Research Brief   **February 2022**

THE HUMANITARIAN-DEVELOPMENT NEXUS

A Framework for Maternal, Newborn, and Child Health, Voluntary Family Planning, and Reproductive Health

WOMEN AND CHILDREN ARE DISPROPORTIONATELY HARMED by conflicts and crises, with maternal, newborn, and child mortality seeing significantly higher rates in fragile settings. Now more than ever in such settings, where both humanitarian and development assistance are being delivered, coordination and collaboration between these actors are needed to address the expanding average duration and affects of conflicts, crises, and displacement. Numerous approaches have been developed to define the humanitarian-development nexus (HDN), and more broadly, the humanitarian-development-peace nexus. However, the effort to operationalize and document the HDN remains incomplete, particularly from the development perspective.

BACKGROUND

MOMENTUM Integrated Health Resilience works to improve access to and availability of high-quality, respectful, and person-centered maternal, newborn, and child heath, voluntary family planning, and reproductive health (MNCH/FP/RH) care in fragile and conflict-affected settings. The project enhances coordination between development and humanitarian organizations and strengthens the resilience of individuals, families, and communities. To better understand how to effectively program in the HDN, MOMENTUM Integrated Health Resilience worked with resource partner Johns Hopkins University's Center for Humanitarian Health to conduct a landscape analysis to develop a deeper understanding of and framework for the HDN.

> The *nexus* marks a turning point in the understanding of humanitarian and development settings by recognizing that previous linear models are obsolete, and that a region or country does not transition *from* humanitarian *to* development aid.

WHY THE HUMANITARIAN-DEVELOPMENT *"NEXUS"*?

The interaction (or lack thereof) between humanitarian and development actors is not a new conceptual issue. The humanitarian-development *divide*, *gap*, or *continuum* are concepts that go back decades, but provide incomplete descriptions of the actual context and settings. The *nexus* marks a turning point in understanding humanitarian and development settings by recognizing that previous linear models are obsolete and that a region or country does not transition from humanitarian to development status, but rather they can exist simultaneously in the same space, as well as fluctuate back and forth.
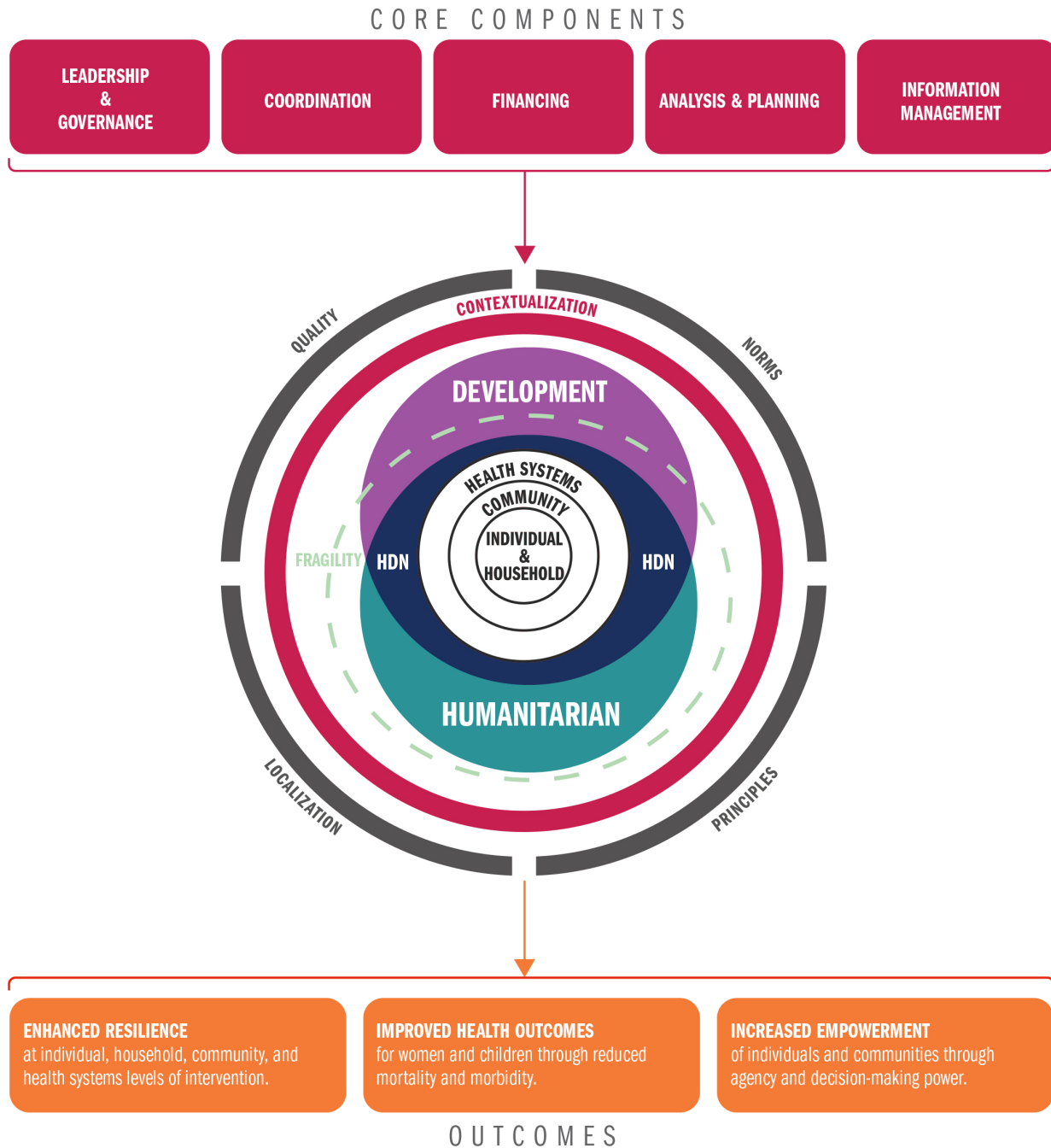
THE HDN FROM A HEALTH AND DEVELOPMENT PERSPECTIVE

There are many definitions of the HDN, most of which are complex and serve a variety of purposes. Therefore, as opposed to providing a definition of the HDN for MNCH/FP/RH programming, the list below entails some key actions that health actors working in HDN contexts should consider.

- Complement and enhance health resilience capacities across individual, household, community, and health system levels.
- Use a holistic approach that considers all phases of preparedness, response, recovery, and development.
- Engage both humanitarian and development actors, and work with a broad group of stakeholders.
- Ensure that interventions are responsive, feasible, operational, and measurable.
- Prioritize vital components of health and MNCH/FP/RH programming, including the health systems strengthening goals of equity, quality, and resource optimization, as well as the Minimum Initial Service Package (MISP), the Essential Package of Health Services (EPHS), and other scalable services.
- Incorporate core components and cross-cutting elements according to context, including leadership, coordination, planning, financing, and information management.
- Develop and report on short-, medium-, and long-term indicators, targets, and benchmarks.

A CONCEPTUAL FRAMEWORK FOR MNCH/FP/RH IN THE HDN

Drawing from frameworks on the HDN put forth by the United Nations and health system strengthening from WHO and USAID, MOMENTUM Integrated Health Resilience developed a conceptual framework to visualize health programming in the HDN. The core components and contextualization are described in detail below.

CORE COMPONENTS

LEADERSHIP & GOVERNANCE

COORDINATION

FINANCING

ANALYSIS & PLANNING

INFORMATION MANAGEMENT

QUALITY

CONTEXTUALIZATION

NORMS

DEVELOPMENT

HEALTH SYSTEMS

COMMUNITY

INDIVIDUAL & HOUSEHOLD

FRAGILITY

HDN

HDN

HUMANITARIAN

LOCALIZATION

PRINCIPLES

ENHANCED RESILIENCE
at individual, household, community, and health systems levels of intervention.

IMPROVED HEALTH OUTCOMES
for women and children through reduced mortality and morbidity.

INCREASED EMPOWERMENT
of individuals and communities through agency and decision-making power.

OUTCOMES

Source: MOMENTUM Integrated Health Resilience

CORE COMPONENTS OF THE HDN-MNCH/FP/RH FRAMEWORK

Core components are the key inputs that shape the trajectory of HDN programming in fragile settings. Current gaps have been identified along with what a HDN approach may entail to improve the quality of interventions developed by humanitarian assistance (HA) and development assistance (DA) actors.

Topic	Current Gaps	HDN Approach
Leadership & Governance	Parallel assistance to local and national systems. Siloes in leadership and governance structures of HA and DA in fragile settings.	Greater complementarity among international, national, and sub-national actors, including HA and DA actors. This may include ministries of health, de facto health bodies, private and public health sectors, UN country team/humanitarian country team and respective UN residence and humanitarian country coordinators, and disaster and emergency management agencies.
Coordination	Fragmented coordination between HA and DA actors, and a duplication/redundancy of interventions in many settings.	Leveraging existing coordination structures, while enhancing intersectoral/cluster coordination within HA efforts; cross-coordination among HA, DA, and peace actors; and develop models of sequencing, layering, and integration for HA and DA preparedness planning and interventions.
Financing	Separate financing/funding mechanisms for HA & DA that are primarily channelled through international agencies and NGOs. HA is mostly short-term funding (i.e., annual; however, multi-year funding is becoming more common for some donors) by a multitude of donors primarily through UN agencies and international NGOs to address the immediate and short-term impacts of crises. DA is multi-year funding (e.g., 3-5 years) from bi- and multi-lateral international agencies. Assistance modalities, including the timeline for distribution of funding and delays in getting resource mobilization structures (e.g., pooled funds or other financial distribution mechanisms) are established and managed effectively.	Flexible, complementary, multi-year funding; more direct funding channelled to local actors in line with localization commitments; greater utilization of contingency funding, including crisis modifiers to accelerate emergency response in fragile settings for DA, and rapid resource-mobilization through Country Emergency Response Funds and Pooled Funds for HA. Innovative funding approaches, such as bonds and insurance, have been implemented for natural disasters and epidemics, and could be considered for conflict and other fragile settings.
Appraisal & Planning	Separate appraisal and planning tools for HA and DA in terms of single/multi-year interventions; differences in capacity and systems strengthening mandates between HA and DA actors; and limited exit and/or transition planning.	Joint appraisal and planning initiatives between HA and DA actors, including complementarity between interventions, and mainstreaming HA processes (e.g., the Inter-Agency Standing Committee's humanitarian process, Joint Response Plans, Humanitarian Response Plans, Common Country Analysis of the Sustainable Development Cooperation Framework between the UN and governments) on the development side.
Data Sharing & Use	Limited information and data sharing among different sectoral pillars within HA and DA actors, and between HA and DA actors; separate metrics and data collection tools.	Enhanced information and data sharing among sectoral pillars and actors; strengthened early warning and surveillance systems; improved data quality; and unified and complementary indicators, benchmarks, and targets.

CONTEXTUALIZATION

Considering the context of each fragile setting is necessary to ensure that interventions meet the needs of affected populations. Within any given context, the **fragility** must be assessed to determine HDN programming feasibility and any key enabling factors or barriers to implementation, including political, economic, security, and social considerations. Other related factors including political will, corruption, and permissiveness of environments must be considered. The **phases** within a crisis greatly shape the nature of HDN programming, as the types of interventions may differ depending on if a context is in the acute, emergency, protracted, or recovery phase. The table below highlights key contextual factors in the HDN framework.

"Fragility is a condition of vulnerability to a range of bad outcomes, and it emerges from the relationship between the state and society. Its severity is determined by the extent to which countries generate the capacities to productively manage internal and external stresses. Fragility increases when stresses threaten to overwhelm capacity, escalating vulnerability to an array of crises, such as violent conflict, political instability, pandemic, disasters or economic collapse." USAID Fragility Analytics Guidance (2019)

Principles	• *Humanitarian principles* of humanity, neutrality, impartiality, and independence. • *Human rights* considerations, such sexual and reproductive health and rights (SRHR) and the framework for healthcare services that entails Availability, Accessibility, Acceptability, and Quality (AAAQ). • *Equity and inclusion* principles applied throughout every phase of programming (e.g., preparedness, planning, development, delivery) to ensure an equitable and inclusive lens that is non-discriminatory, particularly for vulnerable and marginalized groups. These considerations should examine barriers to health care access based on ethnicity, religion, gender, age, and disability, among others.
Norms	These include gender, sociocultural, and religious norms, among others. Programming that takes a nuanced approach with a concerted consideration for these norms will enhance acceptance by individuals and communities and avoid programming that is imposed on affected populations. Social and behavioral interventions that address health outcomes stemming from underlying norms (e.g., gender inequality, harmful sociocultural/religious practices that impact health outcomes) should be well thought out and developed with the utmost sensitivity.
Localization	A cornerstone of ethical programming, localization ensures a person-centered approach that considers the specific needs of the affected population. Localization commitments transcend all aspects of intervention for individuals, communities, and local responders. Capacity strengthening efforts should always apply a localized lens and ensure the ownership, continuity, and sustainability of service delivery. It is essential that diverse community members, and those groups underrepresented in formal decision-making processes in particular, are included in all aspects of preparedness and planning, and leading the process where possible.
Quality	Often embedded within other programming considerations, quality is a vital component of service delivery across every level of intervention. In humanitarian, development, and HDN settings, quality is a pillar that cannot be compromised and must be assessed throughout.

RECOMMENDATIONS

Sustainability of services is a challenge to humanitarian and development actors alike in fragile settings. The balance between planning for short-term (humanitarian) and medium/long-term interventions (development) is often difficult, given the silos between assistance modalities. Exit planning often represents a gap in such interventions, given the complexity of many contexts, including protracted disrupted settings. A greater emphasis must be placed on sustainability; a large component of this is equipping local and national actors with the tools, resources, and capacities to maintain high-quality service delivery to affected populations at any given stage.

A more concerted effort to operationalize HDN MNCH/FP/RH programming according to different contexts, actors, and approaches is essential for the complementarity, convergence, and coherence of humanitarian and development interventions. Some suggested strategies and approaches are bulleted below.

- Greater complementarity between humanitarian and development programs in terms of ***financing and donor mandates*** to reduce silos between emergency financing models and longer-term health investments.

- Joint ***preparedness and planning*** must cut across all forms of humanitarian and development programming, and always include local actors. Humanitarian response plans should be more inclusive of development actors to ensure they have considered how their interventions may affect longer-term development plans. Conversely, when creating development plans in fragile settings, humanitarian actors should be included to ensure a humanitarian perspective, with adaptable interventions that may include prioritizing from comprehensive to more essential services.

- Short-, medium-, and long-term considerations should shape the design and development of ***health interventions***, ranging from minimum to comprehensive services, according to changing contexts.

- Continuing along the line of sustainable health service provision, a ***health systems strengthening*** approach is necessary to preserve development gains and ensure that systems can absorb ongoing shocks and stresses.

- Such provision relies on ***capacity strengthening*** as an essential component at national, sub-national, and local levels in fragile settings, particularly for human resources, to utilize more sustainable approaches for service delivery. This capacity strengthening should also include the **sensitization and socialization of development actors** on HDN-specific guidance by the Global Health Cluster.

- Lastly, there is a need for continual ***documentation and dissemination of good practices*** and lessons learned for HDN programming among humanitarian and development actors, including through South-South exchanges. This practice will allow different actors to capitalize on known, effective approaches to working at the HDN through MNCH/FP/RH interventions, and ultimately improve health outcomes and enhance the resilience of women, children, and communities.

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