

Bridging the Divide

A guide to implementing the **Humanitarian-Development-Peace Nexus for Health**

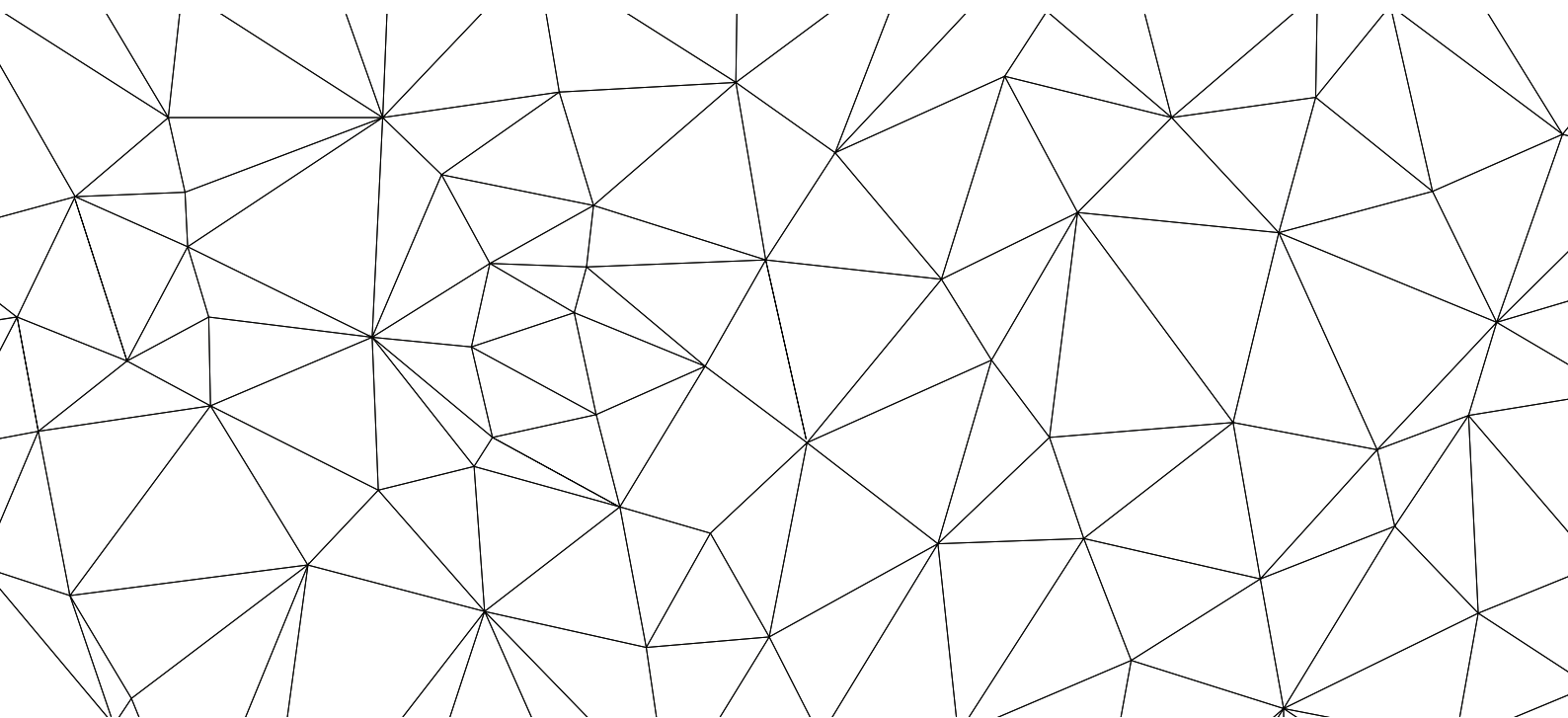


**World Health
Organization**

REGIONAL OFFICE FOR THE **Eastern Mediterranean**

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Preface

IN RECENT YEARS, emergencies have become increasingly protracted and complex, affecting more people and demanding more resources than ever before. Emergencies have a direct impact on health through the injuries, illnesses, psychological trauma and deaths that they cause, as well as an indirect impact – by increasing susceptibility to disease and poor health and through their impact on the determinants of health. For instance, 60% of preventable maternal deaths, 53% of under-five deaths, and 45% of neonatal deaths take place in contexts with conflict, displacements, and natural disasters. Emergencies also affect health through the damage or disruption they cause to health systems.

In complex and protracted crises, the length, scale and complicated nature of the emergencies often necessitates a shift from reactive to more sustainable, long-term responses. Recognizing this, the international community made a commitment, under the “Grand Bargain”, to strengthen the connections between humanitarian, development and peacebuilding. This became known as the New Way of Working.

Based on the humanitarian-development-peace nexus (HDPNx) or “triple nexus” approach, the New Way of Working involves leveraging the comparative advantage of each actor group and working over multi-year timeframes to achieve collective outcomes. The New Way of Working improves efficiency, effectiveness, coherence, continuity and sustainability; it reduces service delivery gaps and the duplication of efforts, addresses the drivers

of emergencies, and facilitates the transition from humanitarian response to stabilization, recovery and development. Although a variety of resources, policy papers and case studies have been published on the importance of HDPNx and its implementation in specific settings, there was no guidance on how to operationalize the approach within the health sector: this guide has been developed to address that gap.

The aim of the guide is to provide action-oriented guidance for implementation of the HDPNx in the health sector, particularly in complex and protracted emergencies. It builds on previous work and links with other global initiatives, such as Health in All Policies, the 2030 Agenda for Sustainable Development and Health as a Bridge for Peace.

Section 1 describes the background to the work and introduces the HDPNx. Section 2 sets out the rationale for the guide, as well as its aim and objectives, target audience and scope. Section 3 explains how to operationalize the nexus for health: it lays out the principles that should guide nexus implementation, describes the six steps of the nexus process, and ends with an overview of conflict prevention, mitigation and resolution, as well as of how health can contribute to this.

A list of the roles and responsibilities of actors and stakeholders involved in nexus operationalization for health is presented in Annex 1. Annex 2 provides a list of selected tools and sources of information that can be used for the health sector assessment. Annex 3 provides a list of indicators for monitoring and evaluating the nexus for health process and its outcomes.

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Acronyms

DHIS2	District Health Information Software 2
HRP	Humanitarian response plans
HDPNx	Humanitarian-Development-Peace Nexus
LRRD	Linking relief, rehabilitation and development
NGOs	Nongovernmental organizations
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PHC	Primary health care
SDGs	Sustainable Development Goals
UHC	Universal health coverage
UN	United Nations
UNDP	United Nations Development Programme
UNSDCF	United Nations Sustainable Development Cooperation Framework
WHO	World Health Organization



1 Introduction to the HDPNx approach

1.1 Background

Over 2 billion people across the world live in fragile, conflict and violence-affected settings, where difficult living conditions are often exacerbated by emergencies such as natural disasters and infectious disease outbreaks, such as the ongoing COVID-19 pandemic (1). Emergencies have a direct impact on health. They cause injuries, illnesses, psychological trauma and deaths, and, through their impact on the determinants of health, they increase the population's susceptibility to diseases and poor health (2,4). For instance, 60% of preventable maternal deaths, 53% of under-five deaths, and 45% of neonatal deaths take place in contexts with conflicts, displacements, and natural disasters (5). Emergencies also affect health through the damage or disruption they cause to health systems (3,6).

In recent years, emergencies have become increasingly protracted and complex, and they are affecting more people and demanding more resources than ever before (7). According to the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), the average humanitarian crisis now lasts more than nine years. It has forecast that in 2021, 235 million people will need assistance globally, at a cost of US\$ 35.1 billion (8). This is the highest number on record.

Improving health outcomes in protracted and complex emergencies requires a three-pronged approach, focused on responding to immediate needs, rebuilding the health system and preventing future emergencies. Traditionally, these three aspects have been divided between humanitarian, development and peacebuilding actors, with each group working independently using its own coordination, planning and resource mobilization mechanisms. However, that approach does not take into account that activities carried out in one part of the humanitarian-development-peace triad may have consequences for the others. For instance, structures and mechanisms put in place during a humanitarian response may have implications for long-term health systems

development, as well as for peacemaking and peacebuilding. Conversely, development work which contravenes the principles of impartiality, neutrality and operational independence may increase the need for humanitarian action.

It is now widely acknowledged that humanitarian, development and peace actions do not occur in chronological sequence, whereby the first transitions toward the latter. Rather, they occur concurrently, often in the same geographical areas and political environments, with mutual interdependence and common goals. Coordination and complementarity between the different groups of actors are therefore vital.

1.2 HDPNx: A New Way of Working

In 2016, the international community acknowledged the need to pay special attention to populations living in fragile and conflict-affected settings and – under the “Grand Bargain” – made a commitment to strengthen the connections between humanitarian, development and peacebuilding activities in order to better reduce risks and vulnerabilities and leave no one behind. This became known as the New Way of Working (9,10).

Based on the “triple nexus” or humanitarian-development-peace nexus (HDPNx) approach (11), the New Way of Working involves leveraging the comparative advantage of each actor group and working over multiyear timeframes to achieve collective outcomes. This improves efficiency, effectiveness, coherence, continuity and sustainability; reduces service delivery gaps and the duplication of effort; addresses the drivers of emergencies; and facilitates the transition from humanitarian response to stabilization, recovery and development.

1.3 Conceptualizing the HDPNx approach

The idea that underpins the HDPNx is not new – in fact, it was a feature of several earlier initiatives, such as the European Union's linking relief,

rehabilitation and development (LRRD) (12), the resilience approach (13), conflict-sensitive approaches to development and humanitarian assistance (14), and the early recovery approach to humanitarian programming (15). However, the HDPNx approach goes further, by combining the objectives of these initiatives. Nevertheless, four years after the commitment was made to adopt the “triple nexus” or HDPNx approach, its conceptualization and operationalization remain underdeveloped.

The first step towards addressing this is therefore to describe what the HDPNx approach entails. In this guide, nexus (or nexus-style) activities have been defined as any health-related activity where at least two of the three groups of actors (humanitarian, development and peace) work together with the aim of: providing immediate life-saving and life-supporting assistance; strengthening or rebuilding national systems, institutions and capacities; strengthening emergency management capacities; or addressing the drivers of emergencies.

Using this definition, it is clear that the nexus approach is already being adopted in emergency countries across the world, even though it may not be conceptualized or labelled as such. For example, in Afghanistan, the establishment and/or reconstruction of blood banks, laboratories and hospital-based trauma units, and the development of patient flow and emergency management systems all contribute to both the emergency response and health system strengthening. Another example comes from the occupied Palestinian territory, where the World Bank, WHO and the United Nations Development Programme (UNDP) respectively supplied funding and technical capacity on health and energy, in order to provide a reliable, cost-effective, eco-friendly energy generating system which addressed hospitals’ immediate and long-term energy needs.

1.4 Challenges and opportunities for nexus implementation

Although the benefits of the nexus are widely recognized, the approach is not always adopted. The

reasons for this include:

- lack of clarity about the nexus approach and how to implement it
- lack of technical or operational capacity
- lack of commitment or leadership by governments
- the complex and nonlinear nature of emergencies, and the impact of conflict dynamics
- insufficient external aid
- competition among humanitarian and development actors
- structural differences between humanitarian and development actors, for instance in their mandates, modes of operation, and operating principles.

Despite these challenges, however, there are also clear opportunities that can support nexus implementation. Firstly, strong global commitment to the New Way of Working, strong political will among donors and the ongoing paradigm shift that is happening as stakeholders realize that protracted or complex crises cannot be resolved by any one group of actors. Furthermore, while there is no new money available specifically for the nexus, there are funds that can be utilized for the nexus approach, such as the Sustainable Development Goals Fund, the UN Secretary-General’s Peacebuilding Fund (16), or the Instrument contributing to Stability and Peace (17).

Secondly, the health-related Sustainable Development Goals (SDGs) provide actors with common objectives and can serve as a reference for the definition of collective outcomes. Thirdly, there are existing collaborations between humanitarian and development actors that can facilitate implementation of the nexus approach. These include intra- and intersectoral partnerships, close relationships between humanitarian and resident coordinators, and informal collaborations between individuals in the same organization. WHO, where there is increasing cooperation between the health emergency and health systems programmes at all levels, is a good example of this.

2 Rationale and scope of this guide

2.1 Rationale

The HDPNx approach is especially important in complex and protracted crises, where the length, scale and complicated nature of emergencies often requires a shift from reactive to more sustainable, long-term responses. Yet although a variety of resources, policy papers and case studies are available on the importance of HDPNx and its implementation in specific settings (18), there are currently no guides – with the exception of the Health Cluster Guide (15) – on how to operationalize the HDPNx approach for the health sector. There is therefore an urgent need for action-oriented guidance on how to implement the HDPNx for Health. This guide has been developed to address that gap.

The work to develop this guide is in line with Agenda 2030 for Sustainable Development (19), the Agenda for Humanity, which calls for a commitment to “leave no one behind” (20), and WHO’s mission to “promote health, keep the world safe, serve the vulnerable” (21).

2.2 Aim and objectives

The aim of this guide is to provide action-oriented guidance for implementation of the HDPNx in the health sector, particularly in complex and protracted emergencies. Its specific objectives are therefore to:

- introduce the HDPNx concept generally, and specifically in the context of health
- outline the principles to consider when

- operationalizing the HDPNx for health
- outline the key steps for implementation of the HDPNx in the health sector
- provide a list of indicators to monitor and evaluate the nexus process and its outcomes
- identify the roles and responsibilities of the different actors in operationalizing the HDPNx for health.

2.3 Target audience

The target audience for this guide is health sector actors and stakeholders, including ministries of health and other health-related sectors; WHO and other UN agencies; and humanitarian and development actors such as donors and international and local nongovernmental organizations (NGOs). Although the target audience is national governments of countries with fragile and conflict-affected settings, we acknowledge that in many settings there will be a need to work with authorities in non-government-controlled areas.

2.4 Scope

The guide covers all hazards and emergencies, but particularly focuses on complex and protracted crises, including localized, national and regional emergencies. The guide is broad and flexible enough to be applied to a wide range of geopolitical settings. However, due consideration must always be given to the unique and pertinent conditions of each context and emergency.

3 Operationalizing the HDPNx for health

The overarching goal of implementing the HDPNx for health is to advance progress towards the achievement of the health-related SDGs, including universal health coverage (UHC) and health security. The objective of operationalizing the nexus is to facilitate the adoption of the New Way of Working by humanitarian, development and peace actors. This involves leveraging the comparative advantage of each actor group and working over multiyear timeframes to achieve collective outcomes.

The HDPNx for health approach should not be a standalone process but must be embedded in the wider nexus process. It should make use of existing frameworks, such as humanitarian response plans (HRP) and the United Nations Sustainable Development Cooperation Framework (UNSDCF), and build on and use existing coordination structures, such as cluster and sector coordination mechanisms.

Whenever possible, nexus operationalization should follow the cycle below:

- establishing the nexus coordination mechanism
- undertaking a joint assessment
- agreeing on collective outcomes/developing and implementing the joint multiyear plan
- harmonizing resources and financing, and
- monitoring and evaluating both the nexus process and its outcomes.

Conflict prevention, peacemaking and peacebuilding approaches should underpin and be integrated into every part of the process.

Ideally, the HDPNx approach should be initiated from the earliest phases of the emergency and remain in operation until a humanitarian response is no longer needed. It is important to note here that the complex, dynamic and nonlinear nature of emergencies means that different parts of the crisis-affected setting may be at different stages of the nexus process. This may in turn lead to differences in the presence and level of activity of humanitarian or development actors in those different areas.

The guiding principles and the steps of the nexus process are outlined in the sections below.

3.1 Guiding principles

The following principles reflect the combined key principles of humanitarian, development and peace actions. They establish the framework that should guide all actors engaged in implementing the HDPNx approach:

- **First do no harm.** Prioritize immediate lifesaving activities while working towards reducing future need, risk and vulnerability.
- **Bridge the divide.** Aim to reconcile tensions between humanitarian and aid effectiveness principles.
- **Integrate nexus approaches from the beginning.** Ensure, where possible, that all health sector partners and stakeholders agree to, actively participate in and contribute to nexus implementation from the earliest phases of the emergency.
- **Advance the localization agenda.** Work with the local community and prioritize partnerships with local actors to build capacity, improve accountability, promote sustainability and ensure that interventions are context appropriate.
- **Ensure conflict sensitivity and peace responsiveness.** Base interventions on a sound conflict and situation analysis in order to avoid exacerbating the drivers of conflict, reduce the chances of recidivism and ensure context-specificity.

3.2 Steps of the nexus implementation process

There are three prerequisite conditions that should be fulfilled before initiating the process in order to improve the likelihood of successful implementation of the nexus. First, there must be the political will from donors to adopt and fund the nexus approach.

Secondly, there must be a commitment by health sector partners to adopt and implement the approach. Thirdly, governments must be willing to engage with the approach, to work with humanitarian, development and peace partners, and where necessary, to put in place processes and systems that facilitate its implementation.

Fig. 1 presents the steps of the nexus implementation process in the HDPNx for health cycle. However, it is important to note that these steps do not always occur sequentially: several of the steps may occur concurrently, or it may be necessary to go back one or more steps in the cycle in order to adapt to changes in the conflict situation.

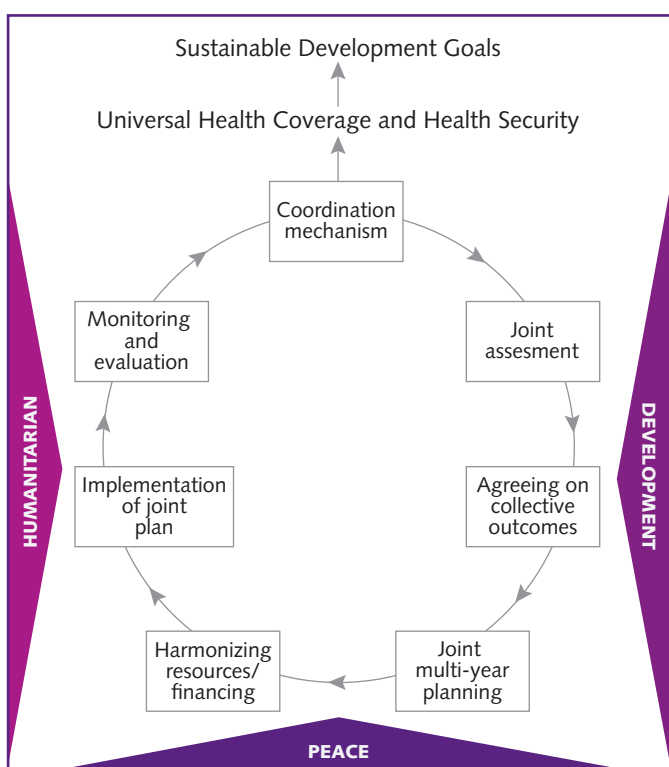


Fig. 1: The HDPNx for health cycle

Step 1: Establishing nexus coordination mechanisms

The first step of the nexus process is the establishment of a nexus coordination mechanism for health. Since there is no one-size-fits-all, this can take many different forms, depending on the context, the situation and the specific timepoint of the emergency.

In the first and most ideal form, the nexus

coordination mechanism is embedded within existing health cluster and health sector coordination mechanisms. In the initial stages of the emergency, for instance, it could be established within the health cluster through the integration of development actors. Once the development-oriented health sector coordination mechanism is activated, the nexus coordination mechanism could be established within it, through the integration of humanitarian actors.

Alternatively, a standalone nexus coordination mechanism could be created. This was the approach adopted in Mali, where there is an HDPNx working group composed of UN agencies, donors and an international NGO that represents the other international NGOs.

Nexus coordination mechanisms may be needed at the national and/or subnational levels and may be established in different forms at different levels. Regardless of the form chosen, the nexus coordination mechanism for health should be synergetic with the nexus coordination structures and mechanisms for other sectors and should facilitate intersectoral partnerships.

There are four other activities that are crucial to the success of the nexus approach and should be carried out as part of establishing the nexus coordination mechanism:

- **Designation of a nexus focal point.** This can be either an individual or a team – composed for instance of the health cluster coordinator and health sector coordinator(s). In each case, the choice of nexus focal point should be context- and emergency-specific.
- **Mapping of health sector actors and activities to identify gaps, interlinkages, overlaps, and potential areas of synergy and complementarity.** The mapping process should:
 - » gather information about each entity's mandate, areas of comparative advantage and current areas of activity, including who is doing what, where, when and for whom;
 - » build on and make linkages with the 4W Matrix, Health Resources and Services Availability Monitoring System (HeRAMS) and other tools used to map the actors and activities in emergency settings; and

- » result in a working document that is revised and updated as the emergency situation evolves and the number and type of actors and capacity in the health sector changes.
- **Development of the nexus strategy.** This should:
 - » include a clear context-, emergency- and timepoint-specific plan for assembling the various health sector partners and defining how they will work together;
 - » define context-specific modalities and methodologies for the joint assessment;
 - » set out guidelines for how actors can harmonize resources, leverage their comparative advantages and ensure complementarity and coherence to reduce gaps in service delivery;
 - » identify the various options for health sector recovery (22);
 - » define how the other steps of the nexus will be implemented; and
 - » result in a dynamic and living document that is revised regularly and with any evolution of the situation.
- **Capacity-building of the health sector actors** in areas relevant to the HDPNx, such as nexus implementation or conflict-sensitive programming, to ensure that all actors and stakeholders are equipped with the skills they need to implement the nexus for health.

Step 2: Joint assessment

The second step in the nexus process is to undertake a joint assessment of the health needs and risks, health system capacities, and operational and political contexts. As with the nexus coordination mechanism, the joint assessment can take different forms to suit different contexts. The three main options for the joint assessment are:

- **Integrated assessment**, which is done by a coalition of the different actors, using the same tools and a common methodology in an integrated manner. The

2017 Recovery and Peacebuilding Assessments that were carried out in Cameroon by the government, World Bank, United Nations and European Union are an example of this.

- **Semi-integrated assessment** may be used in contexts where the cooperation between actors is underdeveloped. It involves harmonizing assessment processes by inviting development actors to contribute to humanitarian assessment processes and vice versa. In Côte d'Ivoire, for instance, humanitarian actors were given the opportunity to contribute to the analysis of the risks and vulnerabilities during the development of the Cadre Programmatique Unique 2017–2020, the country's equivalent of the UNSDCF.
- **Non-integrated assessment**, which uses aggregated and triangulated data from the different assessments carried out by the various actors. These include but are not limited to health systems assessments, service availability and readiness assessment, joint external evaluation, vulnerability and risk analysis and mapping, humanitarian needs overview, and the Health Resources Availability Mapping System (HeRAMS). The relevant parts of such assessments are put together and form the basis of joint identification of potential areas of common concern and joint intervention, and areas where programming can intersect or be combined.

Whichever method is used, the joint assessment should feed into and make links with processes such as the preparation or review of the humanitarian needs overview, the Country Cooperation Analysis, and the recovery and peacebuilding assessments. In semi-integrated and non-integrated assessments, these structured processes can serve as good opportunities for working with other actors and partners. They can also provide a platform for aggregating and integrating information from different sources. A list of selected tools and sources of information that can be used for the assessment is provided in Annex 1. Fig. 2 gives an overview of the three types of joint assessments.





 Level of integration		Integrated assessment: Assessment by coalition of humanitarian, development and peace actors, using the same tools and a common methodology
		Semi-integrated assessment: Inclusion of development actors in humanitarian assessment processes and vice versa
		Non-integrated assessment: Use of aggregated and triangulated data from assessments carried out by different actors

Fig. 2: Types of joint assessment

Step 3: Formulating collective outcomes

The third step in the nexus process is to formulate the collective outcomes, based on the results of the joint assessment. According to OCHA, collective outcomes are defined as “the concrete and measurable results that humanitarian, development and other relevant actors want to achieve jointly over a period of 3–5 years to reduce people’s needs, risks and vulnerabilities and increase their resilience” (23). In the health sector, these collective outcomes are informed by and based around the context-specific indicators for UHC, health security and other health-related SDGs. Health-related collective outcomes are focused on:

- Meeting immediate life-saving and life-supporting needs, while preventing the deterioration of the situation. Where possible, these actions should also contribute to laying the foundation for strengthening or rebuilding national systems, institutions and capacities.
- Supporting, strengthening or rebuilding the health system based on the primary health care (PHC) approach. This should include a progressive widening of access to essential services, reduction in financial barriers to health care, and strengthening of essential public health functions.
- Strengthening emergency preparedness and risk management capacities based on an all-hazards approach, to protect populations from public health risks of both natural and manmade emergencies.

- Preventing conflict and promoting peace-making and peacebuilding by implementing health and peace interventions at different stages of the conflict cycle including in pre-conflict settings, during hostilities, and in post-conflict settings.

The formulation of collective outcomes should be collaborative and iterative. Where possible, all health sector stakeholders – including national actors, financing partners, civil society groups and the government – should be involved in and informed about the process. The collective outcomes should be based on the results of the joint assessment and identified areas of action and informed by the context-specific needs and opportunities.

Once the collective outcomes have been defined, each partner should identify their own entry point of action – that is, specific areas of action which can contribute to the achievement of those collective outcomes. For example, for the collective outcome of achieving UHC, the entry point of action may be to start by creating a basic package of health services, which can then be expanded to a UHC priority benefits package.

Another example is the use of the National Action Plan for Health Security as an entry point for health security as a collective outcome. In this case, the National Action Plan for Health Security from the humanitarian phase can later be reviewed and updated for the development phase. A third example is the development of a recovery and resilience framework that can guide health cluster partners on how to contribute to institutional capacity building and improve health system resilience, while responding to immediate humanitarian needs. A final example is the development of a health information system from surveillance and disease early warning systems, which can be expanded to include other important public health information.

The entry points of action allow the different groups of actors to work towards common objectives of the health-related SDGs in a way that fits their own mandates while paying attention to complementarities with others. It is important to note that different phases of the emergency may require different entry points by different groups of actors, and these may differ over time.

Step 4: Developing and implementing the joint multiyear plan

The fourth step in the nexus process is the development and implementation of the joint multiyear plan, which outlines the modalities for achieving the collective outcomes. There are two main approaches to developing the plan.

The first and more ideal approach involves creating a single plan that covers humanitarian, development and peace needs. An example can be found in Uganda, where humanitarian and development actors in refugee-hosting districts organized themselves around the Refugee and Host Population Empowerment Framework, funded by the UN and World Bank, which was developed to support the Government with its implementation of the 2015/16–2020/21 National Development Plan.

Alternatively, in contexts where it is not possible to have a single plan, the preferred solution is to ensure that the humanitarian response plan covers multiple years, and that both the humanitarian and development plans are closely aligned with each other. This is the approach that was adopted in Cameroon, where the humanitarian community developed a multiyear HRP covering the period 2017–2020, which was in alignment with the 2018–2020 United Nations Development Assistance Framework. The HRP and United Nations Development Assistance Framework were also designed to share a geographic and thematic scope, and during the HRP revision for 2018, OCHA organized working sessions to improve HDPNx thinking among humanitarian actors.

In both cases, the joint multiyear plan should be designed in consultation with the government, where possible. It should clarify the roles and responsibilities, as well as the areas of action and operation in such a way as to ensure coherence and avoid gaps in service delivery. The plan should also be flexible, account for contingencies, and plan for the eventual transition of the administration of the health sector to local authorities as early as possible. Finally, it should include a mutual accountability framework in contexts where this is needed. Suggested roles and responsibilities for the different actors can be found in Annex 2.

Once the plan is finalized, the implementation process can begin. Examples of joint implementation include the European Union-funded Integrated Community Recovery and Resilience project, which began in 2017 and is implemented jointly by WHO and UNDP in Borno state, Nigeria. Another example is the multiyear plan in the Central African Republic, which was established in response to a flare up in conflict. Humanitarian, development and peacebuilding actors worked together to codesign Plan Opérationnel pour la stabilisation de Bambari, which covers the period 2017–2019 and is based on a common assessment of needs and needed responses. The plan also takes a joint programming approach.

Step 5: Harmonizing resources and financing

The fifth step in the nexus process is the harmonization of resources. A key part of this is monitoring and tracking of funding flows, including the inflows and outflows of humanitarian aid and development assistance, as well as associated trends. This provides an overview of the total external funding, facilitates swift identification of any potential dips in funding, and ultimately helps to reduce or mitigate funding gaps.

Another important means of harmonizing resources and financing is to establish a multi-partner pooled fund. An example is the Somalia UN Multi-Partner Trust Fund, which covers both humanitarian and development activities, brings together multilateral organizations, international financing institutions and donors, and organizes its programmatic and operational work according to the priorities identified under the Peacebuilding and Statebuilding Goals of the Somali Compact.

In addition to engagement with donors, the resource harmonization process may require negotiations and agreements among operational health sector actors and stakeholders as to the allocation and harmonization of resources. Agreements resulting from such negotiations can be captured in context-specific frameworks, such as a memorandum of understanding. These agreements should be revised and updated as needed, particularly whenever the situation evolves and/or there is a change in the number and level of activity of the various actors.

Step 6: Monitoring and evaluation

The sixth and final step of the nexus process is monitoring and evaluation. This has two stages: the first stage aims to assess the effectiveness of the nexus process itself, while the second focuses on the collective outcomes and the progress made towards achieving them.

Monitoring and evaluation enables operational plans and the joint multiyear plan to be reviewed and, where necessary, updated. It also promotes mutual accountability among partners.

The monitoring and evaluation process should use indicators that are context- and emergency-specific. Where possible, it should reflect the indicators defined in the joint multiyear plan and related national and international humanitarian and development plans. The monitoring and evaluation should be repeated regularly, and the results used to ensure that the nexus approach is being effectively implemented. This will demonstrate that the bridge between the humanitarian and development agendas is functional and that nexus operationalization is informed by conflict analysis.

A list of guiding questions that can be used for monitoring and evaluation of the nexus approach can be found in Annex 3.

3.3 Conflict prevention, peacemaking and peacebuilding

Peace is a determinant of health and well-being, and so in fragile and conflict-affected settings in particular, securing peace is key to ensuring lasting health gains. Conversely, health and efforts to improve it, such as inclusive access to health care for all, can be powerful vehicles for peace. This means that conflict prevention, mitigation and resolution are public health matters, in which the health sector can play a significant role using its competencies, credibility and networks.

Examples have shown how health interventions can contribute to conflict mitigation and resolution – examples such as the joint mental health and psychosocial project by WHO, the United Nations Children's Fund and the International Organization of Migration, which aims to reduce conflict and social unrest through the provision of mental health and psychosocial support to conflict-affected

and internally displaced communities. Others can contribute to conflict prevention, such as the training of frontline health care professionals to deliver quality health care to everyone, irrespective of affiliation. Health actors could also contribute to conflict prevention, mitigation and resolution, for instance by engaging in advocacy and diplomacy for ceasefires to enable service delivery for patients, in cases where crossing frontlines is required.

In certain contexts, health has been used as a platform for bringing together health professionals from different factions and conflict parties, either for joint training or for dialogue on areas of mutual concern, such as preventing and responding to disease outbreaks and compliance with the International Health Regulations (2005). An example is the WHO advocacy for and mediation of collaboration among health workers in occupied Palestinian territory, which facilitated dialogue and the exchange of knowledge, experience and expertise in areas of mutual concerns, such as infectious disease outbreaks. Finally, monitoring, collecting and reporting data on attacks on health care workers, access barriers, and the impact of barriers on health outcomes can allow health actors to advocate for the right to health and draw attention to violations against this right.

To ensure that health contributes to conflict prevention, mitigation and resolution, rather than creating or exacerbating tensions within communities, humanitarian and development interventions should begin with a comprehensive conflict analysis that is conducted by competent professionals. Given the relative lack of expertise in the health sector on conflict prevention, peacebuilding and peace-making, partnerships with actors and experts from outside the health sector may be required. This will ensure that health programmes are designed in such a way as to be both conflict-sensitive and peace-responsive. Initiatives like Health for Peace, which was created specifically for the Eastern Mediterranean Region, can facilitate such partnerships (24).

Partnerships with peace partners and the Protection Cluster are also important as they can provide health actors with critical information and insight into conflict situations, allowing programming to be adapted quickly, whenever needed.

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Annex 1:

Selected tools and sources of information for health sector assessment

- Country health profiles
- Demographic and Health Surveys (1)
- Health System Assessment Approach (2)
- SMART Surveys (3)
- Assessing a Healthcare Arena Under Stress: A guidance (4)
- Multi-Cluster/Sector Initial Rapid Assessment (MIRA) (5)
- Humanitarian Needs Overviews (6)
- Toolkit for Assessing Health System Capacity for Crisis Management (7)
- WHO Emergency Care System Assessment (8)
- Health Resources Availability Monitoring System (HeRAMS) (9)
- Service Availability and Readiness Assessment (SARA) (10)
- Early Warning, Alert and Response System (EWARS) (11)
- Integrated Disease Surveillance and Response system (IDRS) (12)
- District Health Information System (1)
- Universal Health Coverage Priority Benefit Package (13)
- Essential Package of Health Services in Humanitarian Crises (14)
- Strategic Tool for Prioritizing Risks (STAR) (15)
- Vulnerability and Risk Analysis & Mapping (VRAM) (16)
- IHR Capacity Assessment (17)
- IHR (2005) Monitoring and Evaluation Framework including Joint External Evaluation (JEE) (18,20)
- SCORE for Health Data (21)
- Assessment of Essential Public Health Functions in Countries of the Eastern Mediterranean Region: Assessment Tool (22)
- Conducting a Conflict and Development Analysis Tool (23)
- Conflict Sensitivity Tools and Guidance (24)
- Guidelines for Vulnerability Reduction in the Design of New Health Facilities (26)
- Hospital Safety Index (26)
- Health Facility Seismic Vulnerability Evaluation (27)
- Operational framework for building climate resilient health systems (28)
- Damage and Loss Assessment (DaLA) (29)

Annex 2:

Roles and responsibilities of actors and stakeholders

Actor	Roles and Responsibilities
Nexus focal point	<ul style="list-style-type: none"> • Oversight of creation of health nexus coordination mechanism where necessary, and liaison with wider nexus coordination mechanisms. • Mapping and analysis of health sector actors, their capacities and areas of activity. • Coordination of nexus strategy development. • Advocacy for the active participation of health sector partners and stakeholders in nexus process. • Coordination of joint assessment, identification of priority areas of action and definition of collective outcomes. • Coordination of joint multiyear plan development. • Coordination and oversight of monitoring and evaluation.
WHO	<ul style="list-style-type: none"> • Lead implementation of nexus approach for health, where the government is unwilling/unable to do so. • Advocacy with health sector actors, partners and stakeholders to engage with nexus process, and align and harmonize their resources and processes. • Liaison with wider nexus processes and advocacy for health to be prioritized. • Coordination and oversight of capacity-building in relevant areas, e.g. nexus implementation or health as a bridge to peace. • Documentation of successes, failures and lessons learned in implementing the nexus for health.
Health sector partners	<ul style="list-style-type: none"> • Active participation in the nexus coordination mechanism. • Sharing and exchange of information with other partners. • Participation in joint assessment, identification of priority areas of action and definition of collective outcomes. • Identification of entry points for action. • Harmonization of resources, processes and modes of operation with other partners. • Participation in development and implementation of the joint multiyear plan; for donors, funding of the plan.
Government or ministry of health where possible	<ul style="list-style-type: none"> • Lead implementation of the HDPNX approach for health. • Engagement with international initiatives and requesting of technical, financial and other assistance. • Active participation in nexus coordination mechanisms. • Participation in joint assessment, identification of priority areas of action and definition of collective outcomes. • Participation in development and implementation of the joint multiyear plan. • Facilitation of administrative processes and removal of bottlenecks for organizations working on the nexus.


Annex 3:

Guiding questions for monitoring and evaluation of HDPNx implementation

Guiding questions	Description
1. Is there a functional nexus coordination mechanism?	<ul style="list-style-type: none"> The nexus coordination mechanism governs the HDPNx implementation process. It can be standalone or embedded within existing health cluster and health sector coordination mechanisms, depending on the context and emergency.
2. Is there a map of health sector actors and activities that is updated regularly?	<ul style="list-style-type: none"> The map contains information on each actor's mandate, areas of comparative advantage and areas of activity, particularly what they're doing, where, when and for whom. It is revised and updated based on evolution of the emergency and/or changes to the number and type of health sector actors.
3. Is there a nexus strategy that is updated regularly?	<ul style="list-style-type: none"> This is a context-, emergency- and timepoint-specific strategy plan for assembling the various health sector partners and defining how they will work together. It provides guidelines for how actors can harmonize resources, leverage their comparative advantages, and ensure complementarity and coherence to reduce gaps in service delivery. The strategy also defines context-specific modalities and methodologies for the joint assessment, planning, implementation, and monitoring and evaluation. The strategy should be revised based on evolution of the emergency.
4. Has a comprehensive assessment of the health sector been carried out and has it been informed by a conflict analysis?	<ul style="list-style-type: none"> This is a collaborative multi-stakeholder assessment of health needs and risks, health sector capacities, and operational and political contexts that is informed by the conflict analysis. The result includes identification of priority areas of action. The assessment may be integrated, semi-integrated or non-integrated. It is revised and updated based on evolution of the emergency. It should be completed by an analysis of the context, causes, actors, and dynamics of the conflict.
5. Have the collective outcomes been identified and agreed upon?	<ul style="list-style-type: none"> Collective outcomes are concrete and measurable results that the humanitarian, development and other relevant actors want to achieve jointly over a multiyear period. They are context- and emergency-specific and are aligned with indicators for monitoring health-related SDGs, particularly health security and UHC.

Guiding questions	Description
6. What is the progress toward achieving the collective outcomes?	<ul style="list-style-type: none"> Percentage change for each collective outcome over defined time period.
7. Has a joint multiyear plan been developed?	<ul style="list-style-type: none"> This is a collaborative, multi-stakeholder plan which is either a single plan that covers humanitarian, development and peace needs, or a humanitarian response plan that covers multiple years and is closely aligned to the development plan. It is revised and updated based on evolution of the emergency and/or changes to the number and type of health sector actors.
8. Is there a mechanism in place to harmonize the resources and financing and monitor the flow of the humanitarian and development funds?	<ul style="list-style-type: none"> This mechanism governs the creation and management of multi-donor funding, as well as the allocation and harmonization of resources among actors and stakeholders.
9. What percentage of the total humanitarian and development funds has been allocated for nexus(-style) activities?	<ul style="list-style-type: none"> Percentage of the total funds has been allocated for nexus(-style) activities to be monitored over time.
10. Has a monitoring and evaluation framework with a clear set of indicators been developed?	<ul style="list-style-type: none"> Documented monitoring and evaluation of the nexus process as well as changes to collective outcomes based on the context and emergency-specific indicators defined in the joint multiyear plan.

In recognition of the need to shift from reactive to more sustainable, long-term responses to emergencies, the international community made a commitment under the “Grand Bargain” to strengthen the connections between humanitarian action, development and peacebuilding. Known as the New Way of Working, this approach creates a nexus across the humanitarian-development-peace divide, and by leveraging the comparative advantage of the different actors across the triad, it improves efficiency and sustainability, reduces service delivery gaps and duplication of efforts, addresses the drivers of emergencies, and facilitates the transition from humanitarian response to stabilization, recovery and development.



The aim of this guide is to introduce health sector actors to the New Way of Working, and provide action-oriented guidance on the implementation of the humanitarian-development-peace nexus (HDPNx) approach in the health sector, particularly in countries experiencing complex and protracted emergencies. The target audience for the guide is health sector actors and stakeholders, including ministries of health and health-related sectors, United Nations agencies, donors and international and local nongovernmental organizations.