

A Collaborative Governance model based on Public Consortia for refugee's health: a comparative study between Ethiopia, Afghanistan and Bangladesh-Myanmar

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Abstract: According to UNHCR the global migration crisis in 2024 witnessing an unprecedented number of 304 million migrants.

A great number of articles about refugees show them as victims and think that they should receive all the support without any counterpart, in both directions, to help the country that receives them and the country where they no longer want to live. Or at least help themselves, seeking an intellectual, professional and spiritual growth. What is clear is that the vast majority of refugees take advantage of the welcome they have received to stay on social networks all day long, instead of trying to learn the local language, seek work and education. Some refugees don't even help other refugees with cleaning the refugee center/camp, preparing food, and respecting, for example, the rules of silence and security.

There is a discussion between two paradigms: the pragmatic, competence-based, and the humanitarian, financial-psychological-based.

However, there is no network between the government, schools, universities, employment agencies, companies, social organisations and churches.

Therefore, this work discusses the two paradigms in the light of a Collaborative Governance Model based on Healthcare Consortium to help refugees from Ethiopia, Afghanistan and Bangladesh-Myanmar.

Since the idea is to identify the problems of coordination in the formation of Consortium, that is very similar in any field, this article interviewed six consortia in Brazil (Rio de Janeiro, Sao Paulo e Rio Grande do Sul). Content analysis was conducted according to Bardin's model (1986). The executive directors of the consortia, the target audience of this research, work in Collaborative Governance with municipalities and hospitals, being responsible for integrating strategy (what is and why to do it) with planning (how to do it) and management (analyzing what was done and improving) and providing more specialities, surgeries, and lower-cost medications through bidding processes. The measurement is based on effectiveness and not on efficiency and efficacy, in order to see the applicability to the health crisis among Ethiopian and Afghan refugees.

The main result is the Collaborative Governance model applied in the Ethiopia and Afghanistan contexts and a suggestion to create a CONSORTIUM between UNHCR (United Nations High Commissioner for Refugees) and NGOs to take care of the health of refugees.

Key-words: Collaborative Governance, Consortia in the Health Sector, New paradigm for refugee crises, Spiritual Leadership

I. Introduction

After the discussion of the two paradigms (to pamper or to work?) in the light of a Collaborative Governance Model based on Healthcare Consortium to help refugees from Ethiopia e Afghanistan the article identifies the problems of coordination in the formation of Consortium based on the interviews in Brazil

The importance of refugee education has never been greater than it is today, as the world is facing the highest-ever number of forcibly displaced people and half of the refugee population consists of children below 18 years of age (UNHCR, 2018b, 2020). Refugees are explicitly included as a marginalized group targeted by Sustainable Development Goal (SDG) 4 and the Education 2030 Framework for Action (UNESCO, 2016, p. 9).

Several authors writing about refugees come to the conclusion that their economic success is linked to government aid, in particular in facilitating the integration of refugees into a society with new values, assumptions, beliefs and traditions.

Often the biggest problem is not the language, but the unity for a common purpose, since they are all inhabitants of the same planet, and can also go through wars.

Black et al. (2022) The growing number of global refugees in recent decades, particularly the experience of large refugee flows to many EU countries in 2015, has raised interest in the question of how public policy can help refugees get a foothold in their destination countries. Many destination countries have programs designed to help refugees adapt to their new environments, often providing financial support to help them meet basic needs, as well as offering assistance in finding employment. In doing so, they recognize the challenges that refugees face. At the same time, however, there is growing concern about the increasing burden of welfare spending on refugees, without actually developing a strategy for mutual growth, including involving refugees in the day-to-day work of re-training centers, of a new life.

As Germany is the pioneer and most welcoming refugee nation in the world, it receives a lot of criticism.

Kovács, Ramakrishnan and Thieme (2022) state that the EU's and particularly Germany's calls for "solidarity" and "welcome" were considered hypocritical, where there was a resistance to treat migration and refugee issues as if they were discrete, technical issues that could be divorced from issues of culture, history, economics, and therefore differential responsibility.

Other authors seek solutions for the gradual integration of refugees in big cities, giving them time to recover, emotionally and financially, with their own families.

This article is divided as follows. The first section gives an overview of refugees, particular in Germany. The second section highlights the situation of refugees in Ethiopia and Afghanistan. The third section presents the topic of Spiritual Leadership in Healthcare Consortium for refugees. The section four share the methodology and data collection. The section five shows the discussion of results. Finally, section six presents the model of Collaborative Governance applied in Healthcare Consortium for refugees based on the previous topics.

II. A summary about refugees in Europe: to pamper or to work?

Refugee support organisations appear as an economic sector with a double-edged role. On one side, they promote refugee economic integration through career counselling and qualification measures (Ekmekcioğlu et al. 2023; Lumley-Sapanski 2021; Mozetič 2022; Stingl 2021). On the other side, they simultaneously function as intermediaries between governments and refugees, reproducing the state's temporal priorities, which consist in directing refugees to unpaid volunteer work, or entry-level jobs in low-paid, flexible labour market segments (Giudici 2024; Górný and van der Zwan 2024; Lumley-Sapanski 2021; Mozetič 2022; Stingl 2021). Taken together our findings indicate that, compared to other population groups, refugees possess reduced capabilities to cross borders (Glick Schiller and Salazar 2013; Griffiths 2021).

Marbach et al. (2018) in Germany and at 37.6 billion Euros for refugees that arrived in European countries in 2015–2016 (Fasani et al. 2021). Additional costs may occur in the long run from a negative effect of waiting on refugees' physical and mental health (Hvidtfeldt et al. 2021; Phillimore and Cheung 2021; Schober and Zocher 2022).

In any case, insufficient institutional coordination, administrative delays in registering asylum claims and issuing work documents, as well as geographical distance to labour market services represent common elements that add up and render refugees susceptible to precarious or hyper-precarious (i.e., suggesting lack of freedom to various degrees) working conditions (Anderson 2010; Hemmaty 2024; Knappert et al. 2018; Otmani 2024; Schenner et al. 2019; Spehar, 2021; van Kooy and Bowman 2019).

Liska et al. (2026) found that refugee status poses a significant burden on mental health, largely because of existential hardships. In both countries researched, refugees who were inactive were more likely to feel depressed (Liska et al. , 2026)

Moreover, mental health problems hinder access to employment. Supporting refugees' entry into the labor market is a common element of local integration policies and is shaped by structural conditions. However, beyond environmental and regulatory factors, individual variables—such as a willingness to accept any job (submissiveness) or caregiving responsibilities—also influence labor market participation (Liska et al., 2026).

Pesch, Ipek, and Fitzsimmons (2022) argue, using the example of a refugee in Germany, that Barbara's behavior reflected a common tendency to think of refugees as vulnerable victims who have survived persecution, live in precarious situations, and need various types of support (social, financial, and even emotional).

No evidence-based guidance is available to help managers decide what kind of support to offer refugee employees.

Refugee support service organizations in most countries help refugees settle into their new homes by meeting their essential needs for food, shelter, and language training. However, employment is arguably even more important than language skills in predicting refugees' social integration. In this respect, unemployment among refugees is both individually difficult and problematic for society because it limits their integration.

The charity Talent Beyond Boundaries aims to facilitate skilled employment for refugees. Canada's Economic Mobility Pathways (EMPP) pilot program offers selected and trained refugees a faster route to migration, and the German government funds a network of more than 2,500 members to collect and share national expertise on refugee recruitment and management. Some organizations are likely to adopt these recommendations as a way to perform humanitarian service; others seize these opportunities as a way to combat labor shortages.

To be effective, managers need to know what types and how many workplace integration activities to offer to help refugee employees thrive. We conducted this research in Germany because, following its 2015 influx of migrants, German managers likely gained some experience in hiring refugees. Chancellor Angela Merkel frequently encouraged German citizens to participate in the migration effort with the phrase “We can do it,” referring to refugee integration. Many managers in Germany responded to this encouragement with a moral sense of responsibility to employ refugees. 24% of German companies employed at least one refugee in 2019. Similar trends could emerge in other countries, but German managers are likely ahead of the learning curve and therefore provide a good example for others to learn from.

Herppel et al. (2025) highlights that for Ukrainian refugees, strong emotional and practical connections to their homeland along with expectations of eventual return—may reduce the

incentive to invest in language learning or long-term labour market integration in Germany. Studies have presented mixed and sometimes conflicting results about the impacts of social contact between different identity groups on between-group discriminatory behaviours, attitudes and conflict (Forbes, ; Paluck, Green & Green, 2019). In fact, several studies suggest that mere exposure instead of social contact can lead to heightened intergroup tension and a desire for reduced future interactions (Enos, 2014; Hangartner, 2019). Hence, it remains theoretically ambiguous whether connecting refugees with hosts would augment or diminish future social interactions with natives (Herppel et al., 2025)

If administrators view refugees only as passive victims of disaster, they might assume that charitable aid is their top priority, rather than providing performance feedback, training, or professional development resources. The focus shifts to refugees' vulnerabilities, not their capabilities.

The focus shifts to organizational practices that help develop human strengths. This approach emerged from a broad field called positive psychology, which centers on developing strengths and behaviors that enable people to thrive. For example, positive educational psychology suggests how individuals can enhance learning by leveraging their strengths.

Despite their desire to do good, humanitarian managers rarely give refugee employees space to develop independently. Rather, they tend to overwhelm them with assistance and workplace integration efforts, leading a refugee learner to perceive these behaviors as oppressive.

Lecturers and humanitarians are likely to become disappointed and frustrated when the refugee does not act and perform as they would like. Conversely, humanitarian activities tend to undermine the self-reliance of refugee employees. Driven by their perception of refugees as helpless victims, they believe that heavy-handed interventions are the key to successful workplace integration. They go to great lengths to shield refugees from problems, solving them on their behalf. The intention is protective, but this level of involvement can inadvertently make refugee employees feel stupid or powerless, as if they are incapable of solving problems on their own. Over time, refugee employees may adopt their managers' perspectives and see themselves primarily as helpless victims, which is likely to hinder their performance, lead to disinterest in their work, or even result in higher turnover.

From the end of the war in 1945 until the construction of the Berlin Wall in 1961, an estimated 2.6 million East Germans escaped the communist German Democratic Republic (GDR) and emigrated to the Federal Republic of Germany (FRG), or West Germany. A large proportion of these refugees arrived as children or young adults. According to the data, 32 percent of the refugees were under 15 years old upon arrival, and around 41 percent were between 15 and 24 years old.

Historical literature mentions three main factors that led people to flee the GDR (see Heidemeyer, 1994 and van Melis, 2006). One group of refugees consisted of those who openly opposed the regime. These included members of the Protestant church youth organization, which was oppressed by the communist regime, as well as people forced to work in uranium mining or for the East German police.

A second factor was the centrally planned economic oppression and disenfranchisement of the communist system. Farmers and agricultural workers, for example, fled due to the expropriation and reorganization of their farms for use as agricultural production cooperatives.

In light of this, it seems important that refugees be able to contribute to the food supply in the host nation, primarily fruits, vegetables, meat, and dairy products.

The 1951 Refugee Convention defines a refugee as "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion" (UNHCR, 1951, p. 3).

Statistics from the United Nations High Commissioner for Refugees (UNHCR) indicate that 37,000 people a day are forced to flee their homes due to conflict and persecution (UNHCR, 2019). Education was generally provided to refugees through parallel education systems, separate from those of the host country's native population. However, given the protracted nature of displacement, as well as the growing number of urban refugees, this approach is increasingly seen as impractical. Since 2012, the inclusion of refugee students in national systems has been integrated as a sustainable native-sector change solution (Dryden-Peterson, 2016; UNESCO, 2018a).

Sakaue and Wokadala (2022) found that, in theory, host countries, whose education systems are already burdened by serious problems, can also benefit, as donor funding can improve the overall quality of education for both refugees and students in the host community. The updated education strategy of the United Nations High Commissioner for Refugees.

III. The situation of refugees in Ethiopia and Afghanistan.

3.1. Ethiopia

Ethiopia hosts over a million refugees and asylum-seekers and is one of the largest refugee-hosting countries in Africa. Refugees are hosted in camps and settlements across several regions. This role as a country of asylum, however, increasingly overlaps with Ethiopia's own internal conflicts and large-scale displacement. Refugee health therefore cannot be examined only as a question of services offered by a host state; it must also be considered in relation to the capacity of that state to protect civilians, maintain health infrastructure and preserve humanitarian access during armed conflict. Violence is already an important element of the refugee-health context. Wado et al. (2026) interviewed 1,937 females and 1,536 males and found that about 30.5% of females and 36.6% of males aged 13-17 years experienced at least one form of violence in the 12 months preceding the survey. Previous studies have identified associations between low education and violence among young women, emphasizing that limited education can reduce decision-making power and increase vulnerability (Hillis et al., 2016; UNICEF, 2015).

The violence affecting refugees must be situated within the wider deterioration of civilian security in Ethiopia. The war in Tigray, which began in November 2020, generated extensive civilian mortality, destruction of infrastructure and forced displacement. Weldemichel (2025) describes the conflict as involving organized massacres, sexual violence, enforced disappearances, mass detention and the forced displacement of millions. Violence against civilians is therefore not separate from displacement: it is one of the mechanisms through which new internally displaced populations and cross-border movements are produced.

Gebretsadik et al. (2026), using data from 13,915 households in 19 districts of Tigray, found that 5% of participants reported a war-associated death of a civilian family member. Gunshot wounds were the leading reported direct cause of death, followed by mass killings. The study also identified indirect conflict-related deaths associated with chronic illness, infectious disease, starvation and pregnancy or labour complications. The authors connect armed conflict with displacement, food insecurity, collapse of health services and disruption of essential infrastructure. This is central to the present study because the refugee-health problem is simultaneously a protection problem, a health-system problem and a coordination problem.

Gebregziabher et al. (2025) documented 1,143 casualties associated with 80 drone and aerial bombardment incidents in six zones of Tigray between June 2021 and October 2022; 385 casualties were deaths, 28.3% of the victims were children and 45.1% were female. Affected locations included marketplaces, residential areas, villages, public transportation, churches, hospitals and internally

displaced-person camps. The presence of casualties in IDP camps is particularly relevant: physical displacement does not necessarily create protection when sites intended to shelter displaced populations remain exposed to armed violence.

Checchi et al. (2025), using a survey of the Tigrayan diaspora, reported that among 310 deaths occurring within Tigray during the war period, 224 (72.3%) resulted from intentional injuries. Although the study design requires caution when generalizing the estimates to the entire region, the findings provide further evidence of the extraordinary civilian burden of the conflict and of the need to integrate mortality, displacement and access to healthcare in analyses of refugee governance.

The interaction between internal conflict and refugee protection becomes even clearer when Eritrean refugees are considered. Tufa, Rudolf and Abebe (2024) report that the conflict in northern Ethiopia forced substantial numbers of Eritrean refugees previously hosted in the Shimelba and Hitsats camps to flee again, including relocation to Mai Aini, Adi Harush and other parts of Ethiopia. Abebe, Tufa and Rudolf (2026) further show that, before the Tigray war, the four camps of Mai Aini, Adi Harush, Shimelba and Hitsats housed more than 96,000 Eritrean refugees. When war reached Tigray, people who had already crossed an international border seeking protection found themselves at the epicentre of another conflict. This secondary forced displacement demonstrates the fragility of refugee protection when the host region itself becomes a theatre of war.

The Ethiopian case therefore reveals a cumulative process: armed violence against civilians contributes to mortality and destruction; destruction weakens health systems and livelihoods; insecurity generates internal and cross-border displacement; and conflict in refugee-hosting areas can displace refugees for a second time. Refugee vulnerability is consequently produced not only by conditions in the country of origin but also by the governance capacity, political stability and security conditions of the country and region of asylum.

Other refugee problems identified in Ethiopia reinforce this multidimensional vulnerability. Tesfai (2023) found persistent employment and earnings gaps affecting African refugees. Mohamed, Yadeta and Motuma (2025) reported a substantial prevalence of sexually transmitted infections among young people living in a refugee camp and identified previous STIs, risky sexual behaviour and inadequate knowledge of prevention among the associated factors. Amo-Agyei et al. (2025) similarly highlight the importance of healthcare provision, safer sexual practices and stronger sexual-health education in refugee settings.

For the Collaborative Governance model proposed in this article, these findings have an important implication. Refugee healthcare cannot depend exclusively on a single ministry, humanitarian organization or level of government. Conflict may simultaneously increase demand for healthcare while damaging the institutions responsible for supplying it. A consortium involving UNHCR, NGOs, local and regional health authorities, hospitals, universities, refugee representatives and other service providers could distribute knowledge, resources and responsibilities across institutions. Independent monitoring, transparent procurement, shared information systems and contingency mechanisms for the relocation of services would be particularly important in conflict-affected refugee-hosting regions. The Ethiopian experience thus reinforces the central argument developed from the Brazilian consortia: collaborative governance is valuable not merely because it can reduce costs, but because institutional coordination and redundancy can preserve access to essential services when individual actors or institutions become unable to perform their functions.

3.2 Afghanistan

The health crisis during the pandemic and its aftermath have caused multidimensional shifts within the economic and societal structure for refugees and other marginalized communities. Many countries have implemented programs to cater for the additional needs of underserved populations, but refugees and other migrants are usually not covered by these programs. In this context, this study attempts to explore the impact of the crisis on Afghan refugee's vulnerability and the relationship between health services, relief packages, and risk communication.

In a high level research with 427 Afghan refugees' families from five major cities of

Pakistan, using partial least squares structural equation modelling (PLS-SEM), Sumra et al. (2025) found that Afghans were excluded from humanitarian policies during and after COVID (taking advantage of the culture of exclusion).

Soon after the pandemic, it was discovered what was already known since the pandemic started in China, in the city of Wuhan, China (Huanan Seafood Wholesale Market): the virus was created in a Chinese laboratory, Wuhan Institute of Virology (Egright et al., 2024). China's strategy of sending the couple with COVID-19 to Italy is also not new, given the strong impact of language on the culture, particularly beliefs, of a given society (Stanlaw, 2026; Efimov, Lapteva & Mikhailova, 2015; Frings-Hessami & Oliver, 2022; Nantel & Glaser, 2008; Tabari, Wilson & Ingram, 2016; Englander, 2013). The Italian language has the shortest grammar when compared to any other language and is classified as category 1 (The Foreign Service Institute (FSI), 2025).

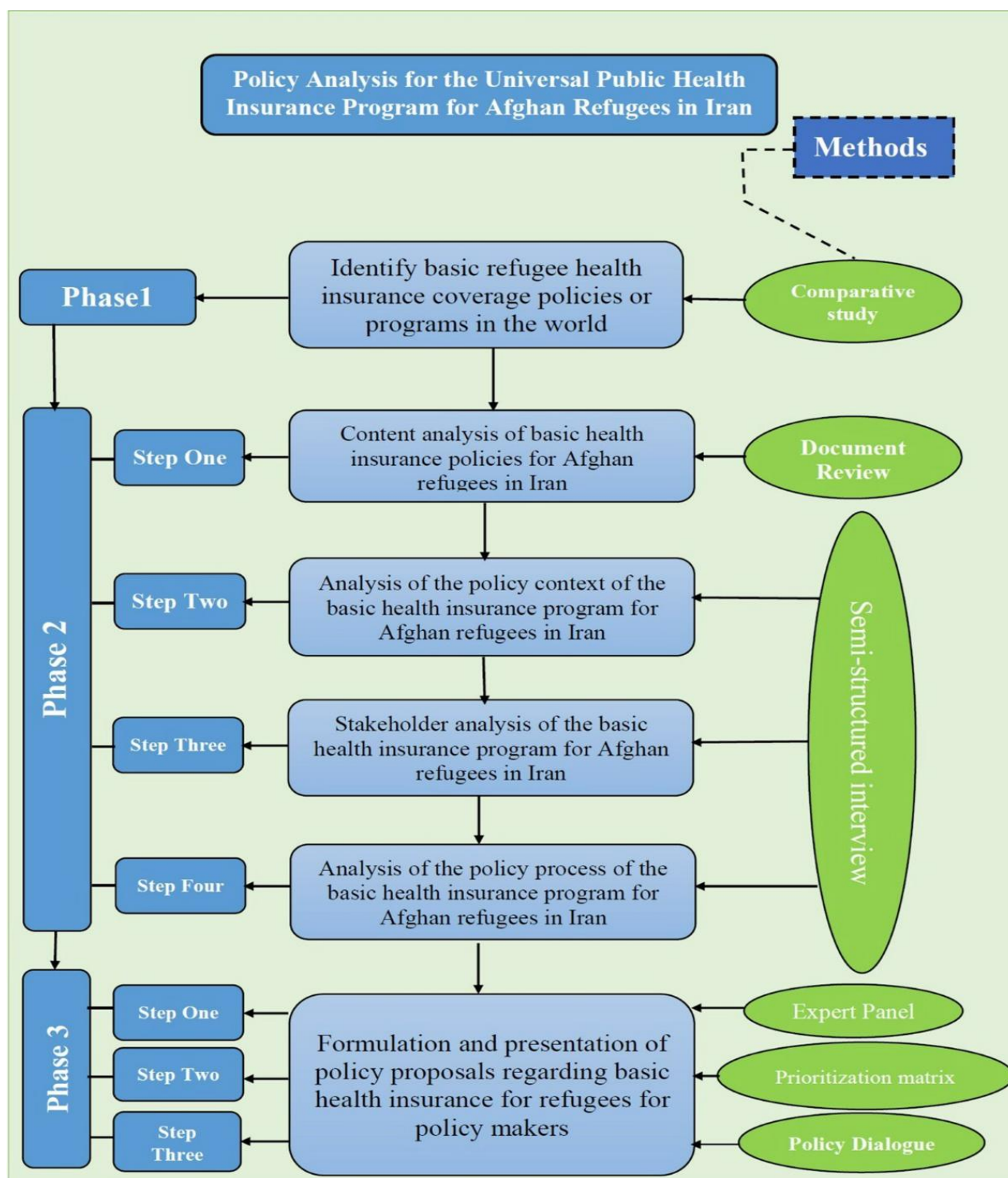
Sumra et al. (2025) construct a model that explains 63.3% of the variance in Afghan refugees' vulnerability with government services. It indicates that Afghan refugees are unable to access relief packages, and there is insufficient communication of risk factors. The lack of government facilities is due to the harder closed-door policy of the Pakistani government which has worsened the vulnerability of Afghan refugees after the sudden victory of the Taliban in Afghanistan (strange decision of Biden's government to remove the troops of the country, creating critics from his own party, in particular, from the ex-candidate Hillary Clinton who was severely punished by the access of her emails during campaign to the White House and against Trump).

The situation of Afghans in Pakistan became extremely serious after the arrest of former Prime Minister Imran Khan, who advocated for the union of Catholics and Muslims at UN conferences.

Sumra et al. (2025), in a unrealistic way, consider that Pakistan government has insufficient ability to provide economic and social protection Afghan refugees in all crises, in particular Taliban return post-pandemic, that have affected Afghan migrants and refugees - medical and socio-economic risks at several levels (Enos et al., 2014). As result of the indifference and bad behavior of the current Pakistan's government is that Afghan in exile in Pakistan has prompted several million Afghan refugees to flee back.

In a second high level study conducted by Amuzadeh-Araei, Takian, Jabbari (2025), a semi-structured interviews was made with 22 key individuals, including managers and experts from the Health Insurance Organization, the Bureau for Aliens and Foreign Immigrants Affairs (BAFIA), the United Nations High Commissioner for Refugees (UNHCR), refugee researchers, educated Afghan refugees, and healthcare service providers. After analyzing the participants' perspectives, 253 factors influencing the policy context of the UPHI program for Afghan refugees in Iran were identified.

Analysis of the policy context of the UPHI for Afghan refugees in Iran, based on the PESTEL framework (Amuzadeh-Araei, Takian & Jabbari, 2025).



The main political factors are: The impact of wars and conflicts on the financial participation of international organizations, Uncertainty in the implementation of memoranda of understanding due to changes in governments, Internal wars, regime changes, and regional developments as factors contributing to the increased influx of Afghan nationals (Amuzadeh-Araei, Takian& Jabbari ,2025).

Since the political factors are very difficult to change due to the fact that the power is too concentrated in the hands of people with total indifference in relation to refugees, the

cultural aspects can be reviewed through community education, in particular physical education due to the lack of habit of reading. Very important to notice that the believes of people, in particular in the Arabic World (strong link with Islamic religion) they are construct by the government through the literacy process first and quickly after in the mosques, the schools and universities.

In one third study, also in Iran, conducted also in 2025, across multiple healthcare centers in Shiraz, Iran , separated the problems of Agegan refugees in Iran, as a function of three primary domains: Predisposing Factors, Enabling Factors and Need Factor (Andersen and Newman, 1973). The results, with frequencies, are: High Costs of Healthcare Enabling 100%, Lack of Health Insurance Enabling 100%, Structural limitations Barriers to medication and specialized care Enabling 26%, Limited government support Enabling 60%, Delay in access to services Enabling 20%, Knowledge and communication gaps Lack of familiarity with NGOs Predisposing 26%, Lack of communication by healthcare staff Enabling 20%, Low literacy and awareness Predisposing 26%, Psychological challenges Perceived and experienced discrimination Enabling 40%, Feelings of isolation and inferiority Enabling 20%, Mental health needs Need 13%, Social challenges Language barriers Enabling 20%, Cultural differences and lack of social support (Khosravi et al., 2026).

3.3 The intersection between the militarization of Chittagong and the Rohingya's Crises by Thomas Christian Eskildsen Overview and distinct historical trajectories

Chittagong Hill Tracts (CHT), an upland area of southeastern Bangladesh adjoining India and Myanmar, must be distinguished from the lowland Rohingya refugee camps concentrated around Ukhiya and Teknaf in Cox's Bazar. The CHT question concerns the relationship between Indigenous Jumma communities, Bengali settlement, land tenure, self-government and Bangladesh's security institutions. The Rohingya crisis derives principally from exclusion and persecution in Myanmar's Rakhine State, aggravated by repeated cross-border displacement. Comparing them is useful for analysing the governance of borderlands, but it would be inaccurate to describe them as one war or to attribute Rohingya displacement directly to the CHT conflict.

Militarization, recognition and territorial administration

The CHT experienced insurgency and counterinsurgency, and its 1997 Peace Accord created commitments related to political institutions, land and demilitarization whose implementation has remained contested. Military and security presence matters not only as a response to armed threat but also for civilian access, movements, institutional accountability and community trust. In the Rohingya setting, refugee-camp security, policing, border management, humanitarian access and regional diplomacy create a different form of securitization. An analytical comparison must therefore distinguish longstanding Indigenous land claims within Bangladesh from the rights of refugees displaced from another sovereign state.

Population, religion, land and local livelihoods

Both settings have ethnic and religious dimensions, but the configurations differ. The Jumma label encompasses multiple Indigenous populations whose religious traditions include Buddhism, Christianity, Hinduism and Indigenous beliefs; the Rohingya are predominantly Muslim and share that faith with most of the Bangladeshi host population. In the CHT, plantation, forest, infrastructure, tourism and land allocation debates interact with displacement and claims to autonomy. In Cox's Bazar, concentrated refugee settlement affects forests, local services, prices, livelihoods and labor markets while humanitarian operations also generate employment and resources. Economic consequences should be measured rather than presumed uniform across host communities.

Health and public-consortium governance implications

The comparison directly informs the article's collaborative-governance proposal. A

consortium serving displaced populations and host communities would need differentiated legal mandates and representation: Indigenous institutions and land authorities in the CHT; refugee protection agencies, camp administration, host-community representatives and Myanmar-related diplomatic partners in Cox's Bazar. In both cases, health referral pathways, interpreters, maternal and mental-health services, disease surveillance, medicine procurement and emergency transport require cooperation across organizations. However, a consortium should not replace refugee rights, national obligations or independent human-rights monitoring, nor should health provision become dependent on security approval without transparent safeguards.

Comparative framework

Table 1 reproduces and integrates the previously prepared comparative matrix. It identifies six axes through which shared governance mechanisms and legally distinct populations can be compared without inferring direct causation.

Axis	Chittagong Hill Tracts (CHT)	Rohingya / Cox's Bazar	Comparative Link
Ethnicity	The central CHT dispute concerns Indigenous Jumma communities, relations with the Bangladeshi state, land rights, political recognition, autonomy and demographic change associated with Bengali settlement.	The Rohingya originate mainly from Myanmar's Rakhine State. Exclusion from citizenship and recurrent persecution have driven mass displacement into Bangladesh.	Both settings connect identity with claims over territory, citizenship, representation and state authority, although the legal and historical foundations differ.
Religion	Jumma communities include Buddhists, Christians, Hindus and followers of Indigenous traditions, whereas most Bengali settlers and the national majority are Muslim. Religious difference overlaps with ethnicity but is not a sufficient explanation by itself.	Most Rohingya are Muslim. In Myanmar, religion has interacted with ethnic exclusion and persecution; in Bangladesh, refugees largely share the majority religion of the host population.	Religion matters through its interaction with ethnicity, citizenship, territorial claims and state relations rather than as a single independent cause.
Economics	Disputes over land, forests, tourism, plantations, infrastructure and development projects tie livelihoods and resource control to political authority.	Large refugee concentrations in Cox's Bazar affect labour, prices, forests, infrastructure and public services, while humanitarian operations also generate jobs and financial flows.	Tension can intensify when access to land, employment and development resources follows ethnic, territorial or legal divisions.
Politics and Security	The CHT experienced insurgency, counterinsurgency and the 1997 Peace Accord; security institutions remain important in debates over autonomy, land, governance and civilian administration.	The Rohingya crisis combines humanitarian, diplomatic, border and security dimensions involving Bangladesh, Myanmar, international agencies and camp governance.	Security policies shape both peripheral populations, but the CHT is primarily an internal Indigenous-territorial issue whereas the Rohingya crisis is transboundary and closely tied to citizenship exclusion.
Geography and Borderlands	The CHT is a mountainous border area adjoining India and Myanmar, with a distinctive ethnic history and contested forms of territorial administration.	Cox's Bazar is located along the Myanmar frontier south of Chattogram and contains a very large Rohingya population, particularly around Ukhiya and Teknaf.	In both cases, distance from the political centre and proximity to international borders magnify questions of mobility, identity, security and territorial control.

Axis	Chittagong Hill Tracts (CHT)	Rohingya / Cox's Bazar	Comparative Link
Core Comparative Proposition	Territorial governance becomes more contentious when Indigenous claims, demographic change, security policy and control of resources converge.	Refugee governance becomes more contentious when mass displacement, pressure on host communities, lack of citizenship, security concerns and international intervention converge.	A borderland-governance lens helps explain how identity, territorial insecurity and unequal access to political or economic resources can cause development, administration and security policies to become tightly interconnected.

Interpretive boundaries

The matrix shows intersecting questions of identity, territory, resource allocation and security, not an empirical demonstration that one crisis caused the other. Its contribution to the Ethiopia–Afghanistan–Bangladesh–Myanmar comparison is institutional: where forced displacement, contested authority and weak trust intersect, health cooperation needs public oversight, clearly specified responsibilities, trusted local representation and transparent information sharing. These propositions constitute a policy design, not evidence that a functioning Chittagong–Rohingya health consortium has already produced measured improvements.

Practical consortium design for southeastern Bangladesh

An operational framework would establish (1) a joint health-needs assessment separating host, refugee and Indigenous populations; (2) referrals linking primary clinics, district hospitals and specialist care; (3) transparent purchasing, stocks and quality checks for medicines; (4) monitoring of availability, referral completion and preventable mortality; and (5) community feedback and independent grievance mechanisms. Participation must be tailored to the distinct legal and political positions of each population. The Brazilian consortium cases discussed below supply organizational experience, but their model requires adaptation to Bangladesh's law, humanitarian coordination rules and conflict-sensitive safeguards.

IV. Advantages and Disadvantages of Collaborative Governance

The theoretical limitations of adversarial or managerial approaches can lead to experiments with collaborative governance (CG) (Busenberg, 1999; Futrell, 2003; Williams and Matheny, 1995).

Ansell and Gash (2007) explain that, in the typical adversarial or managerial process, non-state actors are external observers of decision-making. They may try to pressure or influence decision-makers in public bodies, but it is the body that is ultimately responsible for the outcomes of the policies.

Collaborative governance, on the other hand, transfers responsibility for decision-making from the agency to the actors acting collectively.

However, imbalances in resources, knowledge, and power among different actors, lack of experience in discussions about highly technical problems, varying incentives for collaboration among actors, management levels, and the diverse backgrounds of members have hindered the creation and operation of consortia in the Brazilian health sector.

Collaborative governance is a governance mechanism in which one or more public agencies directly involve non-state stakeholders in a formal, consensual, and deliberative process of collective decision-making, with the objective of creating or implementing public policies or managing public programs or assets (Ansell and Gash, 2007). Walter and Petr (2000, p. 495), for example, describe collaborative governance as a formal activity that “involves joint activities, joint structures, and shared resources,” and Padilla and Daigle (1998, p. 74) recommend the development of a “structured arrangement.” Collaborative local governance is an important topic in public administration, as it seeks to address governance

failures, high costs, and the politicization of regulation, developing contingency approaches to local governance (Berthod et al., 2023).

Given the lack of literature on communication and coordination problems in public health consortia, this research aims to disseminate solutions to these problems, based on a literature review, questionnaires, and interviews.

Collaborative governance has advantages and limitations. Therefore, it is important to evaluate the performance of collaborative governance processes to identify strengths and weaknesses, as well as the keys to successful implementation.

First, it is necessary to consider that individual interests can hinder dialogue between different groups.

The heterogeneity among municipalities in a country as vast as Brazil means that some local governments face greater financial difficulties than others, revealing different economic, political, and administrative capacities (Nascimento et al., 2021). Governments often hesitate to share authority due to skepticism regarding the population's knowledge and self-organization capacity, despite the value of local knowledge as a complement to scientific data (Pomeroy and Berkes, 1997).

Furthermore, governments may use co-management not as a mechanism for sharing power, but as a tool to achieve predetermined objectives, excluding local actors from meaningful participation (Gelcich et al., 2006; Miller et al., 2019). The participation of key (public) or service-providing (private) agencies with municipalities and consortia can generate difficulties, given the different missions, visions, and objectives of these organizations. Similarly, the relationship between the municipalities themselves and public consortia, as we will see in the interviews, can create difficulties, given the different levels at which the management and administration of these entities operate, in addition to the issue of honesty in the handling of information and financial resources.

The contracting of private companies differs from subcontracting to other government units or non-profit organizations because the incentive for opportunistic behavior is often much greater in the for-profit private companies involved (Feiock, 2007).

Although costs are less frequently identified, the benefits of collaboration are commonly discussed in the literature. In service delivery, collaborations promote understanding and strengthen relationships among stakeholders (Resh et al., 2014), facilitate joint problem-solving (Doberstein, 2016), and develop contextually appropriate policy solutions (Leach et al., 2014; Wall and Jeffrey, 2006; Ostrom, 1990). In service production, collaborations provide flexibility to meet the needs of clients and jurisdictions (Milward and Provan, 2000; Provan and Kenis, 2008), reduce costs (Ostrom and Ostrom, 2019), and improve innovation in service delivery (Agranoff and McGuire, 2001). Above all, the results validate the hypothesis that health consortia increase outpatient care compared to municipalities that have not joined one (Nascimento et al., 2021).

According to Nascimento et al. (2021), future research could conduct efficiency tests of clusters in specific consortia, more accurately assessing the effects of health policies in the regions served by these agreements and their contextual characteristics.

It is also necessary to consider transaction costs, which are the costs of information, negotiation, monitoring, and contract execution (Feiock, 2007).

The literature indicates that the provision of public services becomes more effective through knowledge sharing and economies of scale (Bel, Fageda, and Mur, 2014; Bel and Warner, 2015; Hulst and Montfort, 2007; Silvestre et al., 2019; Voorn, Genugten, and Thiel, 2019).

However, it is important to highlight the problem of information overload caused by various

actors, especially political actors who lack technical support. A large amount of information can also come from the public, if they are invited to participate in the consortium, since, after all, they are the target audience.

However, according to Such et al. (2022), this is only a symbolic effort or a late inclusion of the community in the political cycle.

Still, there are some exceptions. The “Healthy and Happy Hague” project is a good example of collaborative governance that, by supporting community participation and involving professional organizations, improves the health of the population. It is important that there is a reciprocal relationship between all actors in the collaboration, regardless of their discipline or intellectual level (Lammeren et al., 2025).

To change the way social and health services are delivered, the neighborhood-oriented approach focuses on low socioeconomic neighborhoods and seeks to empower citizens, improve their resilience and their ability to promote personal well-being.

In addition to information overload, we must also consider the lack of information. Tavares and Feiok (2017) warn that coordination risks arise when local governments believe it is in their best interest to act together, but fail to do so due to incomplete information.

If the consortium considers the opinions of the population, we must take into account the importance of citizens' political ideology in decisions about service delivery. In this case, a more direct measurement of the preferences of residents of participating cities would be useful (Sørensen and Torfing, 2005).

According to Tavares and Feiok (2017), the heterogeneity of preferences among communities leads to the adoption of more formal regional governance mechanisms.

However, the main problem lies elsewhere: “Although voluntary cooperation has been implemented as an alternative way to implement functional decentralization, self-organized intermunicipal governance is generally considered unusual and problematic due to its top-down perspective and: (i) potential variations in the legal-constitutional framework, local institutions and preferences, and (ii) difficulties in the interaction between potential governance mechanisms that affect transaction costs.

V. Spiritual Leadership in Refugee Health Consortia

Spiritual leadership encompasses the values, attitudes, and behaviors necessary to intrinsically motivate oneself and others to experience a sense of spiritual survival through calling and membership. Leaders must connect with their core values and communicate them to followers through their vision, values, and personal actions (Fry, 2003).

Fryback and Reinert (1999) state that spirituality is a personal journey to discover the meaning and purpose of life.

Many studies on spirituality have conceptualized it in terms of meaning and purpose (Batten & Oltjenbruns, 1999; Burkhardt, 1993; Mickley et al., 1992; Pace & Stables, 1997; Sherman, 1996; Sherwood, 2000; Smith et al., 1993; Taylor, Highfield, & Amenta, 1999).

Clark and Heidenreich (1995) defined spirituality as one's views and behaviors in the search for meaning in life. According to Sherman (1996) and Smith (1995), spirituality is a way of being.

Communication and commitment are pathways to spirituality (Camp, 1996; Hall, 1998; Waite et al., 1999). Fryback (1993) highlights that spirituality is related to the struggle for self-actualization (Fryback, 1993); Astedt-Kurki (1995), for example, described spirituality as an individual's ambition for a better understanding of themselves and inner balance. Smith (1995) and Smith et al. (1993) indicated that spirituality should include an awareness of the tragic and self-redefinition, and liberation from self-imposed limitations. Hall (1998) recognized authenticity and openness as cornerstones of this relationship and

precisely defined spirituality in terms of authenticity, commitment, and openness.

Relationships with others involve a sense of community (Sherman, 1996), compassion (Sherman, 1996), altruism (Sherman, 1996; Smith, 1995), and self-giving (Walton, 1999). Chiu (2000) described this relationship as manifested in sharing and helping others. The relationship with nature involves the interaction between the person and the environment (Hungelmann, Kenkel-Rossi, Klassen, & Stollenwerk, 1996; Taylor et al., 1999). Sherman (1996) conceptualized spirituality as an awareness of human-environmental interconnectedness.

Vaughan (2003) argues that spiritual intelligence is related to emotional intelligence insofar as spiritual practice includes the development of intrapersonal and interpersonal sensitivity, but spiritual intelligence requires multiple forms of knowledge and the integration of the inner life of mind and spirit with the outer life of mind and spirit working in the world. Buzan (2001) points out that spiritual intelligence is concerned with being part of a larger scheme of things. It involves seeing the "big picture" of life.

According to Emmons (2005), observers are able to distinguish between Emotional Intelligence (EI) and Spiritual Intelligence (SI) through the more distinctive qualities of SI, such as purpose, lack of ego, joy, and discernment, which are not covered in assessments of EI domains. This is the truly broad perspective: intelligence for something beyond selfish interests. According to Zohar and Marshall (2000), SI is the supreme intelligence that serves as a necessary foundation for the effective functioning of both rational and emotional intelligence.

VI. Methodology

The methodology was clearly designed to address the central question of the formation of Public Health Consortia, focusing on coordination (non-political) issues, starting from a discussion on Collaborative Governance within Public Health Consortia. Semi-structured interviews with key actors from selected consortia were qualitatively analyzed to identify good practices and successful organizational strategies. The qualitative methodology was chosen because it allows for the exploration of development processes and provides insights into the complex and contextual nature of consortia. Systematic text condensation was used to analyze the interview data and generate detailed descriptions of consortium configurations and their defining characteristics. This analytical approach contributed to understanding the factors influencing the formation, sustainability, and effectiveness of consortia. Purposive sampling guided the selection of participants, focusing on individuals affiliated with recognized and high-performing consortia. Before implementation, the interviews were conducted in Brazilian consortia and reviewed by the author. The interviewers used the guide as a flexible framework to ensure coverage of key themes, allowing interviewees to elaborate on relevant experiences and share illustrative examples. Direct quotations were documented whenever possible, and interview notes were subsequently reviewed for clarity. The analysis involved an iterative cycle of coding, interpretation, discussion, and revision to refine emerging themes and strengthen the validity of the findings. To increase reliability, summarized results were returned to interviewees for verification before submission for publication. Content analysis was conducted according to Bardin's model (1986), synthesized by Delgado and del Villar (1994): a) Document selection: The diaries of four teachers, written during the three phases of the training program, were selected based on the described characteristics. b) Formulation of objectives: The objectives of the content analysis are as follows: - To analyze how teachers' self-perception improves throughout the three phases of the training program. - To identify the topics of interest that constitute their "practical knowledge". - To discover the sources of concern or satisfaction

among teachers. - Finally, to compare the data obtained with observations of teacher behavior to evaluate the effectiveness of the training program. c) Identification of indices and indicators: The indices (codes) represent the key ideas, topics of interest, and themes that shape the thinking of teachers in training, which are reflected in the content of their "Practical Knowledge". The indicators used were the frequency of key ideas and the frequency of satisfactions or concerns. The positive (satisfactions) or negative (concerns) evaluations developed by the participant in each phase were recorded. Semi-structured interviews with key actors from the consortia of RJ, RS, and SP were qualitatively analyzed to identify best practices and successful organizational strategies that help students and professionals develop greater environmental awareness. Data collection took place in April 2026.

VII. Analysis of Interviews in Health Consortia in Rio de Janeiro - RJ, Sao Paulo – SP and Rio Grande do Sul – RGS.

The interviews were conducted with the executive secretaries of the consortia in RJ, SP and RGS. The questionnaire is at the end of the article.

7.1. Interviews in Health Consortia in Rio de Janeiro (CISBAF and CISMEPA)

7.1.1 Intermunicipal Consortium for Public Security of Baixada Fluminense CISPBAF

The Intermunicipal Consortium for Public Security of Baixada Fluminense CISPBAF was effectively created with legal personality on 11/12/2018 and is currently composed of 19 municipalities in the State of Rio de Janeiro, with the Mayor of the Municipality of Duque de Caxias as its president. According to the CISBAF website, one of the main objectives of CISBAF is to create a belt aimed at ensuring greater public safety, urban mobility, intelligence in the delivery of public services, monitoring of floods and inundations, among other activities that facilitate the lives of the population and make public services more efficient.

The CISBAF executive secretariat has 27 years of experience in this area. Since 2007, the consortium has offered examinations and procedures.

The consortium is subject to the SUS (Unified Health System) agreement bodies and for this it uses the Regional Inter-managerial Commission - CIR, which has representatives from the State and all municipalities involved in the Consortium.

Consortia can receive resources from parliamentary amendments, but the resource must first be delivered to the leading municipality of the consortium. This creates difficulties, according to an interview conducted at the CISBAF Consortium, since the municipality commits most of its revenue to the payroll of its employees. This causes delays in the transfer of the obtained resource.

Two municipalities have already been taken to court, and after that, the municipalities resumed regular payments.

There is a payment rate between 90-92% of what is stipulated in the cost-sharing agreement.

Cisbaf received a parliamentary amendment which, after bureaucratic procedures and negotiation, was used for 670 elective surgeries on children.

Cisbaf is a consortium that serves 3.5 million inhabitants of 12 municipalities in the Baixada Fluminense region. The consortium has 500 collaborators and 150 employees.

It is a regional management instrument for common actions among the consortium members for the benefit of the population.

Regarding the question about the barriers, the executive secretariat of CISBAF clarifies the difficulty of internal legislation to operationalize the bidding law.

Regarding the question about the benefits, the secretariat says that the benefits of the

consortium are numerous, but the most important are: cost-effectiveness, quality, efficiency, and economies of scale.

Regarding the question about ongoing projects, it mentions program contracts for the execution of specific programs.

It provides as an example the MARQUEFACIL Program, which it launched in 2018, with the objective of reducing unmet demand and expanding the population's access to specialized services. The program is structured based on the accreditation of private providers.

There is another program contract to manage the SAMU base, located at the CISBAF headquarters, which receives between 1200 and 1500 calls a day. SAMU has 7 doctors during the day and five during the night.

Regarding the question of the possible imbalance of resources between small and large municipalities, he makes a comparison between Brazil and Spain, since he was in Catalonia in 2007 to learn about the Consortium (technical visit). There, there is primary care plus hospital care. They accredit private hospitals for elective surgeries. They are public limited companies (clinics) with management freedom. All patient records are electronic and the clinics' budget is the responsibility of the manager. If they monitor the patient's health, there will be less spending and then the manager receives a bonus. It works so well that only 3% of the Spanish population has health insurance.

He clarifies that the Consortium's regulations, and the management of the SUS itself, are quite complex and bureaucratic. One of the reasons is that the resources for the SUS are divided into three parts, with the federal government receiving 50%, the states 25%, and the municipalities 25%.

Regarding the question about the use of financial and human resources, it states that the accreditation of providers follows its own table, and the SUS (Brazilian Public Health System) table is not competitive.

Transparency is very high, and the regularity of payments is published on the consortium's website.

The consortium has a reserve budget to pay the service provider if the municipality does not transfer the money. It is then able to receive payment from the municipality due to the blocking of access to the services offered by the consortium.

Regarding the question about the use of financial resources, it clarifies that the cost-sharing agreement is made through a letter of intent, and administrative expenses are shared among the federated entities.

It mentions Ministry of Health Ordinance No. 2,905/2022, in particular the FINANCIAL AND BUDGETARY RULES APPLICABLE TO THE SUS (Brazilian Public Health System), such as the LETTER OF INTENT AND THE COST-SHARING AGREEMENT, which provide for the financing method of the public consortium.

and Bill 196, which, in addition to amending Law 11.107/2005, provides for community participation in the management of the Unified Health System (SUS) and intergovernmental transfers of financial resources in the health sector.

It mentions the National Registry of Health Establishments (CNES) as a fundamental element in the management of health system information.

Regarding training, it states that there is a Platform for this and the Permanent Education Program has certified 8,000 professionals.

There is a partnership with the State Court of Auditors to resolve doubts about the new Contracts Law, but also courses in the areas of budgeting, law, and planning. All categories have goals, and if they meet the goals, they earn more salary.

Regarding the service provided to the 12 municipalities and the differences in needs and resources, it clarifies that the large municipalities (Duque de Caxias and Nova Iguaçu) accept that the Consortium helps the smaller ones because they are also helped. There was even a case of a meeting in the Federal Capital to request money from a hospital that wasn't even in the mayor's municipality. Since they are very close, having services in a municipality within the consortium's region is essentially an advantage for everyone.

7.1.2. CISMEPA - Consórcio Intermunicipal de Saúde do Médio Paraíba – RJ

On July 1, 1998, through the signing of the Consortium Agreement by the mayors and Health Secretary of the region, the Intermunicipal Health Consortium of the Médio Paraíba Region, CISMEPA, was conceived.

More recently, two important pieces of legislation were significant for the history of CISMEPA.

Ordinance 399/2006, known as the Pact for Life, consists of a set of health commitments, expressed in process and outcome objectives and derived from the analysis of the country's health situation and the priorities defined by the federal, state, and municipal governments. It is a commitment among the managers of the Unified Health System (SUS) to qualify and implement the process of decentralization, organization, and management of the SUS.

Decree No. 6017/2007 establishes rules for the execution of Law No. 11,107, of April 6, 2005, and helped CISMEPA transition from a private law consortium to a public law consortium.

When asked about the barriers, he states that the CIR has become the best tool for dialogue.

The Inter-managerial Commissions operate at three distinct and complementary levels, ensuring that decisions are articulated from national planning to local execution.

1. Tripartite Inter-managerial Commission (CIT) – National Level, Bipartite Inter-managerial Commission (CIB) – State Level, Regional Inter-managerial Commission (CIR) – Regional Level

The agreement refers to the formal agreements that enable shared management. The commissions do not audit accounts, but define the rules of the game, that is, the operational, financial and administrative aspects.

CISMEPA has a 20-year history and is currently only responsible for SAMU after handing over the management of the Regional Hospital to the State. Discussions for the implementation of the Dra. Zilda Arns Neumann Regional Hospital (HRZA) date back to the 2000s, being revived in 2008 with technical discussions within CISMEPA. The hospital was inaugurated on March 29, 2018.

The executive secretary reinforced that the consortium is seen as a mechanism for implementing public health policy. In fact, CISMEPA's main focus is on providing emergency and urgent care through the Mobile Emergency Care Service (SAMU). In a second phase, the intention is to expand actions, mainly for the joint acquisition of medicines.

Regarding the first question, it states that most municipalities (smaller size) are in need and the larger ones are hubs.

He explains that he currently has 10 employees, but indirectly has 300.

Unlike CISBAF, which has a single base, CISMEPA has 16 bases in 12 municipalities.

Regarding question 8, he states that he has two education processes.

The first is with the Permanent Education Center - NEP, which promotes two training sessions per month.

The second mentions the partnership with UNIFOA and UNIFLOR Universities to promote

emergency training, particularly in cardiovascular care.

Regarding the question, he clarifies that there are well-managed municipalities and others that are poorly managed, and this requires some patience in discussion groups and assemblies of mayors and health secretaries.

Regarding question 12, he mentions the regional health centers (NAG) that supplement the Consortium's budget.

Among the challenges (questions 16 and 17) are: identifying development partners that provide technical support, securing financial support for projects, coordinating resources, and ensuring institutional commitment to project sustainability, aligned objectives, and shared values.

On the other hand, factors that can help overcome these challenges and achieve success include clearly defined rules and boundaries, collective priority, openness and transparency, shared resources and equality, member commitment, established governance rules and legal frameworks, periodic communication, organizational events, and promoting hosted projects.

The focus should be on three dimensions - governance, objective and work outcome - and not on the dimensions of control, cost, sustainability and productivity.

7.2. Interview with Consorcio Sao Paulo: Intermunicipal Consortium of the Western Metropolitan Region of São Paulo (CIOESTE)

In 2013, CIOESTE was founded, bringing together a group of 14 cities in São Paulo.

Unlike the other consortia researched, it is a multi-purpose organization that works with mobility, health, education, environment, security, culture and other sectors.

Formed by the municipalities of Araçariguama, Barueri, Carapicuíba, Cajamar, Cotia, Ibiúna, Itapevi, Itu, Jandira, Osasco, Pirapora do Bom Jesus, Santana de Parnaíba, São Roque and Vargem Grande Paulista, CIOESTE covers a region with more than 3 million inhabitants distributed in an area of over 1,000 km². The cities that make up CIOESTE contribute approximately 3% of the National GDP and 10% of the state GDP, consolidating itself as the largest intermunicipal consortium in the country in socio-economic importance.

The mayors' meetings are held periodically to design projects for mobility, health, education, environment, security, culture, and other sectors.

The consortium can contract, bid, carry out works, and even raise funds from outside the country for the projects under development.

The project manager of CIOESTE Saude reports that there are 5 positions, including that of executive secretary.

The main problem, according to the manager, is that CIOESTE has not carried out administrative reform and there are still difficulties in differentiating between commissioned (appointed) positions and positions through public competition. He says that one of the advantages of CIOESTE is that no public money enters and the amount transferred goes directly to the payment of employees and maintenance.

He explains that it is a private political-administrative arrangement under public law, which facilitates direct contracting between the Consortium and member municipalities.

It also explains that the main function of CIOESTE Saúde is the accreditation of consultations, exams, and surgeries, but there is no direct contact with the citizen/patient as in CIRC (Rio Grande do Sul).

It reports that one of the major difficulties is the understanding of the municipalities regarding adherence to the price registration record and that the great challenge is the sensitization of the health secretaries of the member municipalities. It speaks of the need for regional research for better interaction between municipalities, the State, and the Federal

Government.

It also describes the difficulty for larger municipalities, which have more resources, to value the work of CIOESTE Saúde and says that a better understanding of the legislation is necessary, which is somewhat confusing due to overlaps and an excess of information and laws/decrees/ordinances imposed by the Ministry of Health.

7.3. Interviews at Rio Grande do Sul Consortia (CONISA & CIRC)

7.3.1. INTERMUNICIPAL HEALTH CONSORTIUM - CONISA

CONISA, founded on June 7, 1997, was created for the purposes of: providing health care, including the implementation of a compounding pharmacy, hiring specialized professionals, and acquiring devices, instruments, and equipment. Only the compounding of medications stood out until the beginning of 2013.

On April 17, 2012, a protocol of intent was signed between the consortium municipalities to adapt the bylaws to Law No. 11,107/2005 and Decree No. 6,017/2007, which establishes rules for contracting public consortia. From then on, the Consortium was constituted as a public association, with legal personality under public law and of an autonomous nature, non-profit, with administrative, financial, and patrimonial autonomy, governed by its bylaws and the rules of the Civil Code.

Among the various purposes defined for CONISA, priority was given to the purchase of medicines through a central purchasing system, using bidding processes in accordance with Federal Law 8.666, of June 21, 1993, and subsequent amendments.

In the interview, it was observed that the main problems are:

There are only two accountants, one lawyer, and one administrator. Given this scenario, there is a lack of a health professional to help in the selection of service providers in this area (the core area of the consortium).

She also complains that there is no support from the federal and state governments, but rather from the consortium municipalities.

According to the executive manager, the consortium enables broad access to health services, promotes the integration of municipalities, and improves the use of public resources since the greater number of services reduces prices.

One of the weaknesses is the difficulty in finding a provider for a specific exam or consultation. In addition, there is a waiting time to conduct a registration bidding process since the consortium does not have an auctioneer.

Another weakness is the change in municipal management with new mayors and secretaries every 4 years. However, it states that the relationship with the six consortium municipalities is excellent.

It does not work with SAMU (Mobile Emergency Care Service) like other consortia surveyed, nor with emergency services.

It is unfamiliar with the work of the other consortia, which partly hinders innovations in terms of organizational management and service delivery..

Regarding the question of how to reduce inequalities, although the Sarandi Hospital does not have services for more complex diseases, it can quickly find that another municipality within the consortium offers the desired service. If it is not available, it takes the matter to the Assembly so that it can be put out to tender.

Regarding the question of how projects are evaluated collaboratively, the executive manager replies that she holds assemblies with mayors and health secretaries to understand which procedures and exams are necessary, and the consortium presents the costs before proceeding with the bidding process.

Given the political and management obstacles, the services offered by the consortium do not satisfactorily meet the needs of patients from the different member municipalities. Regarding the question "what actions could be implemented to overcome the challenges faced by the consortium?" she mentions increasing financial transfers, organizational restructuring, and greater coordination between the municipalities and the state.

7.3.2 Consórcio Intermunicipal da Região Centro do Estado/RS – CIRC

CIRC is a Public Association of Public Law formed by 34 municipalities in the Central Region, covering an estimated population of 586,582 inhabitants. It acts as a support instrument for municipal administrations, assisting in solving daily demands, developing projects and raising funds in various areas of public management, in addition to promoting shared bidding processes. In the area of health, the Consortium provides continuous services through the purchase of health services via Public Call for Bids, which in 2025 had more than 892 items and 125 accredited companies. It also organizes the scheduling of consultations and exams, ensuring the proper flow of care in medium and high complexity for the population of the consortium municipalities.

The executive secretary of CIRC states that the main problem with consortia is the disregard for the rules of the Court of Auditors regarding the way in which the consortium acquires a service, without a direct relationship with the patient. In the case of CIRC, if the patient cannot get care at the health center, they can go to the secretariat of the municipality where they live, which will assess the urgency and contact the consortium that will "buy" the consultation.

Regarding the biggest difficulties, they mention the bureaucratic political problem of launching more Public Call notices, and the very offer of services from this notice, which may be limited by the 34 mayors participating in CIRC, particularly by the executive leadership.

VIII. Discussion of Results

As we can see from the responses of the interviewed executive secretaries, the Consortium tends to be a good solution to increase the number of specialties and surgeries, reduce drug prices, and offer emergency services, particularly ambulance services, with greater effectiveness. However, we encountered several coordination problems that deserve highlighting, particularly the bureaucratic issue, very present in Latin American countries, due to communication being based on tacit knowledge rather than explicit knowledge, and Brazil's literacy method being syllabic instead of phonetic:

Problems in Consortia

POINT 1. COORDINATION PROBLEMS

In addition to information overload, we must also consider the lack of information. Tavares and Feiok (2017) warn that coordination risks arise when local governments consider it appropriate to act jointly but fail to do so due to incomplete information.

According to Tavares and Feiok (2017), the heterogeneity of preferences among communities leads to the adoption of more formal regional governance mechanisms.

Collaborative governance transfers responsibility for organizational decision-making to stakeholders acting collectively (Feiok, 2001).

POINT 2. RESOURCE DIFFERENCES AMONG PARTICIPANTS

When stakeholders are motivated to negotiate, the asymmetrical distribution of negotiation skills and resources often allows the most powerful parties to dominate the process (Amy,

1987; Weidner, 1998).

POINT 3: DIFFERENCES IN KNOWLEDGE AMONG PARTICIPANTS

Governments are reluctant to share authority due to skepticism about the population's knowledge and self-organization capacity, despite the value of local knowledge as a complement to scientific data (Pomeroy and Berkes, 1997).

POINT 4: DIFFERENCES BETWEEN POLITICAL AND FINANCIAL POWER AMONG PARTICIPANTS

Furthermore, governments may use co-management not as a mechanism for sharing power, but as a tool to achieve predetermined objectives, excluding local actors from meaningful participation (Gelcich et al., 2006; Miller et al., 2019).

POINT 5: BENEFITS AND BARRIERS OF CONSORTIA

Collaborative governance is broadly defined as the functions and structures of decision-making and policy management that involve citizens in a beneficial way, overcoming the limitations of public institutions (Gash, 2022). Regarding the benefits, the CISBAF consortium secretariat highlights that they are numerous, but the most important are: profitability, quality, efficiency, and economies of scale.

IX. A Collaborative Governance Model for Refugee Health

Furthermore, it is important to study how different national institutional contexts structure the configuration and preferences of actors, the selection of tasks for collective action, and the mechanisms available to resolve collective action dilemmas (Andersen and Pierre, 2010; Feiock, 2009; Hulst et al., 2009). Ansell and Gash (2007) constructed a model with four variables: initial conditions, institutional design, leadership, and collaborative process (Figure 2).

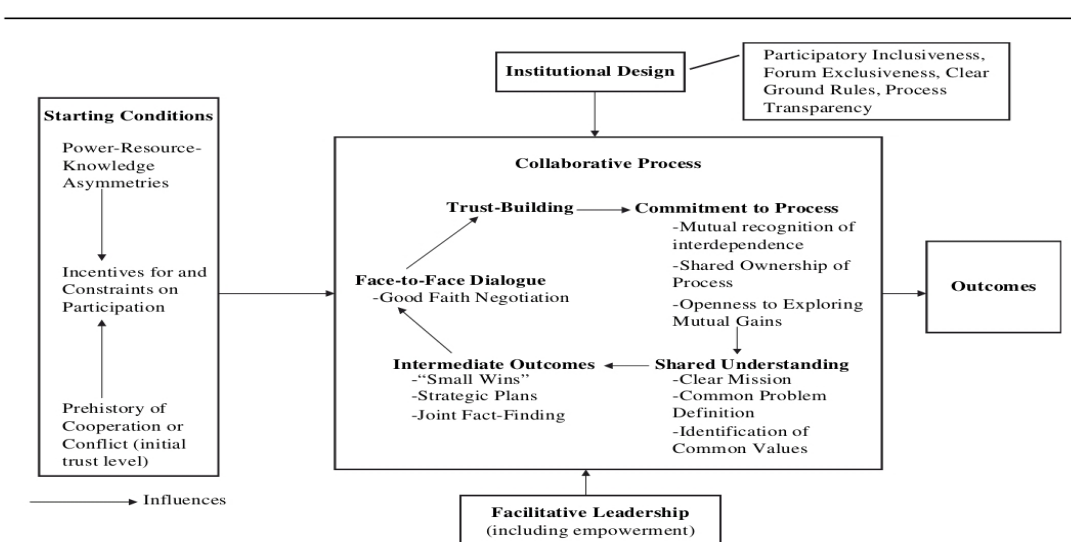


Figure 2 - Collaborative Governance Model (Ansell and Gash, 2007)

The collaborative process is highly iterative and non-linear, and is therefore represented (with considerable simplification) as a cycle (Ansell and Gash, 2007).

They reduce the critical initial conditions to three main variables: imbalances in the resources or power of the different stakeholders, their incentives to collaborate, and their history of conflict or cooperation (Ansell and Gash, 2007).

Indeed, as we can identify in the literature review (Ethiopia and Afghanistan) and in the interviews (Brazil), there is always the problem of resource and knowledge sharing. Consortia, which have the framework of Collaborative Governance, still face coordination problems due to weak leadership, and therefore the difficulty of integrating forecasting, strategy, planning, and management. In fact, larger institutions want to take advantage of smaller ones, and people want to keep knowledge to maintain their positions. Nevertheless, the biggest problem is always one of knowledge: how to create and manage a consortium. It remains to be seen why create a health consortium for refugees from Ethiopia and Afghanistan. Given the serious problems of severe human rights violations, particularly access to healthcare, the union of forces and knowledge within a consortium can help provide medical services more effectively. There is always confusion here between efficiency (cost-benefit ratio) and effectiveness (measuring results from the perspective of the program manager, without a deadline, or project, with a deadline) and impact (measuring results from the perspective of the target audience). Obviously, if NGOs, along with the UN, particularly the UNHCR (United Nations High Commissioner for Refugees), join forces with the private sector and manage to launch tenders for the purchase of medicines, that is already a major step forward. Having a good relationship with all municipalities (primary partners), hospitals and clinics in the consortium (secondary partners) also helps to increase and reduce the cost of medical services. Furthermore, through a consortium it becomes more difficult for governments to sabotage aid measures for refugees.

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