOs rather than with the State […] As they have much more freedom to spend when they engage with civil society organisation […] they deliberately take it. What could prevent any donor or international organization from intervening in an area, in a somewhat remote locality?" (S6).

Meanwhile, at service delivery level, participants highlighted challenges faced by providers and communities. Providers pointed to inadequate support and limited resources while communities were reported to struggle to afford basic care in unsafe, deteriorating facilities. Limited responsiveness and lack of information reduced service utilisation and trust, reinforcing geographical access barriers.

"Because the country offers us (as health workers) nothing. Because if they send you somewhere, they must make sure there is all the equipment needed for us to work…" (O2).

"Sometimes care is available nearby, but people are not informed about it. But is that the State's priority? Have they recruited qualified staff capable of inspiring confidence or encouraging the population to use these services? Are the clinics equipped?" (O7).

Health System Governance Ethical-Citizen Dimension

This dimension, which is informed by both strategic and operational participants' perspectives without direct community voice, encompasses values, participation, ethics, and equity. Participants highlighted financial and geographical barriers that undermine equitable access to care. These challenges were linked to organisational-structural and politico–institutional constraints, particularly the absence of integrated planning that meets population needs and prevent catastrophic health expenditure. Healthcare providers working closely with communities reported adopting compensatory informal practices, including consultations on credit, partial dispensing of medicines and occasional fee exemptions, to address these gaps.

"Sometimes a child comes for vaccination, and we realize the child also needs a consultation, so we give it on credit; some return and pay, but others never do [nou toujou an konvalesans] meaning the health system is constantly lagging" (O1).

Participation in decision-making was described as insufficient, despite being recognised as essential for building consensus and trust. Centralised decision-making was reported to constrain effective action at the operational level.

"The MoPHP alone cannot manage health in a country

[…] our biggest problem is that others who should join to build a resilient health system often ignore the importance of their contributions" (O5).

In the absence of local representatives, owing to the political and electoral context, participants reported that communities lacked advocacy and necessary assistance following shocks.

"If you do not have a representative, if there is no authority to defend the people, the victims, then no one will do it… the data must come from the local authorities…" (O6).

Participants outlined legitimacy as grounded in electoral mandates, but reinforced by effective accountability mechanisms, strong technical capabilities and a clear commitment to nationhood and common interest. In Haiti's context, legitimacy was reported as undermined when electoral processes fail to produce credible, responsible leadership.

"No, the point is, we had elections, but those who arrived and hold key positions are not convinced about what needs to be done" (S2).

"The person must be accountable; the person does not work for themself but for a country. So, if the person does not love the country, does not have the knowledge or the skills, we will go nowhere…" (O5).

They also emphasised the importance of replicating this model within public institutions to foster a merit-based organisational culture and sustain staff motivation. Lack of exemplary leaders, paired with non-meritocratic appointment systems, was described as demotivating staff and perpetuating unsound practices.

"*We fail to put the right people in the right positions […] we refuse to have these models*" (S6).

Finally, participants underscored the role of some leaders in the current context of violence and criticised humanitarian practices, as well as short-term and at times incoherent measures adopted to deliver immediate results. Participants' discourse pointed to a gap between rhetoric and meaningful commitments to strengthening HSG and HSR.

"Because we know the close link between those who regularly govern the country and the armed groups, the bandits…" (S2).

"Humanitarian organizations sometimes refuse to help rebuild a hospital damaged by an earthquake, yet they provide sophisticated and expensive equipment whose safety is compromised by water leaks every time it rains" (O3).

"How can you ask someone who lives from ashes to go and put out the fire? Someone who lives from ashes will not extinguish the fire. The reason is simple: it is from fire that you get ashes. The person lives from the ashes" (S2).

The preceding subsections highlighted the interconnected nature of the HSG dimensions showing how HSG principles overlap within and across them. Participants illustrated this through accounts on the responses to Hurricane Matthew in 2016 and the August 2021 earthquake as well as the Cholera Elimination Plan (2012-2022) and a university hospital's joint public-private governance arrangements. These examples reflected effective local planning, strong leadership, clear communication, and active community engagement.

"In 2016, Hurricane Matthew affected a community in Grand'Anse, Les Irois, which was destroyed by 80%. Yet there were zero deaths. Why? Because the community organised itself. There was leadership, the mayor was involved, communication was effective, people were informed, and they knew what to do and where to evacuate" (S8).

Taken together, these accounts suggest that HSR is dynamic and context-dependent, relying on coherence within and across HSG dimensions. The following subsection further illustrates how local actions can support HSR through this coherence.

Promising Local Actions and Drivers to Strengthen Health System Governance

Participants highlighted several promising local arrangements and opportunities to strengthen HSG. They cited trust-based collaboration with private-sector stakeholders during emergency response as both feasible and supportive of local economic activity.

"The private sector always takes part in emergency response, but not in preparedness […] To achieve the expected results, a certain level of trust must be established. So, we are working with them to show that we are trustworthy, that they can entrust us with their resources. Trust is a key point to maintain this engagement, they must be involved not only in response, but also in preparedness and prevention" (S8).

Participants also emphasised decentralising responsibilities and strengthening departmental and municipal autonomy as important governance arrangements. They stressed the value of structured community participation, notably in aid distribution, led by neutral, equity-oriented institutions in contexts of insecurity.

"Decentralisation. It is also one of the key points if we want resilience in this country. The system needs to decentralise responsibilities and give a certain autonomy to the department […] We must move towards decentralisation at departmental level, and, for Haiti, I believe that if we manage to establish a Municipal focus, we will have a much more resilient system" (S6).

Participants further noted that meaningful reform requires constitutional amendment and subsequent revision of the health legal framework.

"…the country is in a major governance crisis. This already requires a change. What we could call a change of Constitution … it is the root that must be changed to allow the establishment of a sound governance system" (S8).

Finally, they emphasised that improving HSG is an all-of-society endeavour, dependent on effective intersectoral collaboration and solidarity beyond the health sector.

"The sectors should not work in silos. Solidarity cannot take place only within the health sector but across different sectors. For example, agriculture, civil protection, etc. Because in the event of a disaster, it is not only a matter of health… So, we must work in collaboration" (O7).

"Even if the MoPHP could fulfil all its responsibilities, unless other ministries, such as justice, agriculture, or finance, do their part, we will never achieve a resilient health system […] Health must permeate all policies" (O5).

These accounts highlight the importance of trust,

participation and shared responsibility in strengthening HSG, and reflect key social contract constructs explored in the following subsection.

Emergent Social Contract Constructs for an Ex Post Interpretive Framework

Participants' understandings of HSG implicitly reflected core social contract constructs, including accountability, civic commitment, trust, and legitimacy (Figure 3).

Within the organisational-structural dimension, deficits in planning, coordination, and leadership reflected shortcomings in political authority performance, understood as the State's obligation to deliver on its mandate.

"There is indeed a major deficit in overall management that needs to be corrected ... It takes laws to enable us to have uniform structures that can communicate with each other. Once the structures are organised, the next battle is to find the right people who need to be in the right place" (S7).

"…without leadership, without a vision... we always find ourselves lagging, chasing after emergencies, chasing after the bare minimum, but we're not building anything" (S8).

As for the politico-institutional dimension, legal ambiguities and limited transparency pointed to a compromised delegation of authority, whereby the conditional transfer of power from society to governing institutions is institutionally and constitutionally undermined. Accountability, which conditions this governance pact, was described as weak or absent. External actors' role was reported to further constrain national stewardship, the authority delegation and participation.

"…as long as we remain dependent, with our eyes fixed on external aid, they will always practise top down on us ... They come and decide what they want even though they are informed otherwise" (O7).

"…we let things slide ... if we manage to truly cultivate this culture of accountability, we will really change governance" (S6).

Regarding the ethical-citizen dimension, erosion of reciprocity and shared values between health institutions and the population reflected a deficit in relational trust. The citizen-state relationship was described as necessary yet fragile, while civic commitment, an expression of shared values, was identified as lacking.

"…if we don't have the participation and involvement of the population we are working for, we simply cannot operate. Because it is this population that will protect us" (S8).

"…people must be accountable; they don't work for themselves but for their country" (O5).

"This civic engagement ... it has to come from somewhere" (S6).

Finally, trust and collective obligation cut across the three dimensions as recurring conditions whose absence undermines coherence within and across them. Both enmerged repeatedly in participants' accounts of legitimacy, accountability and reciprocity shared responsibility and civic commitment.

"…leadership that can create this trust and bring everyone together around a certain consensus" (S8).

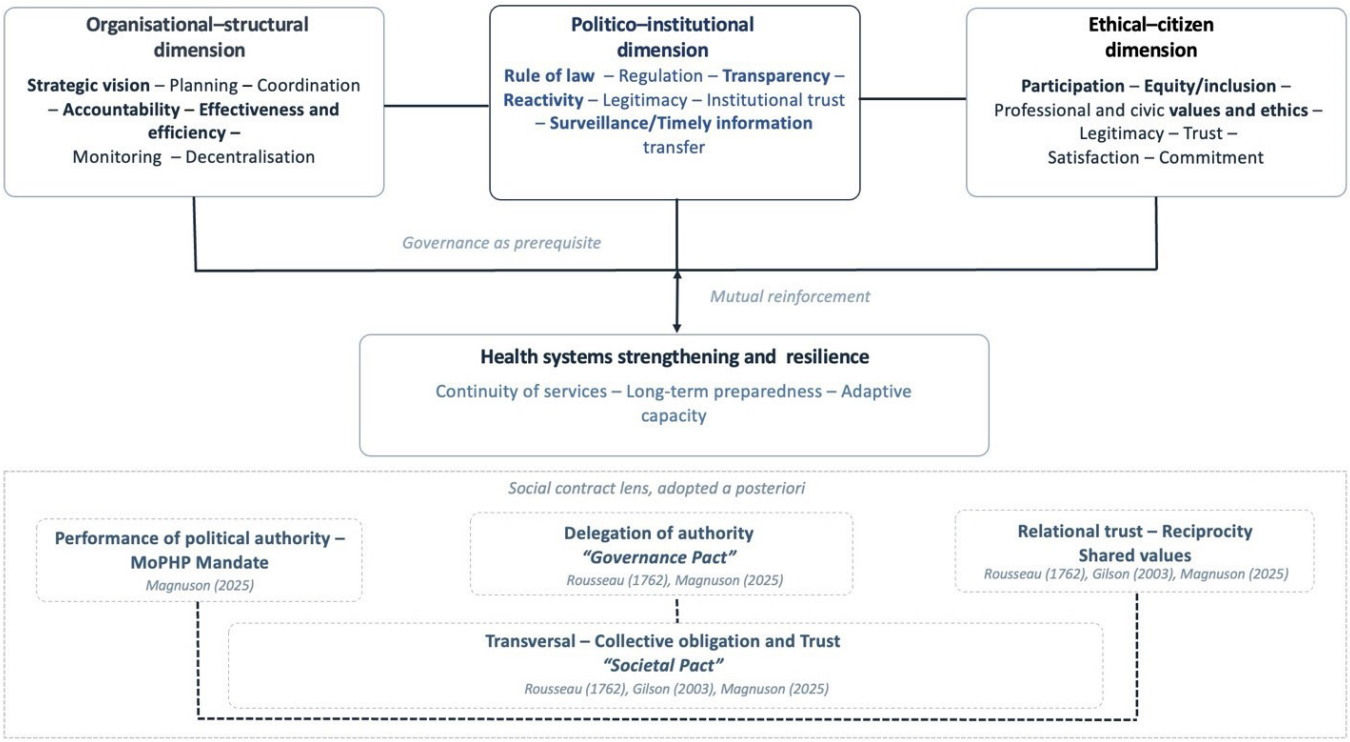


Figure 3. Health System Governance Dimensions, Principles, and the Social Contract Lens. Sources: Authors' compilation of empirically grounded HSG dimensions; Social contract ex post lens adapted from Rousseau, Gilson, Magnuson.[46-48] Note: Social contract constructs (dashed-border boxes) were adopted as an ex post interpretive lens during inductive coding that identified the three HSG dimensions. The lens emerged from, rather than was imposed on, the data. The constructs relational logic aligns with Rousseau (1762), Gilson (2003) and Magnuson (2025). Lateral arrows denote interdependence across HSG dimensions while double-headed arrows indicate mutual reinforcement between governance dimensions and HSR. Abbreviations: HSR, health system resilience; HSG, health system governance.

"…the people who occupy key positions are not convinced about what needs to be done" (S2).

This convergence between participants' discourse on HSG and social contract constructs emerged from the analysis, prompting the *ex post* adoption of a social contract lens to interpret and discuss the findings in the following section.

Discussion

Haiti's HSG weaknesses emerge as interconnected rather than isolated. Deficits in planning, coordination, and accountability occur amid legal ambiguity, limited regulatory authority and power asymmetries, eroding trust, participation and legitimacy. Aid dependency and the short-term logic of humanitarian action further disrupt system functioning. Within this context, participants call for a clearer conceptualisation of HSR and propose a contextualised definition grounded in political and cross-sector commitment, civic engagement, accountability, and shared responsibility. Effective HSG thus appears to depend not on isolated principles but on coherence across organisational-structural, politico-institutional, and ethical-citizen dimensions. Where such coherence is lacking, the State's ability to steer collective action, exercise authority, and sustain public trust becomes fragmented, revealing a breach of the social contract.[46-48] This social-contract lens, adopted *ex post* from the findings, guides the discussion and situates the results within the broader literature.[46,48] The discussion first examines HSR and its relationship with HSG. It then explores how incoherence across HSG dimensions contributes to a crisis of legitimacy and trust before advancing dimensional coherence as a pathway to strengthen HSG and foster HSR in FCAS such as Haiti.

From Ambiguity to (Re)definition – Health System Governance and Resilience in Haiti Through a Social Contract Lens

Defining HSR and clarifying its relationship with HSG has long eluded consensus.[6] This study's participants address this gap by offering a contextualised and politically grounded definition of HSR. According to them, HSR consists of *"a collective political commitment by stakeholders, sectors and institutions to strengthen the health system, promote transitions towards an integrated approach to health and development, shoulder respective and shared responsibilities, and translate lessons learnt into action to optimise adaptation, organisation, planning and preparedness for future shocks, while effectively addressing population health needs."* This definition reframes HSR as a political and institutional obligation, challenging its reduction to managerial or community-level adaptive capacity.[49] From a social contract standpoint, this shift reflects reciprocal obligations, whereby authority is delegated to the State in exchange for the protection of fundamental population rights, including health.[46,48,50] HSG therefore emerges as the basis through which these obligations are exercised, extending beyond a merely supportive role for HSR.[51,52]

Existing literature similarly identifies HSG as a core determinant of HSR[6,53-55] and echoes social contract theory[46-48,51,52,56,57] including its operationalisation through equitable access to care and procedurally fair institutional processes.[50] However it largely presents HSG through its facilitating capacity and provides limited insight into how HSG principles or capacities interact within FCAS.[6,55] This study helps fill this gap by showing how HSG is challenged in practice in Haiti. It moves from a normative checklist to an empirically grounded dimensional framework in which coherence across dimensions emerges as a key precondition for HSR. At the organisational level, plans function as normative artefacts disconnected from funding or implementing institutions. At the politico-institutional level, constitutional ambiguity, budget opacity, aid dependency, and power asymmetries, erode the MoPHP's regulatory capacity. At the ethical-citizen level, responsibilities fall tacitly on communities and frontline healthcare providers, placing costs and risks on already vulnerable populations.[58] Failure to uphold obligations erodes public trust, while disengagement hastens institutional weakening.[59,60] As a result, the health sector forfeits the legitimacy and capacity required to bring about any sustainable transformation.[48,52] This cross-dimensional dynamic alongside the contextualised HSR definition constitutes a central empirical contribution of the study.

Incoherent Health System Governance in Haiti: Legitimacy Crisis and Eroded Trust

Where the social contract is breached, the consequences materialise as erosion of trust and legitimacy on which health systems rely.[52,61] This study findings identify incoherence across HSG dimensions as both driver and consequence of this erosion in Haiti's health system. Where political accountability is absent, appointments are disjointed from competence, and donors operate arbitrarily, the structural conditions for trust collapse.[47,62,63] Lack of transparency and restricted access to information reinforce a generalised sense of unaccountability, undermining trust between national and international stakeholders and between institutions and the population. These findings resonate with existing literature.[47,62,64]

The study shows that trust operates through two related registers in Haiti. In social contract terms, it is the normative basis of the governance pact, shaping delegation of authority and contingent on institutional performance and fulfilment of obligations.[47,48,62] In the findings, trust also functions as an operational resource. It is constructed through interactions between providers and communities and may persist despite institutional weaknesses. This form of trust supports service delivery where formal HSG arrangements are constrained. The findings show a divergence between these two registers in Haiti: reduced institutional credibility coexists with trusting provider-community relationships. This positions provider-community trust as a relevant resource within a context of weakened HSG.

Trust and legitimacy, though intertwined, operate differently. Trust is relational, built through accountable institutional interactions. Legitimacy is normative, grounded in democratic processes and perceived governance fairness.[47,50,62] Beyond these established determinants of legitimacy, our findings identify leaders' accountability, commitment to the common good, and perceived expertise, alongside citizen engagement

and education, as additional legitimacy drivers. Evidence from FCAS corroborates that legitimacy depends on procedural fairness and coherent responsiveness to population needs[65]; while unmet population expectations deepen mistrust.[66,67]

These findings suggest that in Haiti, HSG incoherence has affected both registers of trust. Institutional limitations weaken social contract-based trust while declining institutional credibility constrains the provider-community trust on which frontline healthcare providers rely to deliver services. Trust and legitimacy therefore erode together, reducing the health system's capacity to mobilise collective action and sustain meaningful reform.[68] In Haiti, this dynamic has contributed to the rise of parallel governance structures that further entrench institutional fragility.[69] This pattern warrants further dedicated empirical investigation.

Beyond Principles: Dimensional Coherence for Effective Health System Governance in Haiti

Strengthening HSG in Haiti requires coordinated action across HSG dimensions, whose internal and cross-dimensional discrepancies have contributed to the trust and legitimacy crisis described above. Whilst the literature identifies multiple HSG principles and arrangements applicable to FCAS,[4,6,10] it remains less explicit regarding the context-specific conditions, notably trust, legitimacy, accountability, and power asymmetries, that determine whether these arrangements strengthen or unravel.[26] This study addresses that gap by emphasising dimensional coherence as an operational concept, rather than adherence to a checklist of principles.

HSG is not merely a sectoral attribute; it is the product of coherence among institutional architecture, organisational practices, and civic norms. From a social contract perspective, this implies not only compliance with rules, but also the sustained fulfilment of reciprocal obligations across dimensions. The study empirically demonstrates what previous studies theorise[46,51,56]: when one dimension is constrained, effects extend to the others. In Haiti, effective HSG depends less on the formal presence of individual principles[4] than on whether coherence across organisational-structural, politico-institutional, and ethical-citizen dimensions is maintained in practice.[51,56]

Fragility operates along a continuum, with uneven distribution of HSG capacities across actors, levels, and territories.[8] The findings reflect that nuance. Despite pervasive institutional shortcomings, instances of partial coherence were observed in emergency coordination, public-private co-governance arrangements, and community-level initiatives. These examples demonstrate that partial coherence is achievable even under adverse governance conditions and signal leverage points for institutional rebuilding anchored in existing capacities rather than idealised external models.[1,61] Coherent action jointly pursued by the State, communities, and other health-sector stakeholders hold the potential to restore the social contract rebuild trust, ensure legitimacy, rebalance power asymmetries and strengthen MoPHP capacity to fulfil its mandate and advance HSR in Haiti.

Recommendations

Drawing on participants' insights, these recommendations offer actionable avenues to strengthen coherence in Haiti's HSG, in line with core social contract constructs. For the MoPHP: (*i*) restore legitimate regulatory authority through clarified mandates, competence-based appointments and renewed democratic engagement with citizens and local actors; (*ii*) realign planning with institutional capacity and available resources to reduce inefficiencies and limit aid dependency; (*iii*) ensure transparent and accountable management of public funds in internal, inter-institutional and national regulatory frameworks, independently of donor conditions, to rebuild trust, ensure effective HSG and support HSR; (*iv*) advance effective decentralisation through the devolution of functions and adequate resources to foster participation at subnational (departmental and municipal) levels. For donors and humanitarian actors: (*v*) recognise aid dependency and short-term approaches as constraints on HSG; (*vi*) align resources with national systems under MoPHP coordination; (*vii*) provide predictable, long-term funding consistent with national priorities; (viii) acknowledge and address power asymmetries in programme design and technical assistance, while remaining accountable to national institutions and the population. For operational stakeholders: (*ix*) treat trust as a governance resource and sustain it through equitable, continuous, and responsive service delivery; (*x*) ensure operational actors' contributions to HSG are formally recognised, adequately resourced, and integrated into subnational, national, and international frameworks and plans. For communities: (*xi*) strengthen participation in planning, demand accountability, and exercise the right to information; (*xii*) build on existing community structures and local leadership as sources of HSG capacity. For researchers working in SIDS and FCAS: (*xiii*) further explore the proposed HSG dimensional coherence framework through a social contract lens, with particular attention to the ethical-citizen dimension from a community perspectives.

Reflexivity

The first author began this study optimistically as a female Haitian physician familiar with Haiti's public health network. Political and security instability, which proved more severe than anticipated, restricted field access, data collection, and sample composition. We treated these constraints as inherent to research in such settings and recommend allowing generous timelines, even for native researchers. The first author conducted all interviews and shared similar academic qualifications with strategic-level participants, reducing potential power imbalances during interviews. Among frontline healthcare providers, prior contextualisation of the research helped alleviate concerns about potential employment-related repercussions. The first author also conducted the analysis and coding processes and remained mindful of the potential influence on the diversity of interpretations. This was addressed through iterative analysis, attention to alternative interpretations and systematic examination of deviant cases. These conditions also shaped our interpretation of the findings. The first author paid close

attention to contextual influences, potential selection effects and limits to generalisability, while co-authors guarded against over-interpretation by ensuring that claims remained grounded in participants' discourse and verbatim quotations.

Limits

Field constraints precluded theoretical saturation, and the small sample size likely limited perspective diversity. However, recurring patterns suggest adequate thematic saturation. Security instability during data collection may have introduced social desirability bias, particularly regarding value-laden issues. Snowball sampling heightened the risk of participant homogeneity, while the absence of community representatives limited deeper scrutiny of the ethical-citizen dimension, which warrants further investigation. This study does not seek to generate generalisable findings but rather offers an alternative lens for examining HSG in FCAS. Grounded in the Haitian context, the findings reflect local power dynamics and prevailing perspectives on HSG. Any transfer of these findings to other fragile settings should be made with caution.

Conclusion

This study proposes a definition of HSR grounded in empirical data and identifies dimensional coherence as an essential condition for effective governance in fragile and conflict-affected contexts such as Haiti. Incoherence across HSG dimensions in Haiti reveals a social contract breach that undermines the MoPHP's legitimacy and deprives technically sound measures of the political and moral conditions conducive to their implementation. Restoring coherence across organisational-structural, politico-institutional, and ethical-citizen dimensions is inseparable from rebuilding trust and legitimacy. This requires sustained and coordinated action capable of balancing political will, power relations, actor interactions, and resources. Without it, neither HSG nor HSR can be sustained.

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Disclosure of artificial intelligence (AI) use

Copilot (Microsoft 365), ULB institutional version, was used as an AI tool for language editing.

Ethical issues

This study is part of a doctoral research project and received ethical approval from the relevant ethics committees in Haiti and Belgium:

- Comité National de Bioéthique, Haïti – Reference 2122-45 (August 21, 2022)
- Erasme–ULB Ethics Committee, Brussels – Reference P2022/313 (September 1, 2022)

Participants received written information about the study and provided informed consent. Two participants provided verbal consent and declined audio recording. No participants withdrew from the study. Confidentiality and anonymity were ensured, and data were stored on a password-protected computer accessible only to the first author. Identifying institutional references were removed and replaced with generic descriptions. Each interview was assigned a main code and a simplified identifier reflecting the participant's level of involvement, "S" for strategic and "O" for operational. Given the small sample size and the restricted environment in which senior decision-makers operate in Haiti, the data were not deposited in a public repository. Access may be granted upon reasonable request subject to approval by the relevant ethics committees. All procedures followed the applicable ethical standards and national regulations in each jurisdiction.

Conflicts of interest

Authors declare that they have no conflicts of interest.

Disclaimer

The views presented in this article reflect the perspectives of the study participants and the authors. They do not necessarily represent the official positions of the authors affiliated institutions or of the journal.

Authors' contributions

Conceptualization: Patricia St Louis and Elisabeth Paul.
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Funding acquisition: Patricia St Louis.
Supervision: Elisabeth Paul.
Validation: Maryam Bigdeli and Elisabeth Paul.
Writing–original draft: Patricia St Louis.
Writing–review & editing: Patricia St Louis, Maryam Bigdeli, and Elisabeth Paul.

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Supplementary files

Supplementary file 1. Interview Guide.
Supplementary file 2. Inductive Analysis and the Role of the Negative and Deviant Cases.
Supplementary file 3. Preconditions for Health System Resilience as Identified by Participants.

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