

Women's and Children's Health in Conflict Settings: Barriers and Facilitators to Delivering Effective Services



Engaging and Empowering a Localized Innovative Health Workforce

OVERVIEW

As part of a series that discusses key findings and recommendations from the BRANCH Consortium's research on sexual, reproductive, maternal, newborn, child and adolescent health and nutrition (hereafter "WCH") in conflict settings*, the focus of this brief is on addressing the **barriers and facilitators to delivering effective health services to women, newborns, children, and adolescents in conflict, specifically in relation to the health workforce.**

We acknowledge that the research presented in this brief took place prior to the COVID-19 pandemic, as well as heightened security and conflict tensions that have erupted in some regions since. We also understand that the barriers presented in this brief have most likely been heightened or multiplied due to these factors.

To highlight the impact of the pandemic and ongoing/escalating regional conflict and seeing that evidence around WCH in conflict settings during COVID-19 is sparse at the moment and a gap that needs to be filled, a set of short summaries highlighting key regional messages will also be developed from a series of regional workshops which incorporate aspects of this perspective. The workshops will be held with key stakeholders in health research, practice, and policy, convened by the BRANCH Consortium, PMNCH and our local and regional partner organizations over the

Summer/Fall of 2021 to further discuss the current needs around identifying and deploying an appropriate health workforce, among other key issues.

To access these additional resources, please check-in periodically on the BRANCH website¹, and reference the PMNCH's Call to Action for COVID-19.²

This brief is intended for local NGOs, international organizations, Civil Society Organizations, governments, UN agencies, funders and donors, health care and front-line workers, communities, researchers, academics, and other key humanitarian actors who can all play a part in understanding and bettering WCH in conflict settings.

* BRANCH Consortium's research, to-date, consists of:

1. A set of ten-country case studies that examine implementation and delivery strategy effectiveness,
2. A set of eight systematic reviews that critically examine existing guidance for key interventions such as infectious diseases, NCDs, trauma, WASH, SRH, mental health, IYCF, and nutrition,
3. A 4-part Lancet series on women's and children's health in conflict settings, along with two commentaries.

BRANCH KEY RESEARCH FINDINGS

The health workforce is an important part of ensuring key health services are delivered to populations in need within a conflict setting. However, this is also an area where many challenges are faced, more so where it concerns delivering services to women, newborns, children, and adolescents in conflict settings.³⁻¹¹

According to BRANCH's recent research across 10 countries - Afghanistan, Colombia, Democratic Republic of the Congo (DRC), Mali, Nigeria, Pakistan, Somalia, South Sudan, Syria, and Yemen - the health workforce is the one topic flagged as a major barrier to delivering (health) services to women, newborns, children, and adolescents in conflict settings across all contexts.¹²⁻²²

Shortages *of health care workers* are amplified in conflict settings given access and **security concerns, including limited availability** of qualified and specialized health workers, more so a **lack of female health workers**.

AFGHANISTAN

The Limited Female Health Workforce

Female midwives and nurses are lacking in conflict-affected areas of countries like Afghanistan, Pakistan, and Syria often further hindering women's access to health services.^{13-15, 23, 24} In the case of Afghanistan, societal norms dictate that only women can provide healthcare services to other women, however restrictions on women by Taliban have resulted in a shortage of qualified female doctors, midwives and nurses and a compromised health care system for women.¹³

Across most geographies it was noted that an **unavailability of specialists** such as gynaecologists, surgeons, paediatricians, obstetricians, and physiotherapists, lead to a lack of necessary resources and services for many of the health needs of women, newborns, children and adolescents in conflict settings (e.g., Colombia, DRC, Pakistan, Afghanistan, Yemen, Syria, Somalia).¹³⁻¹⁹ Noting that the other countries where this was not identified was mainly due to an overall lack of basic medical personnel (e.g., South Sudan).²⁰ A lack of trained healthcare workers, including **insufficient trainings opportunities** for the health workforce was also reported. Additionally, **lack of incentives** to retain members of the health workforce was noted.

YEMEN

Unequal Incentives and High Turnover

High health facility staff turnover was a challenge across Yemen, particularly in urban centers.^{25,26} The primary reasons for turnover were economic, including healthcare workers seeking employment outside of Yemen, choosing to work solely at private clinics rather than maintain dual practice, higher salaries for programmatic positions at humanitarian agencies, or shifting to positions with higher or more consistent incentive payments.¹⁸

Unequal rates of incentives provided by humanitarian organizations fostered tension among volunteers and negatively impacted their motivation to work. In de-facto government-controlled areas, palpable tensions arose between long-term staff on facility payrolls and short-term contractors. Government officials also expressed their discontent with the role of international organizations in providing incentives.¹⁸

It was also found that **registry systems were lacking** to keep track of (the number of) health professionals and their location across the country (e.g., Somalia).¹⁹ **Weak coordination** between various institutions, in particular the Ministries of Health and Education, was also reported in relation to building the capacity of the health workforce (e.g., Somalia, Syria).^{12,15,19}

MALI

The Impact of Insecurity

Insecurity was a major issue reported across all country case studies.¹²⁻²² In northern Mali, the ability to deliver services was impacted by the unpredictable and rapidly changing nature of the conflict. The security situation in certain areas could change quickly and often respondents reported feeling vulnerable to attacks. People working in development and humanitarian organizations were frequently targeted in kidnappings, and this impacted costs as well as recruitment and retention of health workers, leading to service disruption and forcing organizations to continuously recruit and train new staff.^{21,27}

POLICY IMPLICATIONS

Based on the BRANCH Consortium's key research findings and recommendations, several policy asks have been suggested for various humanitarian actors to strengthen the delivery of services for and research on women's, newborns', children's, and adolescents' health in conflict settings, particularly in relation to the health workforce.^{12-22,28,29}

1. Local hiring based on priority and needs

Hiring local (health care) workers, particularly based on the priority and needs of the context at hand,³⁰ is important to ensure a continuous workforce, lower security threats, and greater retention during both immediate and longer-term response of needs for WCH in conflict settings. Stronger community trust, and accessibility to women, newborns, children, and adolescents in remote and hard-to-reach communities are also more attainable.

Local hiring was a strategy that was employed by humanitarian agencies to address concerns surrounding health workforce, security, and financing in conflict settings. The local workforce contributed to mitigating security threats and held importance in communicating and establishing trust with the community, particularly women, newborns, children and adolescents in conflict settings.

In Syria, remote management from certain hubs was used to improve accessibility to certain geographic areas when no physical access was possible.¹⁵ Local partners were often regarded as important in providing intelligence about security threats (e.g. Mali, Colombia),^{16,21} with many international respondents highlighting that they relied more heavily on local and national staff and partners to deliver (health) services to women, newborns, children and adolescents in conflict settings for this reason (e.g. DRC, Somalia, Syria, Yemen).^{11,13,15,17,19}

Findings from Colombia, DRC and Somalia demonstrate the importance of **intrinsic motivation** and a **'sense of duty'** for health worker retention in conflict settings.^{16,17,19} National health workers, particularly those who worked with children, felt a need to protect the future of the country. Local health workers were also more likely to **continue to work** even when there were funding gaps and salary delays given their **connection to the communities** which was a way people managed to work around the funding gaps, albeit not a long-term solution or strategy.¹²

BRANCH research also shows the importance of ensuring local actors in conflict settings, including health

workers, are well supported and do not bear disproportionate risks within the response that could hinder their ability to perform. Examples of this include, providing **technical trainings to deliver interventions** effectively, and/or **avoiding any gaps in salaries**, along with **standardized incentive rates** which is also important.^{2,12}

National strategies are also needed to support such plans, ensuring there are sufficiently, high-quality trained and supported health care workers based on local needs and priorities.²

2. Innovation to Optimize Service Delivery

Investing in the development of innovative and adapted modes of WCH service delivery allows for an ease on the burden of work for the health workforce, allows for accessible and cost-effective services to reach dispersed and remote populations, and strengthens the referral system in conflict settings.

The mode of service delivery, and use of innovative service delivery, could also ease the burden of work on the health workforce, particularly in conflict settings. Examples of this include **remote management** (of teams and facilities), use of **mobile clinics** to deliver service to remote and hard-to-reach areas and vulnerable groups such as women, newborns, children and adolescents (e.g., South Sudan),^{20,31} **treatment posts, home visits**, promotion of **community-based services** to bring services closer to populations (e.g., Pakistan and Afghanistan),^{13,14} and integration of **technology** such as WhatsApp or electronic clinical protocols in service delivery in conflict settings.¹²

Implementing **integrated packages of WCH services** (e.g., combining sexual and reproductive health and family planning services, and gender-based violence centres providing delivery care) at the point of delivery is another strategy to **increase the number of services** that can be provided in one visit, **minimize the number of visits** that are needed to a health facility, and **reduce the burden of work placed on health care workers** (e.g., Afghanistan and Nigeria),^{13,22} also leading to more cost-effective and efficient services for women, newborns, children, and adolescents in conflict settings.¹²

Quality care, including respectful and dignified care, and effective community engagement are also key.²

Task-shifting or task sharing is another innovative solution brought forth in conflict settings, whereby tasks are moved, where appropriate, to less specialized health workers. In the case of Pakistan, for example, the Lady Health Workers (LHW) Program has been developed to meet the needs of communities across the country.¹⁴ As a resident of the community, the LHW plays an

important role in providing preventative, promotional and basic curative health services to the catchment area, as well as linking and referring to additional health services. This field-level approach focuses on expanding the health workforce to reach dispersed and remote populations through community-based health workers (CHWs), volunteers and allied health professionals. These roles have a remarkable impact on WCH in conflict settings and enable more women to join the health workforce.^{12,32-34}

Data collection is seen as important not only by BRANCH, but other key stakeholders in the humanitarian field.^{10,35-39} While their primary role is in service delivery, community volunteers or health workers could also play an important role in data collection for monitoring and evaluation at the household level in conflict settings, using newer technologies and devices.²⁹ The use of community volunteers or health workers in data collection can be regarded as a promising approach to overcome some of the challenges to collecting high quality data in conflict settings, also enabling researchers to better understand the humanitarian and service delivery landscape. Additionally, accessible, feasible and cost-effective service delivery is an important component of the implementation research that is needed in conflict settings.

3. Engaging and Empowering Communities

Enabling and equipping local actors to engage in decision-making around funding and programming would ensure that necessary services are being delivered to women, newborns, children and adolescents in conflict settings.

Shifting the balance of power, for instance around **funding and decision-making, to local actors** and away from the larger, sometimes more impeded, international agencies is another strategy that was useful when delivering (health) services to women, newborns, children and adolescents in conflict settings, particularly with aligning funds based on the actual needs of the communities and health workforce.¹² In

Mali, organizations use the term “*faire faire*” when referring to the practice of subcontracting local organizations or community members to deliver services, in particular when there are security concerns, but also as a mean to gain local contextual insights. The term also describes the ways by which organizations fund local health centres or conduct capacity building activities with local health staff.²¹

Often the local (health) workforce is **more aware of the on-the-ground issues** facing WCH, making the **provision of services more relevant** to the changing needs. Utilization of the local workforce is therefore encouraged. External actors can then focus on the monitoring and evaluation of programs and services.

To ensure better collaboration and coordination, it is also important that decisions are aligned with identified local and regional priorities at all levels (e.g., communities, healthcare institutions, donors, governments, local and international organizations, academics, researchers, etc.).

CONCLUSIONS

There are numerous barriers associated with delivering health services to women, newborns, children, and adolescents in conflict settings, particularly in relation to the health workforce. Several solutions or facilitators to ease these barriers have been given for local NGOs, governments, international organizations, donors, and other key humanitarian actors. Collective awareness and action are key.

As a next step, **more research on the topic of the health workforce in conflict settings as it pertains to WCH** is needed.²⁹ With access to more data, a greater understanding of the various issues across regions, conflict-settings and among actors can be drawn and more solutions provided. This can also lead to highlighting the exact needs and asks around implementing policies, programs and country level strategies to support the availability and accessibility of a high-quality and readily available health workforce, among others.

For more information, please visit:
branchconsortium.com

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Resources

Below is a comprehensive list of the briefs in this series that address the impact of conflict on sexual, reproductive, maternal, newborn, child and adolescent health and nutrition and propose potential recommendations:

Policy Brief 1

**Women's and Children's Health in Conflict Settings: Barriers and Facilitators to Delivering Effective Services
Engaging and Empowering a Localized Innovative Health Workforce**

Policy Brief 2

**Women's and Children's Health in Conflict Settings: Barriers and Facilitators to Delivering Effective Services
Strategic, Adaptable and Multisectoral Leadership, Governance and Coordination**

Policy Brief 3

**Women's and Children's Health in Conflict Settings: Barriers and Facilitators to Delivering Effective Services
Comprehensive, Sustainable and Needs-Based Health Financing**

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