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

A Regional Focus on the Eastern Mediterranean

WORKSHOP SUMMARY REPORT

Workshop Overview

In light of the urgent need to address the impact of conflict on women, newborns, children, and adolescents' health (WCH), the BRANCH (Bridging Research & Action in Conflict Settings for the Health of Women & Children) Consortium, the Partnership for Maternal, Newborn and Child Health (PMNCH) and the Knowledge to Policy (K2P) Center at the American University of Beirut (AUB) organized a **virtual regional workshop in the Eastern Mediterranean Region (EMR)** in October 2021 (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 EMR 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 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 50 stakeholders of different expertise from eight different EMR countries that include **Lebanon, Jordan, Syria, Yemen, Afghanistan, Somalia, Egypt, and Pakistan**. Participants were from governments, academic and research institutions, non-governmental organizations, UN agencies, donor organizations, and professional associations (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 took place over two consecutive days. Day 1 began with a plenary session on the context of WCH in the EMR region and followed by moderated group discussions 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

Day 2 began with an overview of findings from Day 1, followed by facilitated dialogues to discuss the way forward for WCH in the EMR region.

The objectives of this workshop were to:

- ***Reflect*** on what the BRANCH evidence tells us about progress and challenges in responding to WCH needs in conflict settings in the region and identify further evidence gaps and needs in 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 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 to read more about the situational context for the EMR.

Group Discussion Key Messages

During the plenary session each break-out group presented the key points raised in their groups. 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 E 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.

Leadership, Governance and Coordination

The challenges addressed by participants in conflicted-affected countries in the EMR reflect on the interference of politics and military in the access to services, absence of a common national strategy, misalignment of priorities and services between national health committees, limited coordination and synergy between humanitarian actors, reliance on non-governmental organizations (NGO), limited trust between citizens and the government and the absence of beneficiaries' voices.

Accountability and trust in conflict-affected countries was a main issue that was highlighted. One participant mentioned that in the context of conflict, issues in government trust arise and political instability also affects the flow of funds radically. **One of the key challenges posed by participants is the need to identify means to hold the government accountable in an environment of political power, leadership, governance challenges**.

The Covid-19 pandemic brought about key lessons learned especially in regards to accountability in the case of inter-sectoral collaboration. One participant mentioned that because current accountability systems are

vertical rather than horizontal, it is limited to the same sector, same ministry, same entity, and is not implemented across sectors.

Lack of coordination among key stakeholder organizations including governmental agencies, NGOs, and service delivery entities was a major concern in conflicted-affected countries. The **absence of a common national strategy and vision** has further aggravated the challenges and led to contradictions in the efforts and priorities between stakeholder organizations. One participant mentioned, that while primary care is the first entry point of healthcare services, lack of communication, coordination and a common vision for priorities has shifted the focus on secondary and tertiary healthcare. Additionally, conflicted affected countries observed **non-integrated vertical programming** for several years, such as programs specific to HIV or family planning, which were extremely challenging during the Covid-19 pandemic. Due to the Covid-19 pandemic, health system priorities shifted to providing services related to Covid-19 and disregarded the need to sustain WCH services.

In conflict affected countries, when government systems are collapsing, NGOs are taking over roles initially indicated to governments. Countries such as Syria (among others), were **highly reliant on family-based and charitable NGOs**. This was reported by participants as a **gap in the health system as it led to major inequalities in WCH service delivery**. Participants mentioned that donors lacked sufficient resources and facilities to provide care for all those in need and raised the concern for sustainability of services once the NGOs stop providing service. Participants also reported that coordination between health professionals from different sectors is a challenge. For instance, in Lebanon, during the challenging Covid-19 pandemic lockdowns and financial crises, lack of coordination and synergy that was already present pre-crises worsened during and post-crisis which led to a waste of resources.

In some context, participants mentioned that despite efforts at the governance level to ensure the availability of services, there is a **lack of awareness to the availability and accessibility of the services at the population level**. One participant mentioned that in Lebanon despite the Ministry of Public Health's extensive efforts in advancing the primary healthcare sector, some citizens still do not know of the availability of these services.

The heavy burden of Covid-19 brought about key learnings in regards to the inefficiencies in the current systems and showed policymakers that there is a need for change. For instance, one participant mentioned that during the Covid-19 crisis gender-based violence increased, and as a result legislations were issued to respond to these cases. Participants also highlighted the importance of **data sharing** as part of Covid-19 and beyond. Participants added that to ensure the implementation of **solid accountability systems there is a need to measure and share data within health systems to enable accountability and showcase impact of actions**. Participants added that to achieve accountable systems it is important to have high-quality standardized indicators that are benchmarked and comparable over time. The situation in conflict affected countries is dynamic therefore an early warning system is needed to pick up any emerging issues (or sudden change at the level of indicators) that could identify morbidities, mortalities and epidemics. Planning, monitoring and evaluation, availability of indicators and data collection in humanitarian settings are also opportunities to facilitate and inform good decision-making. One participant mentioned that in many instances in the region, legislations and policies are ill-informed by evidence and require reform to respond to actual needs.

Participants mentioned that conflict affected countries are working on reforming their health system, therefore integrating WCH into the health system reform was mentioned to be an opportunity in advancing WCH services. One participant added that to prevent duplication of efforts and wasting of resources, there is a need for **mapping of services that are currently being implemented**. This needs to be complemented by **collaborative efforts across sectors with clear assignment of roles**.

In conflict-affected settings, **power imbalances between governments and international and local organizations** are reported as a barrier at the level of governance and leadership. Therefore, participants stressed on the criticality of having clearly distinguished roles for each entity. This will ensure that each entity especially those in civil society are aware of their responsibilities towards beneficiaries and towards other organizations as well.

Stakeholders also highlighted the need to **raise awareness on the importance of diversity and women representation in leadership and governance**. Evidence and data can be used to showcase the benefits of diversity to encourage more gender-sensitive representations.

The Covid-19 pandemic response in conflict-affected settings showcased the gap in the leadership capacities when it comes to dealing with emergencies and chaos. Building leadership capacities in emergencies can be achieved by having an emergency preparedness plan and by conducting exercises and drills on a regular basis to train leaders on operating and responding in an emergency. This needs to be complemented by contingency funds that can be easily mobilized and used in emergencies to ensure the continuity of essential services.

Health Workforce

At the level of the health workforce, participants highlighted key challenges that include **high turnover and low retention, low motivation, conflict-related health issues, limited capacity building and training, lack of support services, poor education, regulation and curriculum, gender inequality, lack of health workforce strategy and strategic vision** that have led to an inequitable distribution of the healthcare workforce in conflict-affected countries in the EMR and in turn deterred accessibility to high quality WCH services.

It was mentioned that midwives in some countries in the EMR lack the proper skillset to provide healthcare services as a result of limited education and training opportunities. Additionally, the curriculum of some healthcare providers does not integrate the skillset needed to perform tasks, and the education system is poorly regulated. The Covid-19 pandemic posed additional challenges for in-person training, yet some countries adapted to provide online training.

The Covid-19 pandemic highlighted several challenges in conflicted-affected countries in the EMR. Participants mentioned that this was a result of a lack of preparedness in responding to the pandemic, which led to panic amongst the health workforce as well as the community. For instance, one stakeholder mentioned that many nurses and midwives resigned due to the risk of Covid-19 exposure and the fear of transmitting it to their families. In addition, lack of personal protective equipment and financial resources has put a heavy burden on the health workforce, causing work-related fatigue and mental health problems. These challenges posed during the Covid-19 pandemic affected the prioritization of many other significant healthcare services, such as sexual reproductive health services including HIV and family planning, causing low-quality service access. One participant added that the Covid-19 pandemic shifted the healthcare system towards centralization in terms of resource access, which led to improper service delivery for women, children and newborns.

Enablers and opportunities discussed are primarily based on **ensuring, securing, developing and implementing management and retention policies and investing in the health workforce through capacity building and training**. Additionally, participants highlighted the importance of conducting an **in-depth assessment of needs and develop context-specific and need-based plans, taking into consideration the importance of the female health workforce, telehealth services, and service needs**. Participants mentioned the need to foster **cross-collaboration** of professional associations, governments, ministries, and NGOs to put together a health workforce focused strategic plan. Also, developing health workforce indicators, **strengthening data collection methods and utilizing the outcomes of the indicators** were reported to be key for proactive health workforce systems. Innovative opportunities are also useful when it comes to the healthcare workforce, especially when healthcare providers are not available in conflict-affected settings. Participants mentioned the need to train informal healthcare providers on basic healthcare assessments and interventions to overcome key gaps in healthcare workforce needs. Others highlighted that despite the need to train informal healthcare providers, it is critical to ensure continuous supervision of task-shifted practices to the informal healthcare workforce.

Several top priority areas were identified when it comes to the health care workforce, these mainly focused on **investing in healthcare workforce planning, management, regulations, leadership and governance**. Investing in workforce planning and management starts by conducting health care labor market analyses and collecting high-quality data. The health care workforce can be trained on the proper collection of high-quality data and its analysis to evidence-informed policies and decisions. In addition, **training and capacity building of the health care workforce is very crucial** in **retaining health care professionals** and in **providing quality health**

services to women, newborns, children, and adolescents. For example, some organizations in Lebanon are provided with a family medicine diploma for primary health care workers to empower them and encourage them to continue their work despite the harsh circumstances the country is facing.

Healthcare Financing

Participants mentioned three main financing challenges that included the **economic crisis, donor fund allocation and sustainability, and weak system-level finance and corruption**.

Participants mentioned that **donor funds are currently restrictive and earmarked to services that may or may not respond to the needs of the populations**. This hinders the ability of these funds to support actual gaps in conflict-affected countries. Participants highlighted that this may be a result of donor fatigue and a decrease of donor funds, hence restricting the redirection of available donations to other needed services. For example, in Yemen, there was a decrease in funds on services related to WCH and instead these funds were redirected to Covid-19 services.

It was further discussed that the **public sector and public system financing is weak, corruption in the local context is lacking, and there is an absence of mapping of services and subsequent financial models**. **Financing is not responsive to the local needs, making accountability a major issue**, particularly when it comes to external financing. One participant mentioned that despite the fact that health facilities are provided with support from different donors to provide services, the facilities continue to charge the user in an attempt to ensure and secure funding.

Participants highlighted that that there is a **need to implement multi-year unmarked and diversified funds to allow a shift in spending as the emergency setting demands**. Participants added that there needs to be an **extensive understanding of actual needs and priorities before applying for funds that are also followed by channeling funds towards a common WCH plan with context-specific priorities**. In addition, it is necessary to **strengthen accountability systems** by building social and financial accountability systems and working with local partners to strengthen public financial management systems. Participants added that it is essential to **shift funds to primary health care and health prevention, invest more in the capacity building of human resources, and fund needs-based WCH services**.

Conflict-affected countries have been enduring **corruption at national and organizational levels**. This was reported as a key barrier to comprehensive and sustainable health financing, one stakeholder mentioned that there is a need to direct funds to the NGOs directly rather than to governments, and to advocate for the separation of politics from health financing.

Stakeholders added that **contingency funds should be part of a national financing plan, where all resources are pooled and allocated to specific preset activities and services**. This will ensure effectiveness in resources spent and prevent duplication of services. Also, **accessing high-quality data on the cost and cost-effectiveness of health care services** is essential to allocate sufficient budgets for WCH services based on population needs.

Way Forward

Deliberations about leadership, governance, and coordination, the health workforce, and financing were successful in creating consensus on the need to mobilize action and ensure accessibility and availability of responsive WCH services in conflict-affected countries. Most of the emphasis was placed on the need for collaboration between the different sectors, responsive allocation of resources, investments in the healthcare workforce, community and youth engagement, and establishment of solid data systems.

Participants discussed and agreed on the following recommendations.

Enable solid and effective leadership and governance systems

- Map the local context needs and reform governance and coordination needs based on priorities.
- Implement health system reforms that integrated WCH needs and services in all policies.
- Develop a national plan to strengthen the health care systems.
- Identify clear roles and responsibilities for each entity/organization on WCH.
- Enforce regulations and standards of care in health care facilities.

Initiate strategic policies on WCH

- Assess country-level policy implementation mechanisms that include barriers and counteractions to activate effective law and policy implementation.
- Introduce policies and regulations that protect the rights of vulnerable groups of society, such as children with disabilities.
- Develop context specific laws based on high-quality evidence.
- Develop national standards and policies for organizations to ensure standardized quality of services.
- Implement a bottom-up approach in policy development to ensure better implementation of policies.

Activate national strategies based on high priorities

- Assess local context needs before applying for funds that would ensure alignment of funds with actual needs and priorities.
- Develop a national emergency preparedness plan with an explicit focus on WCH with delineated funds that can be mobilized during crises and clear roles for the healthcare workforce.
- Perform a health labor market analysis to map the skill mix of the health care workforce.
- Plan health workforce reforms based on labor market analyses and needs.
- Foster cross-collaboration of professional associations, governments, ministries and NGOs to put together a healthcare workforce strategic plan.

Sustain flexible, responsive and accountable financing mechanisms and schemes

- Channel funds from NGOs towards a common WCH plan that encompasses context-specific priorities.
- Implement multiyear, unmarked and diversified funds to allow for a shift in spending as the emergency setting demands.
- Strengthen accountability systems by building social and financial accountability systems and working with local partners to strengthen public financial management systems.
- Secure funds for primary health care and health prevention measures.
- Invest in capacity building of human resources.
- 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.
- Explore sustainable health care financing schemes to ensure access to care by vulnerable populations.
- Implement a series of cost-effectiveness studies around WCH.
- Ensure clear segregation between financing WCH and politics.
- Invest in mobile clinics to deliver WCH services to remote areas.

Invest, manage, integrate and retain healthcare workforce

- Deploy and plan for workforce needs according to the context (i.e., need for female healthcare workforce, telehealth) and service needs.
- Empower the workforce through gender-sensitive representation at the authority level.
- Implement targeted retention and recruitment practices at the level of primary healthcare centers to ensure there is a sufficient and capable workforce to respond to WCH needs.
- Initiate bridging programs to empower the healthcare providers, especially nurses, to be able to practice to their full scope.
- Develop a clear scope of practice for all healthcare providers.
- Advocate and practice task shifting to overcome human resource shortages.
- Integrate the cultural aspect into the deployment of the workforce and delivery of services.

Build capacity of formal and informal health professionals and organizations

- Invest in healthcare workforce capacity building and training.
- Provide health care workers with capacity-building programs, such as family medicine practice diplomas for primary health care professionals.
- Monitor and evaluate the quality of training and capacity building delivered to the health workforce.
- Integrate human rights, ethics, and respectful care in the academic packages provided.
- Invest in leadership response to emergencies through regular simulations and drills.
- Capitalize on community-based interventions (use volunteers) and community health workers, especially when formal healthcare providers are not available.

Inform decisions based on high-quality and up-to-date 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.
- Align monitoring and evaluation frameworks with program/national level indicators to support regular monitoring of services, plans and programs.
- Develop healthcare workforce specific indicators.
- Collect data on the cost and cost-effectiveness of health care services.

Collaborate, cooperate and build alliances among institutions

- Strengthen communication, coordination and collaboration of governments with NGOs and communities.
- Map women, children, and adolescent services and projects provided across institutions to prevent overlap of services.
- Implement a participatory approach across sectors in the development and implementation of services, plans and programs.
- Build alliances among and across different organizations.
- Create channels for data sharing across different stakeholders.
- Assign stakeholder specific roles in relation to WCH service delivery to ensure accountability.

Deliver integrated WCH services

- Implement integrated horizontal WCH programs (e.g. education and nutrition) to cover the population's needs.
- Integrate WCH services (such as sexual and reproductive health and rights) into primary health care.

Empower, involve and co-produce policies and services with the community and youth

- Engage the community in policy development and implementation processes through citizen consultations and policy dialogues to ensure effective implementation of policies.
- Raise community awareness on the importance of diversity and female representation in leadership using evidence that shows the positive impact of diversity.
- Empower youth through education and training to enable them to reach out to communities and deliver health services.

To better respond to the needs of WCH in conflict-affected settings, it is imperative to have legislations and policies that are sensitive to their needs and that are context-specific. This can be achieved by implementing a bottom-up integrative approach in developing and implementing that takes into consideration the possible barriers that might hinder the implementation of the policies and legislations.

For more information, please visit:

branchconsortium.com

Appendix A: Workshop Agenda

Day 1 (2pm-5pm Beirut time, 1pm-4pm CET)

Time	Topic	Speaker
2:00-2:05	**Official welcome and open remarks**	Dr. Fadi El-Jardali, *Professor of Health Policy and Systems – American University of Beirut & Founder & Director – Knowledge to Policy (K2P) Center - 5 mins*
2:05-2:15	**Overview of BRANCH & Regional Context, evidence and findings from BRANCH**	Dr. Zulfiqar Bhutta, *Founding Director Institute for Global Health and Development, AKU and Co-director , Centre for Global Child Health, Sick Kids Hospital, and BRANCH Consortium – 10 mins*
2:15-2:20	**Utilization of contextualized evidence for policy action in the EMR region**	Dr. Etienne Langlois, *Team Lead, Evidence and Knowledge –Partnership for Maternal, Newborn & Child Health (PMNCH) – 5 mins*
2:20-3:05	**Regional Expert Panel:** Responding to Women's, Newborns', Children's, and Adolescents' Health needs in Conflict Settings in the EMR - lessons learned and course ahead	Dr. Hyam Bashour*, Health Systems Strengthening Officer, WHO, Syria* Dr. Hala Ghattas, *Associate Research Professor and Interim Director of the Center for Research on Population and Health at the American University of Beirut (Syria Case Study)* Dr. Hannah Tappis*, Senior Measurement, Evaluation and Learning Advisor at Jhpiego an affiliate of Johns Hopkins University, and associate faculty in the Department of International Health (Yemen Case Study)* Dr. Mushtaq Khan , *Health Advisor Asia & Reproductive Health Advisor MENA – International Rescue Committee (IRC)*
3:05-3:15	**Virtual Break**	
3:15-3:20	**Overview of moderated breakout groups**	Ms. Clara Abou Samra, *Instructor of Public Health and Evidence Lead Specialist- Knowledge to Policy (K2P) Center- American University of Beirut*
3:20-4:35	**Moderated breakout groups**: • Pre-presentation on the Policy Briefs • Focused discussions on the opportunities and challenges and based on three themes: 1. Engaging and Empowering a Localized Innovative Health Workforce 2. Strategic, Adaptable, and Multi-sectoral Leadership, Governance and Coordination 3. Comprehensive, Sustainable and Needs-based Health Financing	Participants Moderated by: Dr. Kyaw Aung, *Chief of Health and Nutrition-UNICEF Lebanon* Ms. Ruby Syal, *Research Coordinator, Sick Kids/BRANCH* Dr. Teesta Dey, *Technical Consultant, Knowledge Team PMNCH*
4:35-4:50	**Reporting back on breakout group**	Moderated breakout groups Rapporteurs
4:50-5:00	**Next steps** for Day 2	Dr. Fadi El-Jardali

Day 2 (2pm-4pm Beirut time, 1pm-3pm CET)

Time	Topic	Speaker
2:00-2:15	Welcome and overview of findings	Dr. Fadi El-Jardali
2:15-3:50	**Facilitated Dialogue (cross-cutting theme discussion)**: • Discussion on findings from opportunities and challenges • Way forward: Policy priorities and context-specific recommendations	Dr. Fadi El-Jardali Ms. Clara Abou Samra
3:50-4:00	**Next steps and closing remarks**	Dr. Etienne Langlois, *Team Lead, Evidence and Knowledge –Partnership for Maternal, Newborn & Child Health (PMNCH)* Dr. Paul Spiegel, *Director of the Johns Hopkins Center for Humanitarian health and Professor of practice in the department of International Health at the John Hopkins Bloomberg School of Public health and member of the BRANCH Consortium* Dr. Fadi El-Jardali, *Professor of Health Policy and Systems – American University of Beirut & Founder & Director – Knowledge to Policy (K2P) Center*

Appendix B: List of Participating Organizations

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

American University of Beirut
Aga Khan University
BRANCH – Bridging Research & Action in Conflict Settings for the Health of Women & Children
Building Foundation for Development
Center for Health and Population Studies
Centre for Strategic Health Studies
Institute of Global Health and Development
International Federation of Medical Students Associations
International Federation of Red Cross and Red Crescent Societies
IRC - International Rescue Committee
IRC, Lebanon
IRC, Regional Office
Johns Hopkins Center for Humanitarian Health
Johns Hopkins University
Jordan Youth Innovation Forum
K2P Center – Knowledge to Policy Center
Lebanese Parliament
Order of Nurses, Lebanon
Ministry of Public Health
PMNCH - Partnership for Maternal, Newborn and Child Health
SickKids Centre for Global Child Health
Syrian American Medical Society
SIDA - Swedish International Development Cooperation Agency
UNFPA
UNICEF
University of Aden
UNWFP
WHO
WHO, EMRO (Division of Child and Adolescent Health)

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 the Eastern Mediterranean

In conflict-affected contexts, with high levels of insecurity, population movement, disruptions in supply chains, and exacerbations of pre-existing shortages of human and financial resources, access and availability of health and social services become a challenge especially for women, children, and adolescents. Those challenges have become more pronounced during the Covid-19 pandemic by further reducing access to essential services, driving up their 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.

The conflict inflicted in the EMR and the Covid-19 pandemic, have imposed several challenges in regards to the accessibility to high quality WCH services. Challenges discussed pertained to the leadership and governance, health workforce and financing levels. Despite the uniqueness in the components of leadership and governance, health workforce and financing, participants highlighted on the continuity of those themes in providing WCH services. Cross-cutting challenges and opportunities include infrastructure and resource availability, accountability and political corruption, standardization of data collection and evidence-informed policies, communication and collaboration of stakeholders, alignment of services with needs and local context, gender equality, sustainability of services and funding, citizen and community engagement, and integration and reinforcement of WCH in all policies.

The political unrest and interferences in health services, have politicized and militarized health and health service delivery, which has led to a division of access to health services. One participant mentioned that due to the armed conflict, there was an overlap of programs and services between partners working on the ground in the humanitarian setting due to communication gaps and lack of coordination. In turn, this has led to duplication of services and waste of resources.

Key system and policy gaps and concerns related to healthcare workforce have posed severe challenges when it comes to providing WCH. The lack of security at the forefront was one of the most highlighted challenge in conflict affected countries. For instance, in Syria, doctors and midwives are constantly afraid of being kidnapped, harassed and abused. As a result, C-section rates have increased in countries such as Syria due to security concerns. In addition, countries in conflict-affected areas lack a clear vision, strategies, evidence-informed decision making and planning of health workforce. Consequently, countries are reactive to the crisis rather than proactive, healthcare workforce are misplaced, inequitably distributed and inefficiently providing healthcare services.

Economic, social, geographical and system challenges have resulted in a high turnover of the healthcare workforce especially nurses. For instance, Jordan faces a challenge in retaining healthcare workforce at the primary healthcare level. In fact, several of the conflict affected countries did not have clear and effective recruitment and retention policies. Additionally, the lack of skillset and sufficient education and training of healthcare workforce and limited investment in the skillset of healthcare providers was regarded as detrimental to the health outcomes on WCH.

When it comes to workforce empowerment, gender inequality and autonomy are key issue in conflicted affected countries in the EMR. This has made it harder for some healthcare professionals especially females to qualify for many health workforce jobs and/or to practice their delineated roles. In fact, in Somalia, although 75% of the Somalian health workforce are women, many of whom are nurses and midwives, less than 10% occupy leadership positions at the local and national levels. Due to the medicalization of care, midwives also often lack autonomy and serve in a subordinate role that is underpaid within the healthcare setting, which has resulted in feelings of being undervalued.

The affected economy in countries resulting from conflict resulted in the inability to provide adequate financing for WCH. The economic crisis also led to instability to afford services, loss of insurance, and lack of access to affordable services. This was evident in Yemen during the protracted conflict nature that stayed for 6 to 7 years where funding showed a 20% decrease. In Lebanon, there has been a protracted crisis for the past 10 years with the Syrian crisis in addition to the devaluation of the local currency, civil unrest, and political instability. This has affected the health seeking behavior of the population. The population that was seeking health services in the private sector, can no longer afford these services, especially with the increase in the unemployment rate, loss of employment-based insurances, the high rate of consultation fees as a result of the

currency devaluation. Despite, the availability of affordable and accessible Primary Health Care Services from the public sector where free immunization services are available, the population still does not access those services due to the lack of trust in the public sector.

To read more about the situational context in selected countries in the EMR, please refer to the following country case studies conducted by BRANCH:

- Akik, C., Semaan, A., Shaker-Berbari, L. *et al.* Responding to health needs of women, children and adolescents within Syria during conflict: intervention coverage, challenges and adaptations. *Confl Health* **14**, 37 (2020). https://doi.org/10.1186/s13031-020-00263-3
- Tappis, H., Elaraby, S., Elnakib, S. *et al.* Reproductive, maternal, newborn and child health service delivery during conflict in Yemen: a case study. *Confl Health* **14**, 30 (2020). https://doi.org/10.1186/s13031-020-00269-x
- Ahmed, Z., Ataullahjan, A., Gaffey, M.F. *et al.* Understanding the factors affecting the humanitarian health and nutrition response for women and children in Somalia since 2000: a case study. *Confl Health* **14**, 35 (2020). https://doi.org/10.1186/s13031-019-0241-x
- Sami, S., Mayai, A., Sheehy, G. *et al.* Maternal and child health service delivery in conflict-affected settings: a case study example from Upper Nile and Unity states, South Sudan. *Confl Health* **14**, 34 (2020). https://doi.org/10.1186/s13031-020-00272-2
- Das, J.K., Padhani, Z.A., Jabeen, S. *et al.* Impact of conflict on maternal and child health service delivery – how and how not: a country case study of conflict affected areas of Pakistan. *Confl Health* **14**, 32 (2020). https://doi.org/10.1186/s13031-020-00271-3
- Mirzazada, S., Padhani, Z.A., Jabeen, S. *et al.* Impact of conflict on maternal and child health service delivery: a country case study of Afghanistan. *Confl Health* **14**, 38 (2020). https://doi.org/10.1186/s13031-020-00285-x

Appendix E: 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