MOMENTUM

Integrated Health Resilience

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THE HUMANITARIAN-DEVELOPMENT NEXUS

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

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MOMENTUM Integrated Health Resilience works to improve access to and availability of high-quality, respectful, and person-centered MNCH/FP/RH care in fragile and conflict-affected settings. This project enhances coordination between development and humanitarian organizations and strengthens the resilience of individuals, families, and communities.

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ACRONYMS

EmONC	Emergency obstetric and newborn care
EPHS	Essential Package of Health Services
FP	Voluntary family planning
H-LiST	Humanitarian Lives Saved Tool
HDN	Humanitarian-development nexus
HDPN	Humanitarian-development-peace nexus
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
iCCM	Integrated community case management
IHL	International humanitarian law
IMCI	Integrated management of childhood illness
IOM	International Organization for Migration
LMICs	Low- and middle-income countries
MISP	Minimum Initial Service Package for Sexual and Reproductive Health in Crisis
MNCH	Maternal, newborn, and child health
NGO	Nongovernmental organization
NWoW	New Way of Working
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
RH	Reproductive health
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
UN	United Nations
UNFPA	UN Fund for Population Activities
UNHCR	UN High Commissioner of Refugees
UNOCHA	UN Office for the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development
WHO	World Health Organization
WRC	Women's Refugee Commission

EXECUTIVE SUMMARY

Numerous approaches have been developed to define the humanitarian-development nexus (HDN), and more broadly, the humanitarian-development-peace nexus. However, efforts to operationalize and document the HDN remains elusive. A broader understanding and translation of these concepts into concrete and feasible interventions that can be documented with measurable outcomes remain necessary, particularly from a development approach. Given that women and children are disproportionately affected by crises, and that the burden of maternal, newborn, and child mortality is significantly higher in fragile settings, the operationalization of the HDN for maternal, newborn, and child health, voluntary family planning, and reproductive health (MNCH/FP/RH) services remains a priority for both humanitarian and development actors. Crises have become more complex and protracted and have ultimately contributed to increased fragility in numerous countries, even entire regions. A more concerted effort to enhance HDN health programming is essential for the complementarity, convergence, and coherence of humanitarian and development interventions. These include a greater emphasis on health resilience for individuals, households, communities, and the health system as a whole in fragile settings.

A holistic approach must be taken during preparedness, planning, response, and recovery, while also recognizing that a linear approach (transitioning programs from humanitarian to development actors) to interventions within fragile contexts is now an obsolete construct. An adaptive approach is crucial and requires the simultaneous inclusion of humanitarian, development, and peace actors at multiple levels among a broad group of stakeholders. Health and MNCH/FP/RH services should encompass vital areas, such as the health systems building blocks, the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises, the Essential Package of Health Services (EPHS), and other scalable services. The delivery of such programming must be shaped and informed by human rights, humanitarian, localization, and equity principles that account for the unique gender, sociocultural, and religious norms of any given context. The ability to uphold such principles and norms while delivering high-quality services is a necessary hallmark of HDN programming that incorporates core components or cross-cutting elements, including leadership, coordination, planning, financing, and information management. Comprehensive programming that is flexible, scalable, and adaptive will ultimately enhance preparedness and the ability to respond to crisis and conflict, while also preserving development gains in the face of humanitarian emergencies.

INTRODUCTION & BACKGROUND

There has been a tremendous shift in recent years in how we understand humanitarian and development settings, and in turn, how we frame interventions in such contexts. Notions of a humanitarian-development *divide*,[1] *gap*,[2] or *continuum*[3] go back decades and are outdated, as they have never fully depicted the overlapping reality and needs of most contexts across the world. Though numerous approaches have been developed to date, a broader understanding and operationalization within the humanitarian-development nexus (HDN) remains necessary, specifically in the health sector. Examining each of these approaches provides a foundation for how these may be translated to the health sector using an HDN lens.

Crises have become more complex and protracted, and have ultimately contributed to increased fragility in numerous countries, and in many cases, entire regions. Furthermore, shocks and stresses such as economic and political instability, gender inequality, the climate crisis, and disease outbreaks (e.g., COVID-19 and Ebola) have exacerbated such fragilities. These interacting factors are often concurrent and amplify the vulnerability of affected persons, as there are currently over 1.8 billion people residing in fragile settings,[4] 82.4 million people who are forcibly displaced[5] worldwide, and as many as 150 million people estimated to be *extremely* poor[6] in 2021 as a result of the COVID-19 pandemic. This has blurred the lines for assistance that was once distinctly aimed at refugees and internally displaced persons (IDPs) living in camp-like settings; the majority of people living in fragile contexts are outside of camps in villages, towns, and cities, often for well over a decade.[7] Countries previously considered relatively stable have become less stable (e.g., Syria and Venezuela), while other, volatile countries continue to be unpredictable and fragile (e.g., South Sudan, Somalia, and Democratic Republic of the Congo [DRC]). The effects of the climate crisis and continuing encroachment of land, combined with global travel make epidemics and pandemics more likely to occur. Though these global trends indicate the need for increasing humanitarian assistance, there are also demands for sustainable development and engaging development actors to enhance capacity for local response, strengthen health systems, and address the disproportionate burden in fragile settings. In such fragile settings, the confluence and continuation of ongoing stresses, defined by USAID as *"long-term trends or pressures that undermine the stability of a system and increase vulnerability within it"* and shocks, which are *"external short-term deviations from long term trends that have substantial negative effects on people's current state of well-being, level of assets, livelihoods, safety or their ability to withstand future shocks,"*[8] are often what require ongoing humanitarian assistance where development assistance is also active. Consequently, while there has always been a need for development and humanitarian strategies, due to policies and funding streams this has not occurred in an integrated and holistic manner. The complex and evolving events and factors stated above require development and humanitarian actors to work together more than ever before in a concerted, complementary, operational, and sustainable manner.

This same integrated and holistic focus is necessary for the planning, provision, and use of health services to those who are disproportionately affected by crises—*women and children*. Programming for maternal, newborn, and child health, voluntary family planning and reproductive health (MNCH/FP/RH) has proven essential for reducing morbidity and mortality rates globally and ensuring that the basic right to health is preserved by leaving no one behind and reaching the furthest behind first.[9] There must be a commitment by all actors to provide comprehensive MNCH/FP/RH programming when feasible, regardless of context. Aligned with the 2030 Agenda for Sustainable Development,[10] targeted and renewed strategies have emerged, such as the United Nation's (UN) Global Strategy for Women, Children and Adolescent's Health (2016-2030)[11] adopted from the Every Woman Every Child movement,[12] which entails a set of commitments[13] for fragile settings to jointly meet the objectives to "thrive, survive, and transform."

These agendas and strategies translate more broadly to different ways in which actors could operate within different contexts using a transformative and sustainable approach for programming, particularly those approaches geared towards women, adolescents, and children. One of the most vital aspects of any given context is its fragility,[14] or vulnerability to shocks and stresses. A country receiving assistance to address massive humanitarian needs due to conflict or natural disaster in one region may simultaneously be prime for development efforts in other, more stable regions. Even within the same country, some regions wax and wane between some stability intermixed with acute crises over decades (e.g., Somalia, Afghanistan, and the DRC). Preparedness and response in these environments should incorporate or enhance resilience to future shocks, stresses, or relapses in fragility, along with mechanisms to scale-up or scale-down the comprehensiveness of interventions based on need and feasibility. The effort to respond effectively within such dynamic contexts requires a nuanced approach by organizations and institutions working at multiple levels that both prioritizes and adapts to the needs of affected populations in the short, medium, and long term.

Efforts to ensure all programming is accountable to affected populations[15] require humanitarian and development mandates to include more robust, participatory approaches for such populations, and uphold commitments to localization[16] and decolonization.[17] These considerations align with more recent and necessary demands in the aid sector to address structural inequalities, racism,[18] and imbalances of power,[19] particularly between the Global North and Global South. Shifting power, decision-making, and funding to countries of the Global South means that national and local stakeholders are at the forefront of joint and sustainable interventions in the HDN.

A HISTORICAL LANDSCAPE OF THE HUMANITARIAN-DEVELOPMENT NEXUS

What is the humanitarian-development nexus? A common understanding of the HDN is important to establish among different stakeholders to ensure that assistance is developed through these guiding concepts. To date, a significant barrier to HDN programming is the translation of conceptual principles into concrete interventions whose effects can be documented.

Numerous discussions have occurred over several decades as to how to best address the gaps, overlaps, and transitions between humanitarian and development assistance. Some of the more recent efforts to address this longstanding issue stem from the Linking Relief, Rehabilitation and Development[20] approach that emerged in the 1980s, which describes the silos between humanitarian and development assistance, with an emphasis on institutions (e.g., donors) and strategic planning. Linking relief, rehabilitation, and development highlights the complex and often inextricable links that exist among humanitarian needs, poverty, and state fragility; however, the model still emphasizes a linear and more rigid approach. The UN's Sendai Framework for Disaster Risk Reduction[21] (DRR) (2015-2030) is a more contemporary approach that emphasizes ways to reduce risk, invest in resilience, and enhance preparedness and response, particularly through the "Build Back Better" approach to recovery, rehabilitation, and reconstruction. A mapping of key stakeholders includes vital members of civil society, specifically, women, children, and other marginalized groups (e.g., persons with disabilities, the elderly, indigenous groups, displaced persons, and migrants). The U.S. Agency for International Development (USAID)'s Policy and Program Guidance, Building Resilience,[22] particularly in response to recurrent crises, has defined resilience as "*the ability of people, households, communities, countries, and systems to mitigate, adapt to, and recover from shocks and stresses in a manner that reduces chronic vulnerability and facilitates inclusive growth*." The method to sequence, layer, and integrate programming between humanitarian and development assistance actors is one such strategy utilized by

USAID to build and strengthen resilience (e.g., the 2012 Sahel response[23]). The European Union has made a similar commitment to enhancing resilience to shocks and stresses in fragile settings, and its Resilience Compendium demonstrates how the resilience approach is being translated to reality[24] through a collection of case examples in different contexts.

The New Way of Working[25] (NWoW) developed in 2016 by the UN and endorsed by the World Bank looks to "*transcend*" the humanitarian-development divide. The premise of the NWoW is to bring together humanitarian and development stakeholders composed of the UN, governments, institutional donors, crisis-affected states, nongovernmental organizations (NGOs), and local and national actors to commit to a set of "collective outcomes" aimed at reducing risks and vulnerabilities for affected communities, and ultimately ensuring that achievements are made toward the Sustainable Development Goals.[26] The approach emphasizes high-level, conceptual targets with an emphasis on areas that may enable or prevent meaningful work at the HDN. These include the importance of resource mobilization, and joint planning and analysis, particularly at the country-level, for crisis-affected states. To translate the NWoW into action, the Organization for Economic Cooperation and Development (OECD) developed its Humanitarian Development Coherence[27] guidance manual in 2017, which builds upon commitments to reduce risk and vulnerability with more concrete and context-specific examples, such as USAID's use of crisis modifiers[28] through its RISE programming in the Sahel[29] (2018) or the European Union's food security programs in Niger (2012). These examples provide insight into the complexity of certain responses and the need to examine sustainability, leadership, political will, and similar to the NWoW, coordination, financing, and risk management. The guidance offers a deeper look at flexible financing, scalable programming (i.e., scale-up/scale-down), decentralization, and the utilization of early warning systems to enhance preparedness. The CORE Group's Humanitarian-Development Task Force[30] has tackled the HDN by addressing coherence of aid interventions by different stakeholders, with an explicit focus on global health.

Taking the HDN concept one step further to incorporate peace, the humanitarian-development-peace nexus (HDPN), often termed the *triple nexus*, is closely linked with humanitarian and development assistance. The OECD has been one of the key drivers of expanding the HDN definition and relevant approaches. In 2021, its Development Assistance Committee created a "Recommendation on the Humanitarian-Development-Peace Nexus"[31] targeting different stakeholders to join efforts around humanitarian, development, and peace planning. This included a pronounced emphasis on political engagement, conflict sensitivity, and peacebuilding, in addition to understanding root causes and structural drivers of conflict through the application of a gender-sensitive lens. USAID refers to "humanitarian-development-peace coherence" interchangeably with the HDPN, which it describes as promoting complementarity and collaboration across humanitarian, development, and peace actors towards a common agenda.[32] Similarly, the Swedish International Development Agency developed a "Guidance Note"[33] for stakeholders in 2020 to work toward coherence across the triple nexus. The focus is placed on alleviating poverty, as the agency has defined this as one of the root causes of violent conflict, fragility, protracted crises, and more recently, climate-related shocks. A targeted set of recommendations for peace initiatives that fall within Official Development Assistance[34] (ODA), as defined by the OECD, include "small p" (qualified ODA) efforts, such as civilian peacebuilding or social cohesion, in comparison with "large P" (non-qualified ODA) efforts, such as peacekeeping and political missions. Although these often fall outside of humanitarian assistance mandates, it is important to recognize the undoubted influence and complexity of peace and the triple nexus, and the need for the humanitarian sector to consider root causes and "peace" aspects.

This complexity of the HDPN was examined closely by Dubois and the Center for Humanitarian Action in 2020 to assess the triple nexus as a threat or opportunity for humanitarian principles,[35] and consequently, humanitarian actors. The center observes that humanitarian actors often distance themselves from peace

components, as the peace components are often politically entrenched and could in some way compromise humanitarian mandates. Recommendations provide guidance for actors to embrace "nexus-thinking," and to move beyond narrower definitions and interpretations of prevention and response efforts to operationalize the humanitarian principles of humanity, neutrality, impartiality, and independence. Despite the effort to orient humanitarian and development actors and their mandates around peace within the triple nexus, barriers to operationalization remain, and must be overcome to make more meaningful strides in this direction. Hugo Slim of the International Committee of the Red Cross used this same sense of realism in 2017 while examining how humanitarian policy and international humanitarian law (IHL) fit together with HDN thinking[36] on the ground beyond simply theory.

THE HUMANITARIAN-DEVELOPMENT NEXUS AND HEALTH: AN OVERVIEW

As the lead global agency for health, the World Health Organization (WHO) has worked to operationalize the HDN by drawing from the NWoW to understand its implications for the health sector, and how humanitarian, development, and peace stakeholders each play a role. A guide[37] developed by WHO and the Global Health Cluster in 2020 provides a set of recommendations to work within the HDN. Various interventions, recommended according to the different stages of a conflict cycle, are defined as three distinct phases of *pre-crisis*, *conflict,* and *post-conflict/reconciliation*. This cycle is not limited to conflict, and may be applied to other settings marked by fragility and experiencing non-conflict crises. Though reflected as distinct and separate phases, these are not always linear, and may even be concurrent or cyclical in nature. WHO highlights four types of engagement among actors in the HDN, driven by context. These types of engagement include *constrained*, *capacity-driven*, *consultative,* and *collaborative* approaches; each is dependent on the government/authority in any given context (political will, non-permissive environments[38]), as this shapes the nature of any response and the processes of joint analysis, planning, and programming. Though primarily disseminated among humanitarian actors, and promoted through the Global Health Cluster, the guidance is not widely read on the development side of the HDN. However, the guide is useful in that it identifies potential entry points, bottlenecks, and approaches for actors to deliver health interventions, including considerations for human resources, health information systems, medical products and technologies, health financing, and leadership and governance.

These components reinforce WHO's Health Systems Framework[39] and USAID's Vision for Health System Strengthening 2030,[40] and include similar elements needed for any health system to remain viable and responsive to shocks and stresses. WHO's guide takes this one step further and recognizes the intricate relationship between health and peace, founded on its earlier conceptual approach of Health as a Bridge for Peace[41] (HBP) and its more recent Health and Peace Initiative.[42] This initiative includes guidance on risk analysis and mitigation given the inherent complexity of many fragile settings, and a visual framework of how to uphold Do No Harm principles while working *in* conflict or *on* conflict. Effective examples include unhindered vaccination campaigns by the WHO, UNICEF, and partners in areas of active conflict such as Afghanistan, Liberia, Somalia, and Sudan through designating "days of tranquility,"[43] or temporary ceasefires between and/or within state and non-state armed groups (1996-2000).

Although less prescriptive than the WHO model, UNICEF has also taken strides to define its approach to working within the HDN. Such strategies are highlighted in UNICEF's humanitarian action update[44] with a focus on linking humanitarian and development programming. With the ultimate goal of addressing the needs and vulnerabilities of children and young people, the high-level guidance stresses the importance of localization, resource mobilization via partnerships, accountability to affected populations (AAP), and social

protection systems (e.g., social cohesion, cash transfer programs). Evaluations[45] of UNICEF's work to link humanitarian and development programming were conducted in 2021, examining fragile and conflict-affected countries (per UNICEF definition) that entailed the highest level of response expenditure. In countries like Afghanistan, marked by a long history of humanitarian, peace, and development activities, UNICEF has not yet been able to "capitalize on convergence" between its humanitarian and development interventions, thus limiting their complementarity and sustainability. Similarly in Myanmar, UNICEF's attempt to address the HDN in both humanitarian and development fora did not bridge the divide, as the discussions between each set of actors were conducted separately. In these complex settings where dual-mandate organizations like UNICEF operate, it is important to utilize such evaluations to better inform and shape programming between humanitarian and development actors.

The Theory of Change[46] jointly proposed by the UN High Commissioner for Refugees, UN Development Program, and UN Research Institute for Social Development addresses such challenges, and argues that a transition from international to locally led responses is a critical component of strengthening local and national capacities to respond to such displacement shocks. In addition, actors across the HDN should shape programming that addresses gender and diversity, social cohesion, legal frameworks, and shifts from parallel to integrated systems.

In terms of health service provision and health systems at large, an integrated model that addresses both host and displaced population needs is crucial. Although this approach is not always feasible in each context, particularly when there is limited capacity and a constraint on resources and accessibility, efforts should be made to move away from parallel programming. Preparedness represents one such effort, particularly through favorable policies for displaced populations to access services, surge staffing availability, supply chain buffers, and emergency fund access, all of which allow continued access to services within a health system despite population movement shocks. Similarly, the International Organization for Migration (IOM) has documented its efforts to operationalize the HDPN,[47] particularly where population movements are dynamic, and highlights two main interpretations of the HDN: "distinct but complementary," so that humanitarian principles are safeguarded and capitalize on the comparative advantage of humanitarian and development action; and "merged but principled," which creates a clear distinction between humanitarian and development mandates, and that the context may dictate when and which humanitarian principles are upheld.

The IOM provides examples from its operations in Colombia, Mali, Nigeria, Somalia, and Turkey, among others. One such example is the Midnimo Unity Project[48] in Somalia, jointly implemented by IOM and UN Habitat, that brought together different stakeholders from government, UN, and local communities to provide durable solutions for displaced populations. Community Action Plans were established that facilitated information-sharing between these actors and local authorities to coordinate humanitarian and development efforts, specifically between stabilization and health programs, including mobile and maternity and child health clinics. Although this is an example of a micro/medium-scale intervention that may not be duplicated in other settings, this level of engagement demonstrates the need for inclusive, community-oriented approaches that entail greater capacity building to achieve such HDN outcomes.

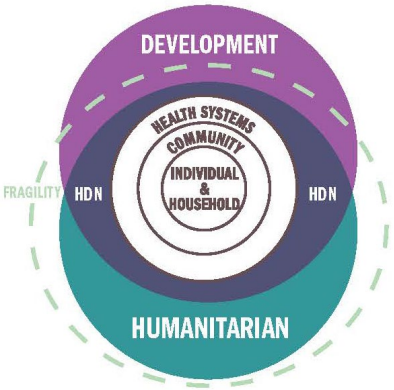
HDN FROM A HEALTH AND DEVELOPMENT PERSPECTIVE

There are many definitions of the HDN, most of which are complex and serve a variety of different purposes. Therefore, rather than providing a definition of the HDN for MNCH/FP/RH interventions, the list below entails some of the key actions that should be considered in HDN contexts. These considerations and actions are part of the conceptual framework, which is presented below.

- Complement and enhance health resilience capacities across the individual, household, community, and health systems levels.
- Use a holistic approach that considers phases of preparedness, response, recovery, and development.
- Engage a variety of humanitarian and development actors, and work with a broad group of stakeholders (e.g., governments, donors, NGOs, UN, civil society, faith-based institutions, and the private sector).
- Ensure that interventions are responsive, feasible, operational, and measurable.
- Prioritize vital components of health and MNCH/FP/RH programming, including the health systems building blocks, the MISP, the EPHS, and other scalable services.
- Incorporate core components and cross-cutting elements, including leadership, coordination, planning, financing, and information management, according to context.
- Develop and report on measurable short-, medium-, and long-term indicators, targets, and benchmarks.

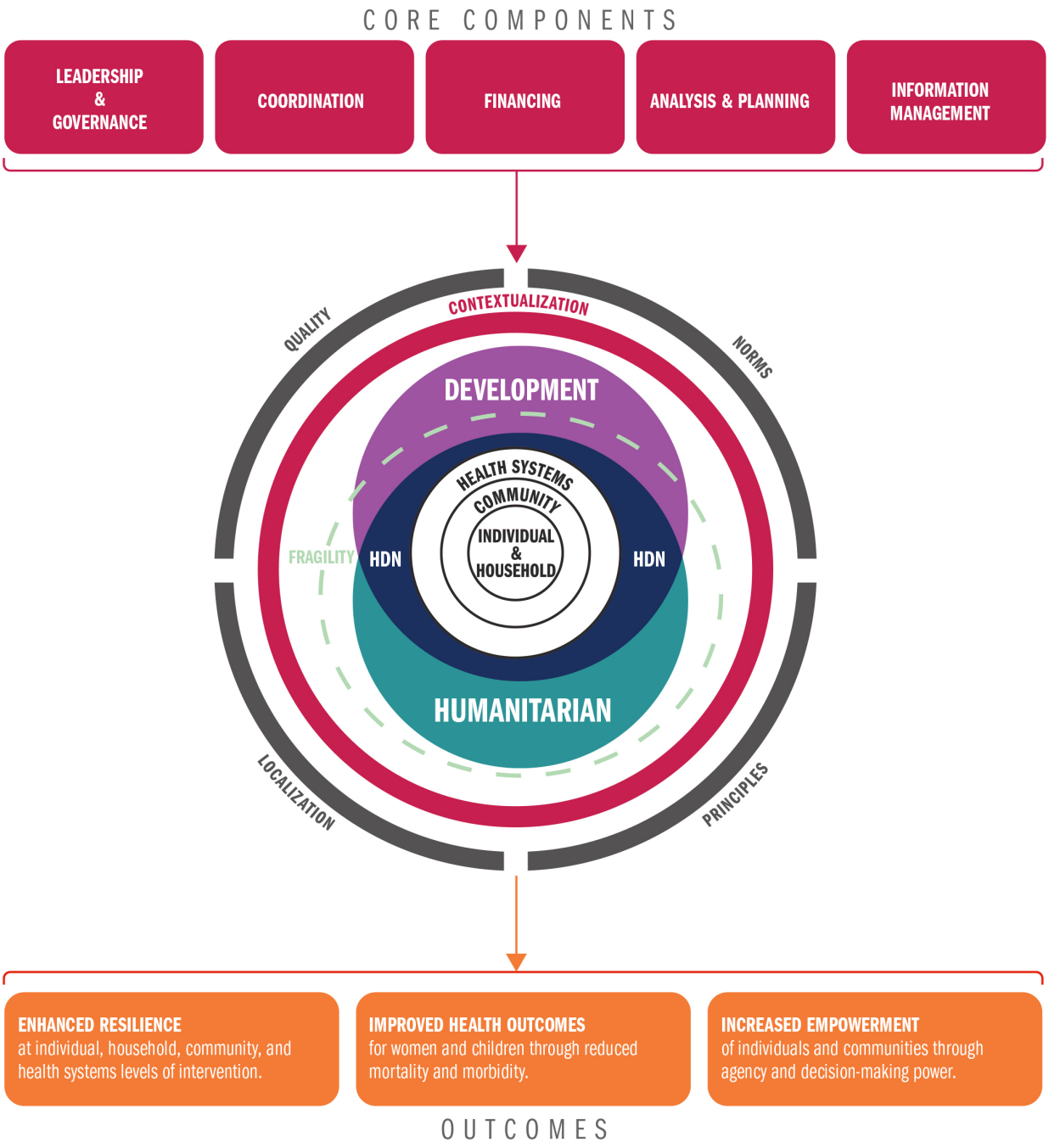
CONCEPTUAL FRAMEWORK

ELEMENTAL FRAMEWORK



EXPANDED FRAMEWORK

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



UNDERSTANDING KEY ELEMENTS OF THE HDN-MNCH/FP/RH FRAMEWORK

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

CORE COMPONENTS

Topic	Current Gaps	HDN Approach
Leadership & Governance	Silos in leadership and governance structures of HA and DA actors in fragile settings. Parallel assistance to local and national systems in place.	Greater complementarity among international, national, and sub-national actors, including HA and DA actors. Depending on the context, this may include ministries of health, de facto health bodies, private and public health sectors, UN country teams/humanitarian country teams and respective UN residence and humanitarian country coordinators, and disaster and emergency management agencies, among others.
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, and peace actors that are primarily channeled through international agencies and NGOs. HA is mostly short-term funding (e.g., *annual; however, multi-year funding is becoming more common for some donors)* channeled by a multitude of donors, primarily through UN agencies and international NGOs, to address the immediate and relatively short-term impacts of crises and conflict. DA is marked by medium/long-term multi-year funding for DA *(e.g., 3-5 years)* channeled through various modalities, including the World Bank's International Development Association (IDA). Assistance modalities, including the timeline for distribution of funding and delays in getting resource mobilization	Flexible, complementary, multi-year funding; more direct funding channeled to local actors in line with localization commitments; greater utilization of contingency funding, including crisis modifiers to accelerate emergency response in the event of shocks and stresses in fragile settings for DA, and rapid resource-mobilization through Country Emergency Response Funds and Pooled Funds for HA. Innovative funding approaches, particularly for preparedness, such as bonds and insurance modalities, have been implemented for natural disasters and epidemics, and could be considered for conflict and other fragile settings.

	structures (e.g., pooled funds or other financial distribution mechanisms) established and managed effectively.	
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 to find points of complementarity between interventions, including mainstreaming awareness of the Inter-Agency Standing Committee's humanitarian system-wide scale-up activation[49] process, humanitarian planning such as Joint Response Plans and Humanitarian Response Plans, and the Common Country Analysis of the Sustainable Development Cooperation Framework[50] between the UN and governments (previously known as the UN Development Assistance Framework[51] or UNDAF) on the development side.
Data Sharing and Use	Limited information and data-sharing among different sectoral pillars within HA and DA actors, respectively, 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

Taking into consideration the context of each fragile setting is a necessary step to ensuring interventions meet the needs of affected populations. Within any given context, the **fragility** must be assessed to determine the feasibility of HDN programming, along with 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 whether a context is in the acute, emergency, protracted, or recovery phase.

PRINCIPLES & NORMS

A concerted effort is needed to ensure important principles and norms are considered across all levels of programming by both HA and DA actors. The degree of importance of each of the principles highlighted below may differ by HA or DA actor working in the HDN, as well as the context; however, these principles and norms remain fundamental to HA and DA actors so that they can work in a complementary fashion, while upholding vital human rights, equity and humanitarian principles, and gender norms, among others. These include the following:

PRINCIPLES

- ***Humanitarian principles*** of humanity, neutrality, impartiality, and independence are essential to humanitarian action. When governments and other stakeholders critical to development activities are

not acting in the best interest of their populations (e.g., perpetrating crimes against their own citizens), how HA actors work with DA actors becomes complex and difficult.

- ***Human Rights*** considerations, such sexual and reproductive health and rights (SRHR) and the AAAQ framework[52] for healthcare services that entails Availability, Accessibility, Acceptability, and Quality.

- ***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 access based on ethnicity, religion, gender, age, and disability, among others.

NORMS

These include gender, sociocultural, and religious norms. 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 people-centered approach that takes into consideration the specific needs of the affected population. Localization commitments transcend all aspects of interventions 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.

TRANSLATING HDN CONCEPTS: MNCH/FP/RH INTERVENTIONS

ADAPTABILITY AND COMPREHENSIVENESS: A NECESSARY FEATURE OF HDN PROGRAMMING

The movement between minimum and comprehensive health services is one of the most critical features of HDN programming. The ability to expand or scale down services in a responsive manner that adapts to context fragility is an essential approach for both humanitarian and development actors.

The Granada Consensus,[53] for example, is an initiative that brought together stakeholders to establish a set of concrete recommendations and guidance to transition from minimum to comprehensive SRH services during protracted crises and in recovery. Jointly led by the WHO, UNFPA, and Andalusian School of Public Health, the consultation identified tools that would enhance SRH programming, such as the Minimum Initial Service Package,[54] while also addressing broader health tools, including the Essential Package of Health Services[55] for community, primary, secondary, and tertiary health. Combining these guidelines with measures to prevent, mitigate, and respond to sexual violence emphasized the critical linkage between the response for health and gender-based violence, and the importance of mainstreaming and integration. The contextualization and adaptation of these tools is a necessary approach for utilization in a specific country (or region). For example, contents of an SRH basic service package were identified (in 2011) for Afghanistan, Liberia, South Sudan, and Uganda. Another collaborative tool developed by USAID and its partners is the Global Handbook for Family Planning,[56] which serves as a resource for providers working in developing countries and those working across the nexus in order to improve such services. Beyond clinical guidance, the handbook provides a comprehensive focus on servicing diverse groups, linkages with maternal and child health, and delivering FP services during public health emergencies.

Within SRH interventions, FP programs recognize the vital link between access to services and empowerment for individuals, households, and communities as a whole. Voluntary access to FP services is central to the mandate of the International Conference for Population Development, a leading global initiative that placed individual dignity and human rights, *including the right to plan one's family*, at the heart of development.[57] The International Conference for Population Development's Plan of Action recognizes that the cornerstones of population and development are reproductive health and rights, along with women's empowerment and gender equality.[58] UNFPA has asserted that contraceptives save lives[59] by eliminating unintended pregnancies and reducing maternal and newborn mortality rates by increasing time between pregnancies, ultimately improving the health and well-being of women and their children. The International Rescue Committee (IRC) and its partners documented key recommendations for humanitarian and development actors to maintain FP programs across the arc of crisis,[60] and traced the loss of essential services in the emergency phase to the restoration of comprehensive interventions through durable solutions programming. The viability of such programs relies on adequate preparedness and the ability to adapt and scale services based on feasibility and the phase (e.g., crisis, post-crisis). The IRC demonstrated how such services were adapted for SRH services provided to at-risk adolescents in the DRC; lessons learned from this pilot were used to adapt different intervention packages to adolescents in northeastern Nigeria and South Sudan.[61] Comprehensive services for FP were provided to South Sudanese refugees in Uganda, along with RH and HIV/AIDS services for those displaced in camps in neighboring Ethiopia.[62] These programs indicate the need for flexible and comprehensive programming that can adapt to the evolving needs of populations in such fragile settings, particularly populations who continue to face recurrent crisis, both in-country and also in neighboring regions that may be experiencing periodic instability.

Similarly, the Women's Refugee Commission (WRC), Inter-Agency Working Group on Reproductive Health in Crises (IAWG), and FP2030 released a set of recommendations for contraceptive services based on a state-of-the-field landscaping assessment.[63] This includes recommendations for agencies operating in the HDN to prioritize contraception through preparedness, response, and recovery phases, affirming that contraception should be included and prioritized as a lifesaving intervention throughout all phases. This requires actors to engage in preparedness activities, particularly around supply chains; these can be a major barrier to accessing the full range of contraceptive methods for women affected by recurrent or ongoing crisis,[64] as highlighted through the DRC case example by Save the Children, International Rescue Committee, CARE, and the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative at Columbia University. These organizations and their partners were funded for more than 10 years to institutionalize FP so that it is prioritized within acute phases of emergency response (Rohingya Response, Syria Response, Venezuela Response, Yemen Response) in addition to being prioritized within the longer-term health systems strengthening[65] work that these agencies were doing in fragile settings (Chad, DRC,[66] Mali, Niger, Nigeria, Somalia, and Uganda). This work demonstrated that it is feasible to deliver high-quality FP[67] in crisis-affected fragile settings, while prioritizing adolescents[68] and other marginalized groups. It required[69] capacity strengthening, community collaboration, data-driven decision-making, and strengthening supply chain systems[70] within these HDN contexts.

For nutrition programming and efforts to incorporate the HDN, the nutrition sector has developed countless models of implementation. One example is the community-based management of acute malnutrition or "CMAM Surge" Approach, which utilizes CMAM as an entry point to strengthen health system capacity.[71] The integrative aspect of nutrition and health is one such mechanism to enable service delivery to children and enhance preparedness during normal and emergency periods or phases, as implemented in Malawi, Ethiopia, Burundi, Chad, and Niger. USAID's Advancing Nutrition program works to address the root causes of malnutrition and develop long-term investments in comprehensive and integrated nutrition interventions.[72]

PRESERVING DEVELOPMENT GAINS IN FRAGILE SETTINGS: A SYSTEMS APPROACH

Development programs, such as the World Bank-funded Health System Strengthening for Better Maternal Child and Health Results Project[73] implemented in the DRC, have taken a more holistic approach to address utilization, equity, quality, and access to services through a comprehensive RMNCAH package that encompasses nutrition, universal health coverage, sexual and gender-based violence (SGBV), community health, and FP. A core aspect of this multi-year project entails health systems strengthening and preparedness to ensure rapid response to the sudden onset of an emergency, such as the most recent Mount Nyiragongo volcanic eruption[74] in North Kivu province in May 2021. Including contingency planning within the health system for such emergencies is a critical component of working at the HDN in fragile settings, and reiterates the need for flexible, scalable programming that does not compromise development gains in the face of emergencies.

The volatility of fragile settings requires that the systems that support interventions are responsive to various shocks and stresses. Whether it be through the inclusion of crisis modifiers, as aforementioned, or in considering humanitarian assistance as cross-cutting with development programming objectives, as with USAID's current Yemen Programming Approach,[75] actors in such fragile contexts must continually adapt to ensure delivery of services and access by populations. As one of the largest humanitarian crises in our current history, with over 20 million people without access to basic health services in Yemen, USAID has invested in development programming to strengthen health resilience at the community and health systems level[76] in partnership with John Snow, Inc. The three-year Systems, Health, and Resiliency Project,[77] or SHARP, focuses

on improving health outcomes for women and children and on support services for life-threatening conditions, including malnutrition, cholera, and diarrhea. The program objectives[78] demonstrate a comprehensive approach to strengthen the health system across multiple levels of interventions. This includes creating demand for primary health services; improved access through a referral system and subsidized care and financing; revitalizing community-level services by engaging midwives and volunteers; improving local governance of health service provision; and improving health information systems.

Other program models for resilient services have emerged from humanitarian and dual-mandate organizations in such contexts. Through programming delivered in multiple governorates impacted by conflict in Yemen, Save the Children found that in contexts where political solutions seem distant[79] the demand for SRH services did not decline, and asserts that an RH model should be adaptable, innovative, and quality-focused, even during the acute phases of a crisis or conflict. Ongoing capacity strengthening and a systems approach is a critical component of such adaptable models. Beyond health system strengthening, other dual-mandate actors have approached the HDN through cross-sectoral and integrated approaches. This includes CARE's focus on "micro-contexts" in HDN programming[80] through tailored interventions that focus on gender equality and norms, women-led/women's rights organizations as catalysts for change in such contexts, and Resilient Market Systems,[81] which are closely linked to food security, livelihood opportunities, and economic empowerment.

THE WAY FORWARD

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. A gap in such interventions is often transition or exit planning, given the complexity of many contexts, including protracted settings. A greater emphasis must be placed on sustainability, and 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 case study[82] developed by Medair, the CORE Group, and USAID explores the feasibility and viability of health service delivery handover from humanitarian actors to the ministries of health and local NGOs in DRC, Iraq, and South Sudan by using an exit matrix tool. First piloted in the DRC by Medair, a "spider tool"[83] composed of seven components was developed to assess the potential for partial or complete success in handover through "exit benchmarks." These included the security situation, financial capacity, access to health services, quality of treatment, preparedness, potential sustainability, and measles coverage. The tool is intended for application and adaptation in other low- and middle-income countries (LMICs) and fragile settings, using global and country-level indicators. Although the presence of international actors is often necessary in complex and fragile settings, particularly when local responders have been impacted, such tools demonstrate that great efforts are needed to ensure that local and national actors are at the forefront of service delivery to ensure long-term sustainability. An inclusive, localized approach should be used from the start of programming, thus moving away from the notion of *handover* or *exit planning*.

Greater investment in strengthening local and national capacities has proven necessary in attaining sustainability and enhancing preparedness measures in the short- and long-term, specifically for specialized services such as SRH. The WRC, International Planned Parenthood Federation, and Rahnumah Family Planning Association of Pakistan collaborated on an initiative to incorporate SRH into Disaster Risk Reduction[84] in crisis-affected areas of Pakistan. Implemented in Pakistan over 5 years, the pilot phase used

the Community Preparedness for Reproductive Health and Gender[85] facilitation kit (jointly developed by the WRC and UNFPA) to then launch trainings for the community health workforce, intended to build capacity and enhance readiness and response efforts. A base of evidence and tools was also developed following the pilot phase to capitalize on lessons learned and best practices, along with scaling SRH services within disaster risk reduction and as part of a concerted effort to integrate and institutionalize these services.

Through a dual approach to engage stakeholders at the *community level* (e.g., union councils, local women's organizations, emergency services) and *policy level* (e.g., National Disaster Management Association and Provincial Disaster Management Association), gaps and areas of prioritization were identified, including the establishment of SGBV referral systems; blood donor lists for emergency transfusions; birth planning activities; and transport for emergency obstetric and newborn care (EmONC). Another preparedness toolkit was developed by FP2020 (now FP2030). It is intended for country-level decision-makers and stakeholders, including governments and national and local organizations, particularly youth and women-led organization, who want to ensure SRH services are delivered during emergencies while also prioritizing preparedness across all programming phases.[86] Programs such as this work to enable resilience across the service continuum for individuals, households, communities, and health systems.

RECOMMENDATIONS

A more concerted effort to operationalize HDN health and MNCH/FP/RH programming according to different contexts, actors, and approaches is essential for the complementarity, convergence, and coherence of humanitarian and development interventions. This includes greater complementarity between humanitarian and development programs in terms of ***financing and donor mandates*** to reduce the 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 incorporate 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 planning development actions in fragile settings, humanitarian actors should be involved to ensure a humanitarian perspective, which can include adaptable interventions that may prioritize essential over more comprehensive services.

Such short-, medium-, and long-term considerations should shape the design and development of ***health interventions*** that range 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 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 use 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, continual ***documentation and dissemination of good practices*** and lessons learned is needed for HDN programming among humanitarian and development actors, including through South-South exchanges. This practice will allow different actors to capitalize on 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.

ANNEX: TOOLS AND RESOURCES

1. **Essential Package of Health Services (EPHS):** Often termed the Basic Package of Health Services Package (BPHS), the EPHS was developed by WHO and designed to adapt to various contexts in emergencies. The six-step process for implementation includes: 1) agreeing on the use of an EPHS, 2) defining the contents of a package, 3) health system review and feasibility analysis, 4) costing, 5) implementation plan, and 6) monitoring EPHS implementation. [https://www.who.int/health-cluster/about/work/task-teams/EPHS-catalogue/en/]

2. **Humanitarian Lives Saved Tool (H-LiST):** The Humanitarian Lives Saved Approach was developed by the Johns Hopkins Center for Humanitarian Health in collaboration with the Lives Saved Tool (LiST) team at UNHCR. The tool is a seven-step process used to prioritize maternal and child health, nutrition, and water, sanitation, and hygiene (WASH) needs, at specified coverage levels, to save the most lives within humanitarian settings. [http://humanitarianlist.org]

3. **Integrated Management of Childhood Illness (IMCI):** IMCI is a case management process developed by WHO and UNICEF to allow for high-quality treatment for children in resource-poor settings. The process includes assessing a child's illness, classifying the illness based on signs, identifying treatment, treating the child, counseling the caretaker, and providing follow-up care. [http://apps.who.int/iris/bitstream/handle/10665/42939/9241546441.pdf?sequence=1]

4. **Integrated Community Case Management (iCCM)**: This approach utilizes supervised community members linked to facility-based services to deliver interventions in the community. The iCCM strategy is to train, support, and supply community health workers to provide diagnostics and treatment for multiple illnesses for sick children who face difficulty in accessing facility-based care. [https://www.who.int/maternal_child_adolescent/documents/statement_child_services_access_whounicef.pdf]

5. **Minimum Initial Service Package (MISP):** The MISP is a package and set of guidelines for SRH that outlines the essential and lifesaving SRH needs required for affected populations at the onset of a humanitarian crisis. The MISP was developed by the IAWG and UNFPA with support of stakeholders and implementing partners. The key aims of MISP implementation are that there are no unmet needs for FP, no preventable maternal deaths, and no SGBV or harmful practices during humanitarian crises. [https://www.unfpa.org/sites/default/files/resource-pdf/MISP-Reference-English.pdf]

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