The Health of Women, Newborns, Children and Adolescents in Conflict Settings: Improving Evidence and Guidance for Effective Action

A Regional Focus on West Africa - Nigeria & Mali

WORKSHOP SUMMARY REPORT

Workshop Overview

In conflict-affected contexts in West Africa and elsewhere in the Africa region, with high levels of insecurity, internally displaced persons, supply chain disruptions, and exacerbations of pre-existing shortages of human, material and financial resources, access and availability of health and social services is a challenge especially for women, newborns, children, and adolescents living in these regions.

The ongoing Covid-19 pandemic has further exposed these already existing challenges by further reducing access to essential services, driving up the risk of falling into poverty, reducing access to education and essential nutrition services, and driving up violence against women and mental health issues, among other issues. In order to urgently address the impact of conflict on women, newborns, children, and adolescent (WCH) health, the BRANCH (Bridging Research & Action in Conflict Settings for the Health of Women & Children) Consortium, PMNCH and the University of Ibadan organized a **virtual workshop in the West African region** in November 2021, **with a particular focus on Mali and Nigeria** (see Appendix A for the Workshop Agenda).

The intent of the workshop was to further **enhance research and evidence, along with coordinated advocacy and action for improved WCH in conflict settings, as well as disseminate findings of recent research from BRANCH and others working on WCH in conflict settings, discuss outstanding national and regional evidence needs, and build relationships among partners from various constituencies in the West African region to further an action-oriented research and evidence-based advocacy agenda to meet these needs and advance policy dialogue**. This workshop also aimed to reflect on the current regional situation of WCH in conflict settings, with a particular focus on understanding key challenges in implementation, existing evidence and gaps, the impact of Covid-19, and identifying synergies to move forward together.

This multi-stakeholder virtual workshop brought together more than 70 participants which included policymakers, academia, non-governmental organizations, donor organizations, private sector, civil society, and healthcare institutions, among other stakeholders from the West Africa region

(particularly Nigeria and Mali) with the aim to join forces for a common vision for WCH in conflict settings in the region (see Appendix B for List of Participating Organizations). Consideration was also given to gender, age and type of position held to ensure representation from all relevant and needed groups.

The workshop began with a plenary session on the context of WCH in the West African region, followed by moderated group discussions that were guided by policy briefs developed by BRANCH. During the moderated country-focused break-out sessions, participants discussed and provided further insights on pre-selected topic areas in more detail (see Appendix C for Break-Out Group Discussion Themes). Each break-out group consisted of a diverse range of stakeholders to ensure the dialogue was well-informed by different perspectives.

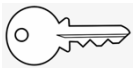
The three moderated groups were as follows:

- Group 1: Engaging and Empowering a Localized Innovative Health Workforce
- Group 2: Strategic, Adaptable, and Multi-sectoral Leadership, Governance, and Coordination
- Group 3: Comprehensive, Sustainable and Needs-based Health Financing

The objectives of this workshop were to:

- ***Reflect*** on what BRANCH evidence tells us about the progress and challenges in responding to WCH needs in conflict settings in the region and identify further evidence gaps and needs in the region, along with potential key research questions to be furthered explored.
- ***Identify*** (additional) factors contributing to, or hindering multi-stakeholder collaboration, accountability, evidence building and advocacy for effective WCH plans and programmes in conflict affected contexts in the region, especially in light of Covid-19 and including post-Covid rebuilding efforts.
- ***Discuss*** how to leverage the available BRANCH evidence and experience, build on this evidence and strengthen linkages across disparate stakeholder groups working on issues across the continuum of care for more responsive evidence-informed policy, financing and action for WCH in conflict affected contexts in the region.
- ***Develop*** a set of advocacy actions, building on BRANCH recommendations and relevant aspects of the PMNCH Covid-19 Call to Action, aimed at driving more responsive policies and strengthening response and programming for WCH in conflict settings, and to ensure that the key points from these regional workshops continue to advance.

See Appendix D and E to read more about the situational context for Nigeria and Mali.



Group Discussion Key Messages

During the plenary session each break-out group presented the key points raised in their respective teams. The plenary session also served to identify overlaps between the groups and regions, such as common monitoring and evaluating measures, accountability measures, and regional synergies for working together in conflict settings (see Appendix F for a list of key resources that were used to guide the discussions during the break-out groups and plenary for the workshop). Key messages that emerged from the plenary session are outlined below.

Data Collection and Management

Participants explained that the dearth of data in conflict zones in the West Africa region is a major gap. There was **insufficient data on the health of pregnant women and children, lack of real-time data on conflict zones in West Africa region, and lack of much needed contextualized evidence**. The

limited data that was available was stated to have **poor representation** (for example the SMART survey does not provide detailed data by health district) and **not disaggregated, making it difficult to inform tailored health programs for women and children** in conflict zones.

Furthermore, **evidence on adolescent health in the West Africa region was non-existent** and there were also huge gaps in data mapping of organizations working in the humanitarian context. Equipment data was also largely unavailable to plan supportive actions.

There were also identified challenges in the completeness of data when it was available and the existence of this **information in "silos" as available data was not being shared or open**. Humanitarian organizations who work in these conflict settings also identified challenges, such as the requirement of some contracts or funding/grants with agencies and funders to have certain data which was difficult to access.

Cost of surveys in the districts was one of the main causes of the sparce data available in the region. Furthermore, disaggregating the data makes the costs of surveys even higher. There was an urgent need to collect more data in conflicting regions of West Africa and Africa at the Ward and Local Government Areas (LGA) or districts through improved collaboration between local researchers in academic institutions based in the country, international agencies and local/national non-profits, and humanitarian organizations.

Mapping of humanitarian organizations and other agencies who are providing health services for women and children in conflict affected regions are needed as this will be a necessary step to create a **multi-stakeholder framework for coordinating humanitarian programs**.

To better respond to the needs of women, children, and adolescents in conflict-affected settings, it is important to have **real-time evidence and contextual data** that will help advocate to policymakers, government workers, funders and potential partners as this will aid policy making and decision making to improve health services. Strengthening the information system in the West Africa and AFRO region by **training health professionals and organizations on data collection, analysis, storage among others** would also be very useful.

Leadership, Governance and Coordination

There were identified challenges in this area as participants noted **the lack of political will and commitment to promote the health of women and children in conflict areas**. There were also several reports of the **interference of politics and military in the access to services**, **absence of a common national strategy** for humanitarian health delivery especially for women and children, and a **lack of financial support for service delivery** from the national government of many countries in West Africa. Limited coordination and synergy between humanitarian actors, reliance on non-governmental organizations (NGO) who usually operate “in silos”, and multiple insecurity challenges such as bandits, kidnappers and herdsmen have further complicated health service delivery.

The discussions revealed how the **government has abdicated their responsibilities and roles of provision of quality reproductive, nutrition and public healthcare services to non-profits and humanitarian organizations**. The discussion also highlighted the involvement of **politics and the military and paramilitary agencies which sometimes negatively influence the health service delivery to the target outcome**. For instance, one participant noted that during the Covid-19 pandemic total lockdown period it was noted that only top humanitarian organizations who had some level of political influence were given approval to operate in Nigeria, while others did not have this clearance from the government and had to pause or discontinue their programs in providing access to quality health services. This was noted to disrupt or reduce the funding of these humanitarian organizations in the conflict region.

The communication and coordination gap between humanitarian agencies, government agencies and academic organizations have led to the duplication of services and waste of resources as there is an overlapping of programs/services between organizations working on the ground in conflict and humanitarian settings. The lack of communication and coordination among key stakeholder actors was noted as a major setback on the implementation of a national action plan or strategy to ensure that the health of women and children in humanitarian settings are covered.

Participants also highlighted that humanitarian programs for **women and children should be implemented and targeted mostly at the local government or district level** as primary healthcare is the foundation of healthcare delivery as this is not the current case in Nigeria and Mali. For instance, a participant noted that working and collecting disaggregated data at the Primary Facility level in Mali makes programs more expensive, hence, causing a strain on the limited budget that is currently available. There were also discussions on how it is important to better **integrate maternal and child health programs at the primary, secondary and tertiary health facilities as this will enable the delivery of comprehensive health services to women, newborns, children and adolescents**.

Power imbalances between governments and international and local organizations was reported as a barrier at the level of governance and leadership. Therefore, participants suggested that there could be a **mapping exercise for humanitarian organizations which showcases the aims and objectives of each organization, with each entity given clear distinguished roles**. This will not only lead to clarity of purpose for each entity (especially NGOs), but it will also reinforce each organizations' responsibilities towards beneficiaries and other humanitarian agencies. Furthermore, it will help in creating a **multistakeholder platform** where governments, UN agencies, ministries, academic organizations and NGOs can coordinate and work together on WCH in conflict settings. The forum will help in producing guidance and equitable policies in service delivery for WCH in conflict areas in the areas of planning, implementing, monitoring and evaluating programs, and can also assist in financial governance.

Lack of accountability and transparency coupled with the alarming rates of corruption in the region was also a major challenge addressed. There were suggestions that **direct allocation of resources to humanitarian health service delivery** by the government is needed to increase accountability. Also, there is the need for **NGOs and civil societies to be funded directly** and to implement programs as they currently implement most programs in conflict affected regions. Furthermore, the development of **accountability mechanisms, and addressing corruption and power imbalances between government, international NGOs/CBOs** is needed.

There is also a need to have **legislations and policies that are sensitive to the needs of women and children, and that are also context-specific**. This can be achieved by **implementing a bottom-up integrative approach** that involves multiple stakeholders in developing and implementing programs for WCH that takes into consideration the possible barriers that might hinder the implementation of policies and programs.

Health Workforce

On this challenge, there were two health workforce related challenges: **inadequate health workforce to cater to WCH in conflict settings** in the West Africa region and the **lack of access to the already depleted or inadequate healthcare professionals** delivering services to women and children in humanitarian settings.

First, participants reported challenges such as a **lack of motivation due to poor welfare of healthcare workers, inter healthcare professional conflicts and sometimes unpaid salaries or owing of salaries to healthcare professionals**. Other factors that were reported to have led to the reduced health workforce included **inadequate training programs, poor renumeration/salaries, inadequate health facilities, poor working conditions and lack of a health workforce coordination plan to ensure equitable distribution of health professionals** to cover regions affected by humanitarian crises in the

area. All of these factors have led to many healthcare professionals fleeing from remote communities and those regions affected by humanitarian crisis to urban cities or even high-income countries where there is better renumeration and working conditions.

There were also **issues with security for health workers working in humanitarian and conflict settings** in the region, as healthcare professionals are inequitably distributed because of fear of theft, harassment, abuse and kidnapping in hard-to-reach areas and humanitarian areas. One participant highlighted how some UN agency workers were kidnapped some time ago by terrorists in Nigeria. There was also an earlier insecurity issue of a bombing of the UN headquarters in Nigeria in the early 2000s.

Second, there were also identified **challenges in accessing the target population** (women and children) by the already depleted healthcare professionals. This was due to some factors such as **socio-cultural barriers, geographical/distance barriers, and security barriers**.

Poor motivation, welfare and safety challenges has led to **low retention, migration and relocation of health workers** away from conflict affected countries and this has negatively affected the availability of a qualified health workforce to provide WCH services. There was an urgent need to ensure better welfare and motivation for humanitarian and health workers, as well as ensuring an equitable distribution of the health workforce through having a **health workforce strategy to cover underserved communities in countries affected by conflict**.

Healthcare Financing

Healthcare financing challenges highlighted include **inadequate funding from the government** in the West Africa region (including Nigeria and Mali) for women and children affected by humanitarian crisis, **restrictive funding from international donors, poor health insurance coverage and lack of accountability and transparency**.

Donor funding which comes mostly through grants were reported to be restrictive and based on the priorities of the funding agencies and **not necessarily based on the local needs of women and children who are affected by conflicts**. These 'envelop' fundings were noted to cover specific vertical health services and were not flexible enough to cover other health programs that were sometimes in even a greater need by children and women living in these humanitarian regions, such as nutrition programs for children and family planning needs for women in humanitarian settings.

Another main challenge highlighted was poor financing for programs for WCH in humanitarian settings by the government in the AFRO and West Africa region. It was reported that there was **no specific budget line for funding these programs by the government**. Furthermore, other identified challenges included **corruption, lack of accountability, and lack of transparency by government agencies**. For instance, in Nigeria it was noted that the financial power rested majorly on the Federal government which is controlled at the central level/political capital, with little financial power on the local government area (district level) that directly controls the primary healthcare centers where the majority of service delivery takes place. This **imbalance in financial power has led to an "top-down" implementation of humanitarian programs** and resulted in poor access to health services for women and children at the local government and community levels.

Inadequate funding of programs for WCH in conflict areas have encountered poor coordination and communication between humanirarian organizations, funding agencies, government and other partners which has led to **duplication of services and wastage of already scarce financial resources**. Furthermore, most funding for programs given to international NGOs are restrictive and based on the funder's priorities. Improving funding mechanisms by **internal mobilization of resources from the private sector and government** will help to solve this challenge.

Way Forward

Several action-oriented plans were proposed to overcome some of the challenges and improve quality health delivery for women and children affected by conflict. Significant and urgent action was required on the need to improve and promote multistakeholder collaboration of humanitarian organizations, the government and funders, retainment and recruitment of healthcare workforce, improved community-participatory programmes, and ensuring a bottom-up health program approach to ensure local ownership.

Additional crosscutting challenges and opportunities discussed include improving accountability and transparency, reducing political corruption, standardization of data collection and evidence-informed policies, improving the data management system, better alignment of services with needs and local context, involvement of district or local government area (LGA) health systems, sustainability of funding, citizen and community engagement, and integration and reinforcement of WCH in all policies.

Participants agreed on these next steps:

Bridge the research and policy gap to inspire action

- Research will have to be conducted with the consensus and participation of policymakers.
- Dissemination of research to policy makers is crucial to inspiring action.
- Strengthen think tanks in the academic institutions that have linkages with humanitarian organizations in the field to ensure that evidence that is generated and is contextualized.
- Wide dissemination of data and findings to other agencies, such as humanitarian coalitions, private sector coalitions and non-governmental organization coalition is needed.
- Map the local context needs/challenges and reform coordination needs based on priorities.

Ensure a multi-stakeholder approach to programmes

- Collaboration between the government, academic, humanitarian organizations and the United Nations system is key.
- Research should be conducted with the consensus and participation of policymakers and other key stakeholders.
- Dissemination of research to policy makers is crucial to inspiring action and implementation of programs.
- Identify clear roles and responsibilities for each entity/organization working on WCH.
- Enforce regulations and standards of care in health care facilities and for humanitarian organizations.

Mobilise flexible, sustainable, and accountable financing mechanisms

- Look inwards in the mobilization of resources, such as looking at private sectors (e.g., Dangote company) in Nigeria which have shown some interest in humanitarian funding in the country.
- Joint planning is crucial to ensure that there is efficiency in the usage of available resources.
- Accountability and transparency in the planning, implementation and usage of funds is essential to mobilize more funds.
- Ensure that the government takes up the mandate in financing healthcare for women and children affected by conflict through the implementation of policies and programs.
- Use the results of the research findings to advocate for funding to international agencies and financial bodies.
- Improve primary healthcare funding of programs.
- Invest in capacity building of human resources and humanitarian organizations.
- Coordinate and allocate funds toward health care system strengthening.

- Allocate a sufficient budget for WCH services at the government level to ensure the continuity of essential health services and to meet the needs of the population.

Inform decisions based on high-quality, up-to-date and contextualized data on WCH

- Standardize, collect, share and utilize data for evidence-informed decision making.
- Strengthen local data systems by training health care workers on collecting, analyzing, and producing high-quality data regarding WCH.
- Collect data on the cost and cost-effectiveness of health care services for WCH.
- Strengthen information systems in conflict areas and countries in the West Africa and AFRO region, especially by using the opportunity that has been presented by Covid-19.

Enable political commitment, effective leadership and governance systems

- Reform governance and leadership in the health sector based on the priorities of women and children affected by conflict.
- Ensure advocacy to the legislature and policymakers to create a bill to support the equitable distribution of the health workforce and providing funding for humanitarian health programs.
- Enforce minimum standards in primary, secondary and tertiary health facilities.
- Create a humanitarian national action plan or policy to strengthen the healthcare system.
- Prioritize the primary healthcare delivery system for coordinating health service programs for women and children to improve implementation of programs.
- Develop an oversight function for humanitarian programs.

Invest in and retain healthcare workforce

- Invest in the training of healthcare workers in data collection, analysis, storage and management, especially to those who serve those affected by conflicts.
- Develop a health workforce strategy that will ensure the equitable distribution of healthcare professionals to provide high quality health services to women and children in conflict settings.
- Ensure better renumeration, welfare and motivation for health professionals.
- Create “Task-Shifting” policies for ensure healthcare coverage at the primary care level and remote areas where a medical doctor may not be readily available.

For more information, please visit:

branchconsortium.com

Appendix A: Workshop Agenda

VIRTUAL WORKSHOP

The Health of Women, Newborns, Children and Adolescents in Conflict Settings in West Africa: Improving Evidence and Guidance for Effective Action

Tuesday, November 30, 2021
1-4:30pm WAT (12-3:30pm GMT)

AGENDA

SESSION	FOCAL QUESTIONS AND SESSION CONTENT	FACILITATORS & SPEAKERS
INTRO **10 mins** *12:00-12:10pm GMT* *1:00-1:10pm WAT*	**Welcome** Prof Samuel Jegede (Univ of Ibadan) **Opening Remarks** Dr Zulfiqar Bhutta (Aga Khan Univ, SickKids, BRANCH) Dr Etienne Langlois (PMNCH)	Chair: Prof Samuel Jegede (Univ of Ibadan)
SESSION #1 **50 mins** *12:10-1:00pm GMT* *1:10-2:00pm WAT*	**Focal questions for Session #1** - What are the key findings from the BRANCH Consortium's research on women's and children's health and nutrition (WCH) in conflict settings? - How do these findings relate to the W Afr (Nigeria & Mali) context specifically? **Content of Session #1** 1. Overview of findings from the BRANCH-Lancet Series on Women's and Children's Health in Conflict Settings 2. Reflections on relevance of the findings for Nigeria and Mali	Chair & Speaker: Dr Zulfiqar Bhutta (AKU, SickKids, BRANCH) Speakers: Ms Michelle Gaffey (SickKids/BRANCH) Dr Anushka Ataullahjan (SickKids/BRANCH) Prof Patricia Donli (Univ of Maiduguri & Gender Equality, Peace and Development Centre) Dr Salimata Samake (Action Contre la Faim)
BREAK #1 **5 mins**		

SESSION #2
75mins
 	
1:05-
2:20pm GMT
 	
2:05-
3:20pm WAT
	Focal questions for Session #2:
	- What are the key evidence and guidance gaps in Nigeria and Mali with respect to:
	  ○ service delivery for conflict-affected women and children?
	  ○ humanitarian health response coordination for women and children?
	
	- What are the options and potential next steps to fill these evidence and guidance gaps?
	
	Content of Session #2
	1. Breakout groups to address the focal questions
	2. Report from breakout groups and plenary discussion
		Chair:
		Prof S Jegede
		
		Breakout Group Moderators:
		Prof Adebola Orimadegun (Univ of Ibadan)
		
		Dr A O Lawanson
		(Univ of Ibadan)
		
		Dr Moctar Tounkara
		(Université des Sciences, Techniques et Technologies de Bamako)
		
		Plenary Moderator:
		Dr Z Bhutta

BREAK #2 **5 min**		
SESSION #3 **60min** *2:25-* *3:25pm GMT* *3:25-* *4:25pm WAT*	**Focal questions for Session #3:** - How can we better bridge research and policy action to sustain and accelerate national and regional commitments to women's and children's health in conflict-affected contexts? - How can we improve multi-stakeholder and multi-sectoral collaboration to deliver quality health services more effectively for conflict-affected women and children? - How can we ensure more consistent and more flexible funding and other resources to support quality health and other services for conflict-affected women and children Nigeria and Mali **Content of Session #3** Panel discussion with moderated Q&A	Chair: Prof Isaac Albert (Univ of Ibadan) Panellists: Ms Sylvie Fouet (UNICEF Mali) Prof Adenike Grange (Former Nigeria Fed MOH) Dr Khalilu Muhammad (UNICEF Nigeria) Mr Adeyemo Andronicus (Nigerian Red Cross) Ms Chloe Simard (Government of Canada) Ms Boniface Uslari Zebulun (Nigerian Security and Civil Defense Corps)
CLOSING **5 mins**	**Closing**	Chair: Prof S Jegede

Appendix B: List of Organizations

Below is a list of organizations and affiliations that attended the workshop:

Action Contre la Faim, Mali
Aga Khan University
BRANCH - Bridging Research and Action in Conflict Settings for the Health of Women and Children
Gender Equality, Peace and Development Centre (Maiduguri)
Government of Canada
Nigeria Red Cross
PMNCH - Partnership for Maternal, Newborn and Child Health
SickKids Centre for Global Child Health
UNFPA
UNICEF Mali
UNICEF Nigeria
University of Ibadan
University of Maiduguri
Université des Sciences,Techniques et Technologies de Bamako
WHO

Appendix C: Break-Out Group Discussion Themes

The following themes were assigned to focus the discussions during the Break-out Sessions:

Group 1: Healthcare workforce in Conflict-affected countries in the EMR

Part 1: Barriers and Gaps

1. What are the key challenges at the level of the healthcare workforce in the EMR that is deterring the implementation of effective WCH services in conflict-affected countries? *Probe:*
    - *At the level of management of HWF, recruitment/ retention, planning, training, and capacity building*
    - *Particularly for the female workforce, including concerns around safety and security.*
    - *How are youth being engaged and prepared as the potential next (healthcare) workforce?*
2. What are some additional policy gaps in regards to empowering and engaging the healthcare workforce in conflict-affected countries in the EMR?
3. What were the key challenges and lessons learned at the level of the healthcare workforce from the Covid-19 pandemic in conflict-affected countries in the EMR?

Past 2: Enablers, Facilitators, and Opportunities

4. What are the key enablers, facilitators, and opportunities at the level of management, recruitment and retention, planning, and capacity building that would support the healthcare workforce in implementing effective WCH services in conflict-affected countries in the EMR?

Group 2: Leadership, Governance, and Coordination in Conflict-affected Countries in the EMR

Part 1: Barriers and Gaps

1. What are the challenges at the level of leadership, governance, and coordination that hinder effective WCH health services in conflict-affected countries in the EMR?

Part 2: Enablers, Facilitators, and Opportunities

2. What are the enablers and opportunities for effective leadership, governance, and coordination to ensure available, accessible, and high-quality WCH services in conflict-affected countries in the EMR?
    a. *accountability, governance, reporting, monitoring, and evaluation*
    b. *How can more women be included in this dialogue and take on these roles?*
    c. *How can the perspectives of emerging youth leaders add to this dialogue?*
3. How did the Covid-19 pandemic affect the leadership, governance, and coordination of WCH services in conflict-affected countries in the EMR?
   (Probe: health sector reforms, the shift in power between governmental and international entities)

Group 3: Healthcare Financing in Conflict-affected Countries in the EMR

Part 1: Barriers and Gaps

1. What are the challenges at the level of financing that hinder effective WCH health services in conflict-affected countries in the EMR? *Probe:*
    - *What are the challenges when it comes to ensuring the sustainability of adaptive programs in conflict areas?*
    - *To what extent are the funding opportunities aligned with the actual WCH priority needs of the community in your countries?*
    - *Are there adequate monitoring and accountability mechanisms implemented at the funders and the consumer levels?*
2. How did the Covid-19 pandemic affect the sustainability and progress of the WCH services provided in your countries?
   (Probes: supply chain interruptions, financing essential services, budget allocations)

Part 2: Enablers, Facilitators, and Opportunities

3. What are the enablers and opportunities for effective financing of WCH services in conflict-affected countries in the EMR?
   Probe: What works around health financing and what doesn't? Models of financing?

Appendix D: Regional Context for Mali

West Africa and the AFRO Region (including Nigeria and Mali) have been witnessing conflicts which have imposed several challenges on women and children accessing high quality health care services. These challenges have been exacerbated by the current Covid-19 pandemic.

Since early 2012, Mali has been disrupted by a complex and evolving conflict that has led to high insecurity, unpredictable waves of civil unrest, and ongoing political instability. Those living in the country's northern regions have been particularly impacted. Mali's history, varied geography and complex ethnic fabric have combined to produce a rich culture but also large developmental inequalities between regions, perpetuating historical internal divisions.

Different from populations who become entrapped in conflict areas, the population of northern Mali has been mostly displaced with many fleeing their homes for cities both within the region and also to non-conflict regions. The majority of the displaced population fled to the southern regions, more specifically to the capital city of Bamako. Access to care is a key issue of concern for internally displaced persons (IDPs), in particular women and children, which increased to almost 200,000 people according to the most recent estimates from OCHA. It is also possible, and likely, that the conflict has affected health system functionality and service delivery even outside of the insecure areas. Estimates from the most recent humanitarian response plan state that, at present, 1.7 million individuals have compromised access to health care.

Delivering programs and services to Mali's 19.3 million habitants is challenging for the more than 150 organizations operating in multiple sectors. Coordination of such a large number of actors is complex, with little government involvement. The growing insecurity also led to health professionals fleeing the area making human and financial resources limited, and the evolving and unpredictable nature of the conflict makes planning difficult. Identifying strategies to overcome the barriers to delivering services to conflict-affected populations is essential in ensuring their health needs are met.

To read more about the situational context in Mali, please refer to the following country case study conducted by BRANCH:

- Ataullahjan, A., Gaffey, M.F., Tounkara, M. *et al. C'est vraiment compliqué*: a case study on the delivery of maternal and child health and nutrition interventions in the conflict-affected regions of Mali. *Confl Health* **14**, 36 (2020). https://doi.org/10.1186/s13031-020-0253-6

Appendix E: Regional Context for Nigeria

West Africa and the AFRO Region (including Nigeria and Mali) have been witnessing conflicts which have imposed several challenges on women and children accessing high quality health care services. These challenges have been exacerbated by the current Covid-19 pandemic.

With a current estimated population of over 200 million people, Nigeria is the most populous country in Africa. Despite having the largest economy on the continent, it lags in development and is ranked 157th on the Human Development Index. Nigeria also has the most unequal distribution of wealth, with the northeastern states being among the most deprived. There is marked inequality between the northern and southern regions of the country on all important development parameters including those pertaining to the health sector and this inequality has been growing in recent years. Due to the combination of its size and relatively poor health sector performance, Nigeria is the second largest contributor to both under-five and maternal mortality in the world, with over 800,000 deaths in children under the age of five each year (30% of which occur in newborns) and nearly 20% of all global maternal deaths.

Since 2009, the Boko Haram conflict has exacerbated pre-existing low coverage levels of health services and provoked a serious humanitarian crisis. There was also a late initial response to provide aid in Nigeria, with the extremely difficult security situation playing an important role, along with political, social and economic factors both internally and internationally. There has been no humanitarian assistance provided in some parts of the country. More than half of existing health facilities in the state were heavily damaged, looted, or closed and half of the population settlements were also inaccessible. Resources were grossly insufficient to provide a satisfactory level of services even to the approximately 1.5 million IDPs who could be reached.

Within the northeastern quadrant of Nigeria, the lack of effective regional governance, widespread physical disruption and food insecurity has resulted in an estimated 37, 500 deaths. The physical inaccessibility and near total absence of social services resulted in the internal displacement of more than 2.4 million Nigerians, mostly in Borno State. As many as 7.1 million people, at least 50% of whom are children, are estimated to be in need of humanitarian assistance. In Borno, a high proportion of health facilities remains inaccessible and 80% of the state is considered to be “high risk”, seriously compromising the ability of government authorities, UN agencies, and NGOs to deliver goods and services. Access to food, safe water, protective shelter, and health care is grossly inadequate for the population. Outbreaks of cholera, yellow fever, and meningitis have further complicated the response, including an ongoing endemic for polio.

A minimum package of health interventions was developed, which encompassed a wide spectrum of RMNCH interventions. As a result, the RMNCH status of the population appears to have made considerable progress, perhaps because much of the population has become more accessible due to displacement towards more secure population centers. Additionally, a well-coordinated humanitarian response, combined with innovative approaches to RMNCH service delivery, has yielded positive results even in the face of serious political, manpower and financial constraints. However, implementation of this strategy was greatly hampered by the harsh realities of the humanitarian context such as ongoing security issues, limited access to the affected population, massive internal displacement, and an inadequate health workforce, as well as less-than-optimal funding, which all contributed to undoing the beneficial impact of the response.

Surveillance and being able to collect useful, representative, and timely data on a regular and consistent basis pose a problem in all humanitarian settings. The impact of security issues on the ability to collect accurate data in a way that is representative of the entire target population is major. Ongoing insecurity led to constant population migration, partial or total destruction of health facilities and, therefore, of service delivery, and impedes the ability of mobile teams to reach people in need. The quantitative data available may not reflect a totally accurate account of the health status of the population.

To read more about the situational context in Nigeria, please refer to the following country case study conducted by BRANCH:

- Tyndall, J.A., Ndiaye, K., Weli, C. *et al.* The relationship between armed conflict and reproductive, maternal, newborn and child health and nutrition status and services in northeastern Nigeria: a mixed-methods case study. *Confl Health* **14**, 75 (2020). https://doi.org/10.1186/s13031-020-00318-5

Appendix F: Key Resources

BRANCH Consortium Website - Bridging Research & Action in Conflict Settings for the Health of Women & Children
www.branchconsortium.com

BRANCH Consortium Policy Briefs - Women's and Children's Health in Conflict Settings: Barriers and Facilitators to Delivering Effective Services

1. Engaging and Empowering a Localized Innovative Health Workforce
2. Strategic, Adaptable and Multisectoral Leadership, Governance and Coordination
3. Comprehensive, Sustainable and Needs-Based Health Financing

https://www.branchconsortium.com/resources

BRANCH Consortium Summary Briefs - Women's and Children's Health in Conflict Settings

1. The Current Landscape of the Epidemiology and Burden
2. The Current Evidence and Guidance Landscape for Identifying and Implementing Priority Interventions
3. Prioritizing and Packaging Health Interventions - Deciding What to Deliver, When and How
4. Barriers and Facilitators to Delivering Effective Services
5. Key Messages and Next Steps

https://www.branchconsortium.com/resources

Lancet Series - Lancet Series on women's and children's health in conflict settings - papers and linked comments
https://www.thelancet.com/series/conflict-health

- Commentary – Doing better for women and children in armed conflict settings
- Executive Summary
- Lancet Series Paper 3 – What Have We Learned from Ten Country Case Studies (Singh, et al.)

Conflict and Health Collection - Delivering health and nutrition interventions for women and children in conflict settings: country case studies from the BRANCH Consortium.
https://www.biomedcentral.com/collections/branchconsortium

- BRANCH Country Case Study – Afghanistan
- BRANCH Country Case Study – Pakistan

BMJ Collection - Reaching conflict-affected women and children with health and nutrition interventions.
https://www.bmj.com/branch

PMNCH Covid-19 Call to Action
https://pmnch.who.int/news-and-events/campaigns/pmnch-call-to-action-on-covid-19