MOMENTUM

Integrated Health Resilience

Research Brief

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THE HUMANITARIAN-DEVELOPMENT-PEACE NEXUS

A Cross-Country Case Study Brief on Mali and South Sudan

Drawing from the case studies developed for Mali and South Sudan, this brief aims to synthesize key findings, commonalities, and differences in each context as it pertains to the humanitarian-development-peace nexus (HDpN) and applications to family planning, reproductive health and maternal, newborn, and child health (FP/RH/MNCH) interventions (1,2). These themes were drawn from the original HDN conceptual framework developed for MIHR by the Johns Hopkins Center for Humanitarian Health (3). Both Mali and South Sudan are deeply complex and fragile environments, with the caveat that such fragility is not uniform across each country. Significant themes are outlined below and summarized in a comparative table of findings for each country drawing from both the conceptual framework and the WHO Health System Building Blocks (3,4).

INCORPORATING HEALTH SYSTEMS STRENGTHENING & RESILIENCE: ESSENTIAL IN FRAGILE CONTEXTS

In countries with diverse, large, and recurrent shocks and stresses, such as Mali and South Sudan, a concerted effort is needed to reduce backsliding in health development gains. The feasibility of health systems strengthening and health systems resilience efforts have been examined in various fragile contexts. More recent examples demonstrate the need to invest in systems strengthening and resilience (5,6). Both case studies identified examples of resilience-building and linkages with preparedness and recovery, particularly at the grassroots, community level. These included the examples of preparedness and response to floods through efforts of the South Sudan Red Cross in collaboration with other agencies, which entailed assessing and increasing community capacities to respond to flooding, essentially placing communities at the center (7). In Mali, the Analysis of the Resilience of Communities to Disasters (ARC-D) tool was adapted by MIHR for health in both Gao and Timbuktu (8,9). These initiatives are part of MIHR's broader health resilience-building efforts (10). Similar to South Sudan, an essential feature of the ARC-D Health tool was to involve communities in surveillance, the identification of risks, and the development of mitigation measures by specifically examining the impact on the health system as a whole.

LEVERAGING THE NEXUS FOR HEALTH INTERVENTIONS AMIDST RECURRENT FRAGILITY

In both Mali and South Sudan, fragility was not uniform within each country. While there were regions that continued to experience recurrent fragility, other areas were quite stable. These pockets of stability provided an opportunity for targeted nexus programming using an area-based approach (11). It was in these areas where there were some pilots of resilience programming, particularly in Mali where the humanitarian situation has improved in numerous regions. Although the northern part of Mali continues to face significant instability, there were opportunities to transition to medium- and longer-term solutions that matched the reality of needs. Examples emerged of multisectoral, integrated programming between health and other sectors, including food security, livelihoods, education, social cohesion, and conflict management. The protracted nature of the Malian context along with its complexity and movement between fragility and stability (and back) contributed to more integrated, multi-sectoral work. Other novel approaches were piloted including the integration of health services with income generating activities (IGAs) and a transition to cost recovery models in areas where economic conditions had improved. In Mali, MIHR implemented a transitional coverage model for health facilities over a 4-year period, reducing the amount of coverage each year to eventually reach a point where health facilities (CSCOMs) will be able to cover their own costs through their respective community health associations (ASACOs) (12). The various health financing models that were implemented worked to transition to economic recovery (and development) and also promote financial autonomy of the health system, thus enabling sustainability, which is a cornerstone of the nexus. In both countries, decentralization of the health system was a pivotal aspect of implementing a more tailored approach at the sub-national level, and this supported implementation in areas of greater stability that were better primed for nexus programming. Mali has gone further in decentralization than South Sudan, given its longer development history and more established health system.

POLITICAL WILL AND ENABLING POLICY ENVIRONMENTS: NECESSITIES FOR EFFECTIVE HEALTH GOVERNANCE

The ability to engage and work with each respective host government was identified as a critical aspect for humanitarian and development stakeholders in both countries. The degree of political will and capacity had an impact on health governance, including health policies that influenced the design and delivery of FP/RH/MNCH interventions. The impact of sanctions was apparent in both contexts, but more pronounced in South Sudan. Sanctions resulted in limited government involvement in decision-making and planning, and ultimately, hampered long-term sustainability for the health sector. In South Sudan, the ability of humanitarian and development stakeholders to engage with the government was further limited due to issues of government capacity, transparency, and accountability (13,14). Limited government investment in the national budget over the last several years—despite its promise to do so and the means to provide such funds—contributed to an over-reliance on international actors, namely institutional donors, United Nations agencies, and non-governmental organizations (NGOs) (15). Targeted sanctions have had an indirect impact on the ability to deliver health services, and 'zero-cash policies' (i.e., policies that restrict payments to government personnel) coupled with inconsistent pay rates and schedules between Ministry of Health (MoH) and non-MoH staff have created parallel and discrepant hiring structures (16,17). Despite numerous legitimate reasons for restricted engagement with specific persons sanctioned in the government of South Sudan, among other challenges, the culmination of these factors has contributed to a *modus operandi* where the government has often been bypassed and marginalized, particularly at the national level, thus raising concerns around the sustainability of services. Even with the challenges to collaborate at the national level, there should be a common framework for engagement with government health technocrats at the sub-national levels, specifically state and county, to improve sustainability and enable such counterparts to eventually take over and lead service delivery.

In Mali, the creation of ONASR, the government sub-ministry for RH, in 2020 represented a key step in streamlining all RH interventions across the country with the intention to reduce the discrepancy between humanitarian and development interventions, and ultimately align health services with national development plans in place (18,19). The integration of RH and FP in all humanitarian health packages was one such undertaking. Other recent policies, such as the introduction of "non-objection letters" requiring government permission and disclosure of funding details and implementation plans, may contribute to better alignment between humanitarian and development interventions within the existing health system, if implemented carefully and with safeguards to ensure the autonomy of health actors to deliver services driven by health needs. The political landscape has contributed to disruptions to health service delivery, most notably recent and recurrent coups in 2012, 2020, and 2021. The impact of such disruptions includes the discontinuation of funding for any activities deemed non-lifesaving by the United States government, in line with Law 7008, which limits funding to such activities during coups (20). Similarly, World Bank agreements between development actors and the government have dictated that interventions should stop in the event of a coup (21). Significant contingency planning and pre-positioning of supplies and financial resources have worked to counteract and mitigate the impact of these and other unforeseen interruptions.

FP/RH/MNCH INTERVENTIONS & THE NEXUS

Maternal, child, and infant mortality rates in Mali and South Sudan (see Table) have prompted humanitarian and development actors to re-examine how FP/RH/MNCH interventions may be better aligned and integrated. Given that fragility in both countries has been protracted in nature, implementation of solely humanitarian activities, such as the Minimum Initial Service Package for Reproductive Health in Crises (the

MISP) is not always fit-for-purpose for long periods of time (22). In both contexts, there were challenges in the prioritization and implementation of FP, often deemed by stakeholders who were interviewed as a "development" activity that was not lifesaving in nature. In South Sudan, FP was often deprioritized due to "other more pressing" health (e.g., emergency obstetric care) and non-health (e.g., acute food insecurity) needs. In Mali, FP uptake was lower in the northern regions (e.g., Gao, Timbuktu) than in other parts of the country. Parallels between both countries emerged in terms of challenges in community acceptance of FP due to socio-cultural barriers and the length of time needed to implement such interventions. In northern regions of Mali, FP was often referred to as being "at odds with religion," prompting health actors to develop targeted campaigns, including a formalized advocacy document for communities developed closely with religious leaders titled "Islamic arguments in favor of family planning."

In South Sudan, where resistance to FP was often rooted in cultural beliefs and practices, there were multiple efforts to enhance community acceptance. One such program was the roll-out of the government-established Boma Health Initiative (BHI) that specifically addressed safe motherhood and child health (23). Actors such as MIHR have integrated FP services using Boma Health Workers (24). In both Mali and South Sudan, health was used as the entry point to FP and other sensitive interventions by drawing explicit linkages to improved MNCH outcomes, such as the advantages of birth spacing. Additionally, sexual and reproductive health (SRH) self-care interventions were promoted for communities affected by displacement and other recurrent shocks and stresses (e.g., flooding, access barriers during conflict). Similarly, preparedness in terms of supply chain was a recurrent theme, and measures were taken to mitigate the effect of stock outs, including pre-positioning of buffer stock during expected periods of instability or lack of access due to flooding.

BREAKING ORGANIZATIONAL SILOS: KEY FOR THE HDPN

In both case studies, organizational silos were frequently cited as key barriers to working across the nexus. This was especially the case in dual/multi-mandate agencies (i.e., combined humanitarian, development, and/or peace). In Mali, a "fourth mandate" was even cited given prominent stabilization/counter-terrorism efforts underway (25). Efforts to overcome these barriers were often driven by the efforts of individuals, rather than organizations themselves, given the difficulty in traversing long-standing administrative barriers and divisions within and among various organizations (or units within organizations). This challenge was further complicated by a lack of alignment in programming and funding cycles, with an average of 1-2 years and 3-5 years for humanitarian and development interventions, respectively (26,27). These core discrepancies hindered the ability to plan and transition between humanitarian and development actors. Some examples of complementary approaches emerged, including what one agency referred to as "accordion-like" programming where humanitarian and development teams are integrated and can be expanded in response to increased needs. This approach would effectively eliminate the often rigid, ill-suited designation of a context as either purely "humanitarian" or "development."

THE COORDINATION & FINANCING LANDSCAPE: CORE COMPONENTS OF NEXUS IMPLEMENTATION

Each case study outlined complex financing and coordination mechanisms given the presence of humanitarian, development, and peace actors. While humanitarian funding has remained stable in South Sudan, the needs have increased. These needs were driven by acute and protracted conflict, in addition to recurrent shocks and stresses, such as droughts, floods, and disease outbreaks. According to the 2023

Humanitarian Response Plan, 9.4 million people were in need of humanitarian assistance and $1.7 billion was required. Official Development Assistance reached $2.08 billion in 2022. Development health funding has been channeled through two mechanisms up until 2023: the Health Pooled Fund (7 states) and World Bank (3 states). In 2024, after a significant reduction in development funding, it was combined into a multi-donor trust fund under the World Bank with UNICEF as the lead partner agency. Development funding has resembled humanitarian funding in terms of ensuring lifesaving services with limited development (i.e., 'longer-term humanitarian funding'). The increase in humanitarian needs coupled with shrinking development funds has hindered sustainable development (38,40,41,59–61). Rapid response funding was another mechanism utilized by both humanitarian and development actors during the onset of emergencies. These funds were not jointly released, rather humanitarian and development actors each had their own mechanisms to activate the use of such funds. On the development side, the Health Pooled Fund was able to access a contingency envelope of approximately $200K per year from an average annual portfolio of $60 million. Relative to this modest amount, the World Bank was able to activate its own contingency funding of $40 million for more recent emergencies, including COVID-19, flooding, and Ebola. In terms of coordination, multiple coordination fora existed, which were reported to be fragmented, siloed, and duplicative (including for community health cadre). There was a fledgling HDpN coordination body with limited political will and buy-in. The Partnership for Peace, Recovery, & Resilience initiative, which was relaunched in 2022 (as a newer iteration of the 2018 initiative) was expected to enhance engagement among HDP actors. Given this initiative is still in its infancy, it is too soon to assess its progress and success.

In Mali, humanitarian needs have continued to rise as a result of recurrent climate shocks, internal conflict, food insecurity, malnutrition, and heavy displacement among the population. In 2023, the highest recorded needs were recorded with 8.8 million people in need and $751.5 million required. Official Development Assistance was $1.2 billion in 2022. Health financing models have been implemented in different regions, including in the north. Given economic conditions and the protracted humanitarian situation, many regions continue to provide free health care to communities. Actors such as MIHR, Médecins Du Monde, and International Medical Corps have implemented transitional coverage to shift from total (free) to targeted coverage for health services. Targeted coverage has narrowed coverage for the most vulnerable, including women and children. Such financing needs have been implemented to support the government's goal of universal health coverage.

This would allow health facilities to sustain themselves. The feasibility and sustainability of such efforts at scale are uncertain given limited economic means of communities in the aftermath of humanitarian crisis (12,45,46). In terms of coordination platforms, these have included both humanitarian and development actors. The nexus was discussed in many of these platforms, albeit more conceptual than practical. Pragmatic applications are needed for the implementation of the HDpN. Some steps have been explored to achieve this operationalization include transitioning from the humanitarian clusters to thematic working groups in more stable geographic areas.

COMPARATIVE TABLE OF FINDINGS: SOUTH SUDAN AND MALI

Dimension	South Sudan	Mali
Health Demographics (28)	**Under 5 Mortality Rate** **91** *(# of deaths per 1,000 live births)* **Neonatal Mortality Rate** **40** *(# of deaths per 1,000 live births)* **Maternal Mortality Ratio** **1,223** *(# of deaths per 100,000 live births)* **Contraceptive Prevalence** **4** *(% married women 15-49 y, any method)*	**Under 5 Mortality Rate** **97** *(# of deaths per 1,000 live births)* **Neonatal Mortality Rate** **33** *(# of deaths per 1,000 live births)* **Maternal Mortality Ratio** **440** *(# of deaths per 100,000 live births)* **Contraceptive Prevalence** **17** *(% married women 15-49 y, any method)*
Contextual Overview	Gained independence in 2011 after separation from Sudan following decades of conflict. Peacebuilding efforts underway since the Revitalized Agreement in 2020. Recurrent conflict has contributed to long-term fragility (insecurity, violence, displacement, climate shocks [flooding] and disease outbreaks). A weakened health system has led to some of the lowest health indicators globally (28–32).	Gained independence in 1960, post-colonial rule. Recurrent coups (2012, 2020, 2021) have contributed to persistent volatility. Presence of non-state armed groups, terrorist insurgencies in north continue to destabilize the country along with severe climate shocks (drought). Deterioration of government relationship with France, subsequent withdrawal of French development funding. UN Peacekeeping forces withdrew in 2023 (33–37).
HDpN Snapshot	Humanitarian, development, and peace actors consistently present since 2011. Development health assistance channeled through two core mechanisms; the Health Pooled Fund (recently stopped functioning) and World Bank. Limited complementarity between humanitarian and development assistance with development assistance resembling humanitarian aid, only administered over longer timeframe (i.e., "long-term humanitarian funding"). Sustainable development has been hindered by a lack of peace. Limited focus on health systems strengthening and resilience due to recurrent fragility (5,38–42).	Extensive history of development programming since 1960. More pronounced and continuous humanitarian needs since the 2012 coup, with a reliance on humanitarian actors to deliver health services, particularly in the north of the country. Over $62.2 million has been channeled for peacebuilding initiatives via the Peacebuilding Fund. Increased focus on resilience activities has emerged given recurrent fragility. Securitization and stabilization efforts have been widely criticized for more significant funding channeled for military objectives in comparison with humanitarian support (25,43–46).

Dimension	South Sudan	Mali
FP/RH/MNCH	Significant shift in 2022-2023 with the loss of coverage to 220 of 797 health facilities in Health Pooled Fund areas (see financing). FP/RH/MNCH interventions are outlined in the Basic Package of Health and Nutrition Services. The BHI was developed to address gaps in community needs, but has been inconsistently rolled-out due to significant shortage of funding and Boma Health Workers. MIHR has supported FP within the BHI package to increase FP uptake. In 2022, MIHR conducted a Social Norms Assessment to support social and behavior change given FP interventions need long-term commitment. Discrepancies between perception of FP as life-saving activity among different humanitarian and development actors, thus impacting prioritization and integration within RH/MNCH interventions. There remains a lack of adequate infrastructure, accountability, and access to routine quality data to support prioritization of FP among other health services (5,23,47–50).	Government commitment has included FP/RH in the national health and social development plan (PRODESS). Progress remains limited for the 2030 SDG targets. ONASR (RH sub-ministry) has rolled out a new requirement for the integration of RH and FP in all humanitarian health packages to better align humanitarian and development interventions. MIHR has implemented resilience-building activities, including the ARC-D for Health toolkit. Other efforts have entailed the integration of multisectoral interventions to better reflect needs in a constantly evolving, fragile context encompassing health, food security, livelihoods, economic recovery, social cohesion, and conflict management. Integration of IGAs with health activities and cost recovery interventions have been developed to transition from a humanitarian situation to more stability. Barriers to FP uptake include community resistance, often rooted in religious beliefs. Advocacy materials have been developed with religious leaders to promote FP for health (8,18,51–54).
FP/RH Supply Chain	Supply chain for FP/RH commodities currently rely on “push system,” and are not driven by consumption rates. Interim efforts underway to align procurement and utilization rates. Pre-positioning efforts during shocks and stresses included a buffer stock to Boma Health Workers. Other contingency measures included SRH self-care interventions for women in regions with barriers to access.	Significant pre-positioning for FP/RH commodities has taken place for areas marked by insecurity, climate shocks, and access barriers (both physical geographic access and communication). These measures have included reducing the distribution frequency of stock and planning longer pre-positioning periods (6 months) when feasible. Supply chain was identified as a “pull system” driven by consumption rates.

Dimension	South Sudan	Mali
Health Workforce	Zero-cash policies limit compensation to MoH staff. More stability in NGO positions relative to MOH post given relatively higher salaries and consistent pay schedules. Sanctions have made working directly MoH staff even more challenging. Parallel hiring structures in the public health sector have emerged because of discrepant payments, hiring practices, top-ups. Some efforts to limit discrepancies, including MoH circular for incentives for entire health workforce (government, NGOs). Localization efforts still limited given reliance on international staff (16,17).	Increased stability in working for the government relative to NGOs; latter is perceived as less stable, more intermittent in terms of hiring. Necessity of local recruitment, especially in northern regions due to access and security constraints. This has helped enhance localization (albeit only to a certain degree) and has improved retention of staff and their capacity. Examples of transitional coverage models are in place by MIHR with financial compensation for staff slowly phased out over a 4-year period. Other models implemented, such as those by Médecins Du Monde included coaching government-hired staff to ensure sustainability (12,55).
Leadership & Governance	Engagement with the government has been limited. Reasons for this include sanctions and issues with transparency, accountability, and capacity. Over-reliance on international actors, including donors, UN agencies, and NGOs. Health system is decentralized in theory, but in practice the system remains quite centralized (13,14,56,57).	More collaborative engagement between government and international actors. Recent requirement of obtaining 'non objection' letters by government, and disclosure of details around funding and implementation has provided more leadership and control to the government. Decentralization of health system has enabled more ownership and sustainability at sub-national level (58).
Financing	Humanitarian funding has remained stable, but needs have increased. Development health funding has been channeled through the Health Pooled Fund (7 states) and World Bank (3 states) up to 2023. In 2024, development funding was combined into a multi-donor trust fund under the World Bank in partnership with UNICEF. Development funding resembled humanitarian funding in terms of ensuring lifesaving services with limited development (i.e., 'longer-term humanitarian funding'). Sustainable development remains hindered by increased humanitarian needs, decreased development funds, and absence of peace.	Humanitarian needs have continued to rise. Health financing models have been implemented in different regions. Given economic conditions, many regions continue to provide free health care. Actors such as MIHR, Médecins Du Monde, and International Medical Corps have implemented transitional coverage to shift from free total health to targeted health services to enable health facilities (e.g., CSCOMs) to sustain their operations (including staff coverage). Financing models implemented by various actors have been in line with the government goal of universal health coverage. Economic conditions and increased humanitarian needs continue to limit the ability of communities to sustain themselves and prioritize their health.

Dimension	South Sudan	Mali
Coordination	Multiple coordination fora for both humanitarian and/or development actors. Fragmentation was cited as a critical barrier when it came to coordination. Siloed efforts between and across humanitarian and development platforms. Reported to be duplicative, particularly in the case of community health cadre. A fledgling HDpN coordination body and revamped initiative of the Partnership for Peace, Recovery, & Resilience initiative (2022). Both were expected to enhance engagement among HDP actors, though concerns around political will and buy-in remain.	Coordination platforms include both humanitarian and development actors with discussion of the nexus reported to be taking place, although in more conceptual rather than practical terms. Some pragmatic applications are still needed for the implementation of the nexus. Some steps have been taken including the transition from humanitarian clusters to thematic working groups in geographic regions deemed more stable. This ties in with the need to leverage implementation in geographic areas deemed more stable and thus primed for nexus interventions.

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