Summary Brief 4

BRANCH
Bridging Research & Action in Conflict Settings
for the Health of Women & Children

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

As part of a series that discusses findings from the BRANCH Consortium's research on sexual, reproductive, maternal, newborn, child and adolescent health and nutrition (hereafter "WCH") in conflict settings, this brief provides an overview of the barriers and facilitators to delivering an array of effective WCH services in conflict settings, sharing possible solutions that emerged across geographies and contexts.

This brief is intended for local and international NGOs, governments, UN agencies, funders and donors, health care workers, communities, and other key humanitarian actors who can all play a part in understanding and improving WCH in conflict settings.

Overview

There are huge challenges in providing health services in conflict settings, mainly due to the changing nature of conflict, the extent and number of emergencies, as well as constant security issues and breaches.[1]

Humanitarian actors, both local and international, as well as national authorities must navigate and negotiate multiple obstacles that challenge the delivery of essential WCH services interventions in conflict settings. Nonetheless, humanitarian organizations can also find creative solutions to respond to the health needs of women, newborns, children and adolescents in conflict-affected settings.

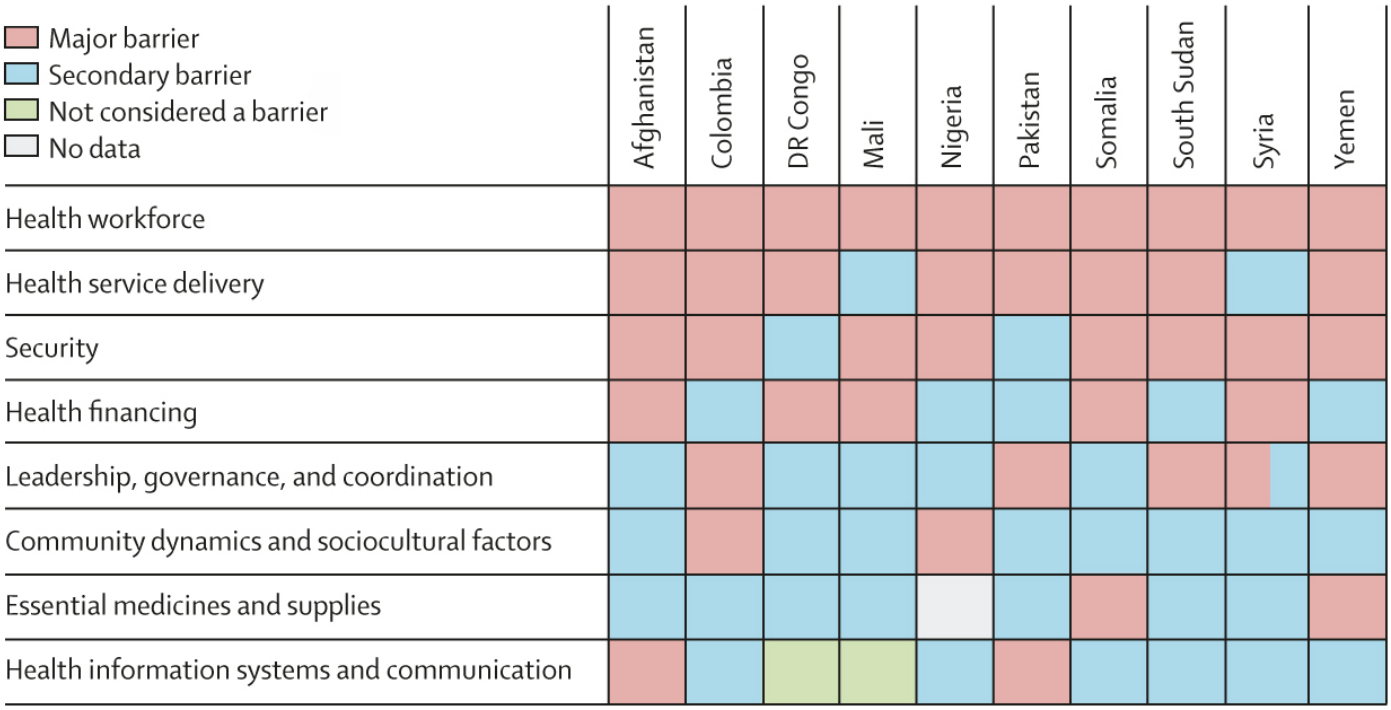
The BRANCH Consortium recognizes the crucial role that non-governmental organizations (NGOs), both international and local, play in the current humanitarian landscape when providing services for WCH, especially as these NGOs are often challenged by limited resources, insecurity, and other obstacles often at great personal risk.[2]

From the BRANCH Consortium's research across geographies and types of conflict settings – mainly in Afghanistan, Columbia, DRC, Mali, Nigeria, Pakistan, Somalia, South Sudan, Syria and Yemen – some consistency among the prioritization of key WCH interventions was found, despite variations in contexts and decision-making processes, such as: antenatal care, basic emergency obstetric and newborn care (BEmONC), comprehensive emergency obstetric and newborn care (CEmONC), immunization, treatment of common childhood illnesses, infant and young child feeding (IYCF), and malnutrition treatment and screening. On the other hand, those **services which were found to be largely absent across the various settings included: adolescent-focused health services, services around newborn health, and sexual and reproductive health services such as abortion and post-abortion care, contraception and family planning services, as well as maternal care services for stillbirths**.

The prioritization and provision of health and nutrition services is largely due to a number of barriers and facilitators that emerge in conflict settings, not to mention that donors tend to largely prioritize what is delivered, by whom and to where. To better structure the identified barriers and facilitators, a set of humanitarian system building blocks (an adaptation of the WHO health systems building blocks[3]) were developed, and findings around the barriers to health service delivery for WCH were classified according to the following domains:

- leadership, governance and coordination
- health financing
- health workforce
- health service delivery
- essential medicine and supplies
- health information systems and communication
- security
- community dynamics and sociocultural factors.[4]

Barriers to Implementing Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Interventions in Ten Country Case Study Settings[4]



This figure summarizes findings from key informants interviewed in each of the ten country case studies. With major and secondary barriers coinciding with the extent to which a wide range of stakeholders involved in WCH programming have reported each health and humanitarian system building block to be a hinderance to implementing WCH interventions in a given setting.

Social Determinants Affecting the Health of Women, Children and Adolescents

The effects of armed conflict on WCH is brought about by a combination of many risk factors, including the nature and exposure to conflict, the level of risks and vulnerabilities experienced by these populations, and the social determinants of health. These social determinants of health include the social and economic factors that affect the health risks and outcomes of people and communities and is mostly responsible for health inequities. While also present in all humanitarian settings, **those social determinants affecting health in conflict settings include lack of safe water and sanitation, poor quality housing, poor nutrition, and lack of timely access to quality health services**.

These social determinants influence the health, development, and quality of life particularly for children and newborns, since they deteriorate their basic human rights, pose threats to security, create a greater number and magnitude of traumatic events, and diminish their opportunity to formal education and play as a way of developing social and motor skills.

Conflict, and the associated trauma, can also often lead to women undertaking new social and economic roles and can, at times, leave them more vulnerable if they are isolated and exposed to violence and a lack of resources. **Conflict-affected women and adolescent girls are also more commonly exposed to sexual and gender-based violence including exploitation and rape, which is often used as a weapon of war.**[4]

What Can Work?

For each of the barriers identified when delivering WCH services in conflict settings, a number of lessons learned and possible solutions and recommendations have been generated through the research conducted in Afghanistan, Columbia, DRC, Mali, Nigeria, Pakistan, Somalia, South Sudan, Syria and Yemen, with comparisons made across each of these regions.[4-14]

Leadership, Governance and Coordination

Recommendations pertaining to leadership, governance, and coordination roles and strategies include the use of **multiple cooperation strategies** that can change over the course of a conflict with response coordination mechanisms at global, regional, and especially national levels, along with enhanced resources, and more data collection and research.

For example, the most notable facilitator to implementing interventions for infectious diseases and vaccines was coordinating a **multi-sectorial approach** by working with Ministries of Health (MoHs), prominent local leaders and community health workers (CHWs), and **integrating programmes at the community level** to ensure accurate and harmonised messaging. Reliable surveillance and population data in camp settings was also important in the roll-out of interventions.[15]

Additional strategies for cooperation and balancing of decision-making power between levels of humanitarian actors include **de-centralisation of operations** by partnering with and contracting local organisations and conducting a thorough **political analysis on the power balance** between the various actors.

Health Financing

Strategies to address funding shortfalls include **donors funding the total cost of providing services and interventions** to women, newborns, children and adolescents in conflict settings (both direct and indirect costs) and considering the use of **multi-year programs** to ensure consistent programming and **linkages with national health systems**. For continuity of services, funding could be sought from **different donors**, and donors could also consider giving **funding directly to the local organizations** providing services and/or providing **unmarked funds** to enable programmes to fill in gaps in service delivery.

Health Workforce

A weakened healthcare workforce and a lack of health workers during times of conflict is a large concern across the board. Strategies put in place aimed to increase the number of health workers include **increasing training programs** for health staff, **task shifting or task sharing, hiring other types of health workers** (e.g. community midwives, community health workers, traditional healers, traditional birth attendants), **expanding the catchment area** and populations for which health workers were responsible, and mainly **locally hiring** and ensuring local actors and health workers are well supported (e.g. via technical trainings to be able to deliver interventions effectively, not having gaps in salaries) and do not bear disproportionate risks within the response. **Ensuring training, fair compensation and support to female health workers is of particular importance**.

Health Service Delivery

Delivering health services to a wider population, in particular those in hard-to-reach areas, requires **innovation and mobilization of resources**, such as using **new modes of delivery** (e.g. remote management, technology such as WhatsApp or electronic clinical protocols) or **expanding the use of existing delivery methods** (such as mobile clinics, treatment posts, home visits). Other instances could include the **promotion of community-based services** to bring services closer to populations, implementing **integrated packages of services** to address an array of concerns that may be presented in one visit as opposed to multiple visits, as well as **shifting the balance of power (e.g. funding, decision-making) to local actors** who know the needs on the ground.

Where the use of internet is more viable, the use of **near real-time monitoring and reporting** is a possibility. For example, the adoption of e-Health technology by primary healthcare services in Syria strengthened the monitoring of patients accessing care, enabling follow-up and improving health care seeking behaviour around health issues such as non-communicable diseases.[4,13,16]

Essential Medicine and Supplies

The availability of medical supplies and surgical equipment, including those specific to treating children, was a commonly reported barrier affecting intervention delivery within trauma and injury specifically.[17] Procuring essential medicine and supplies to health facilities and clinics is an ongoing issue in the provision of most essential services, with suggested strategies including developing a more **strengthened and coordinated procurement process**, together with an **electronic logistic information system with real time tracking** and securing more funding for this aspect of programming and services.

Health Information Systems and Communication

Availability of health information for decision-making is crucial in the allocation of resources and prioritization of interventions and programs. The BRANCH Consortium calls for a more **"unified health information system"**, whereby **gaps in data are filled** and more **baseline surveys** are taken to compare against end-line data, and analysis on the improvement of health outcomes can be done.[2]

Use of **different types of information channels**, such as via telephone, to obtain information on which to base a response is needed, along with an **array of data collection methods** (quantitative and qualitative).[4,18]

Security

Addressing security concerns as it pertains to the health workforce and access to health services requires a range of strategies, including the **deployment of mobile clinics** and **remote management** to improve accessibility to certain geographic areas when no physical access was possible, **pre-positioning of stock and supplies**, developing **contingency plans** on reduced movement and the presence of health staff, generating patient **evacuation plans, (cross-) training personnel** about duties and rights of their medical mission, including **security plans** to reduce personal security risk, and relying on local partners to provide intelligence about security threats and deliver services.

Regarding the delivery of sexual and reproductive health services, for example, there was value in being prepared with contingency plans in the event that the changing security situation disrupted service delivery. Cross-training staff in different roles in the event there are any gaps in human resources or having emergency drug stocks were noted as examples of such contingency plans.[19]

Community Dynamics and Sociocultural Factors

The use of humanitarian assistance as a political tool can have resounding damaging effects on the community's perception of, and trust in, lifesaving WCH services.[1] Strategies to mitigate this include the **recruitment of local staff** and use of **social science methods in programmes to better understand community perceptions and expectations**, and shape how humanitarian interventions have been valued in countries.

In the case of mental health (as well as for water, sanitation and hygiene interventions[20]), **utilisation of local community members** was important when delivering these interventions as it allowed for increased access to and acceptability among target populations, along with the integration of services. For example, mental health services incorporated into school- based programmes created safe environments for affected youth.[21]

Conclusions and Next Steps

The dynamic nature of modern conflict and the expanding role of Non-State Armed groups in large geographic areas pose new challenges to delivering WCH services.[1] However, the humanitarian system is creative and has developed new solutions to bring lifesaving services closer to populations by hiring and training other types of health workers, often from the affected community, and by using new modes of delivery. **All solutions should include policies aimed at narrowing the gender gap between male and female health care workers** in terms of decision-making power, compensation and other forms of support. Successful humanitarian responses also factor in various key perspectives into service delivery such as the communities that are being served, ensuring safety and security of healthcare seekers, users and health workers, among others.[4] These solutions, when rigorously evaluated, can represent a concrete, timely response to current implementation challenges and remind health authorities of their responsibility to deliver basic health services to the whole population.

Understanding the humanitarian response from different perspectives is important to know more about how pieces work together, or do not, as well as to identify what gaps in response exist. However, this is impeded by poor availability and quality of coverage, access and utilisation data on health services for women, newborns, children and adolescents in conflict settings.[22]

More work needs to be done to understand the complex interplay of actors and players in conflict settings, however there are a several solutions that can already begin to be utilized to improve WCH service delivery in conflict settings. **The BRANCH Consortium recognizes and values the primary role that local actors bring to improve timely and appropriate WCH care delivery and encourages the utilization of this role to greatly improve response and mitigation measures.**

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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:

BRANCH Consortium Summary Brief 1
Women's and Children's Health in Conflict Settings: The Current Landscape of the Epidemiology and Burden

BRANCH Consortium Summary Brief 2
Women's and Children's Health in Conflict Settings: The Current Evidence and Guidance Landscape for Identifying and Implementing Priority Interventions

BRANCH Consortium Summary Brief 3
Women's and Children's Health in Conflict Settings: Prioritizing and Packaging Health Interventions - Deciding What to Deliver, When and How

BRANCH Consortium Summary Brief 4
Women's and Children's Health in Conflict Settings: Barriers and Facilitators to Delivering Effective Services

BRANCH Consortium Summary Brief 5
Women's and Children's Health in Conflict Settings: Key Messages and Next Steps

For more information about the barriers and facilitators to delivering effective WCH services in conflict settings, please refer to this paper from the Lancet Series on women's and children's health in conflict settings.